

# CPA: should it carry a government health warning?

## A personal experience

*P. E. Watson*

In common with other psychiatric units throughout the land, we have been struggling to come to terms with the Government directives regarding the Care Programme Approach. A great deal of time has been spent attempting to devise a system which is workable and useful but which might leave some time for face-to-face contact with patients; implementing it forces the psychiatrist into a catch-22 situation. If things are seriously wrong for a patient, the psychiatrist could be criticised for not putting somebody on CPA, or criticised for putting them on it but not carrying the process through thoroughly enough. In spite of this, I have participated in the scheme, if only because the consensus would seem to be that it is necessary to have the system in place, mainly as a defensive measure or in the hope of ensuring adequate resources. My overwhelming feeling, however, has been that it has been a time-consuming way of formalising good practice, and that the time spent filling in the forms would be better spent talking to the patients. I have always felt uncomfortable listing needs and solutions with the patient and 'the team', because it seemed reductionist, but I thought that this was my idiosyncratic response, and that I should get on with it. Recently, however, there was a near disaster with a patient which served to strengthen my reservations.

B, who has given her account of events below, is a 30-year-old single woman with a long history of contact with the psychiatric services. She had a very good academic record at school and went to university to study Engineering. While at university she had the first breakdown and had to withdraw from her course. Years of treatment for unrelenting symptoms of depression followed, and there were frequent overdoses. She had numerous and prolonged periods in hospital and at times had to be nursed on a disturbed ward. She was regressed and withdrawn, and unresponsive to a wide variety of medication and electroconvulsive therapy. She had a prolonged period of out-patient psychotherapy; although this enabled her to live with her parents rather

than in hospital, she remained depressed, intermittently despairing and hopeless, and constantly thinking of suicide as a way out.

It was at this time, ten years ago, that I first met her. She was very much a perfectionist, with impossibly high expectations of herself and with a vicious conscience, which resulted in excessive self-blame and guilt when she did not live up to her own expectations. She found change of any kind very disturbing and she inhabited a black and white world where she hoped people would be perfect. When someone failed to live up to this hope, she had great difficulty in dealing with the massive anger which resulted. She would then be unable to accept any help from this now denigrated person and she would feel abandoned, angry, despairing and suicidal.

She was referred to a specialist hospital for 18 months in-patient psychotherapy. She has always said that she cannot remember what happened in the therapy there, but on her return she was able to live independently and hold down a part-time job. Her previously intense anger towards her mother appeared marginally less overwhelming and she was able to accept some help from her. It was thought by the therapist at the hospital that she might need ongoing support, so that somebody could acknowledge how difficult life would be for her. I did not see her for 18 months after her discharge, but she began to have difficulty in continuing to work and was referred back to me by her general practitioner.

Since then I have seen her for supportive psychotherapy over the past 6–8 years, initially fortnightly, but subsequently (when it became clear that she would require long-term support) on a monthly basis. She has not been able to manage a paid job over recent years but has done voluntary work, taught literacy classes, worked for voluntary mental health organisations and on local mental health committees as a 'user'.

Her most recent admission to hospital was arranged because she was in a state of exhaustion and despair, having contemplated suicide.

Once in hospital there was no evidence that she had a biological depression and she was warm and interactive with patients. We agreed that she would have a period of rest and then resume her usual daily activities from the ward prior to discharge. This was agreed and she appeared confident with the plan.

One week before discharge, her primary worker at the day hospital let her know that he would be leaving in three months time. She was upset about this, but was able to express her feelings about it and felt that she could cope with it as she had with many other changes of carers. Two days later we agreed to meet with her CPN to formalise her care plan under the CPA. She had not previously registered on CPA, but the policy was that we would now register people whose treatment involved several professionals when they left the hospital. Unknown to me, B had inquired of her CPN two weeks before whether she would be registered on CPA. She was well aware of the procedure through her work on mental health groups and committees.

At the meeting, B said very little, but she knew the meaning of the CPA and contributed to the writing of the care plan. This involved seeing me and her CPN regularly for support, for monitoring her mental state, and for medication. She agreed that she needed help in keeping social contacts, structuring her time, and establishing routines by attending the day hospital and the day centre. It felt to me like an artificial process and a very reductionist way of listing B's 'needs'.

The following day she went to the day centre, and while there she decided to go home and kill herself. She attempted suicide by a violent method which she had never previously used, and had a very lucky escape. She had been too disturbed to think or talk about her feelings, and had reverted to the acting-out behaviour typical of many years previously. She returned to the ward complaining that even this attempt had failed, so she had no option but to proceed with her life.

We attempted to understand what had happened to stir up this murderous rage which she had turned upon herself. She said that she did not know why – “if I were a good patient I'd say it was about T [her primary worker] leaving, or because I was to be discharged”. These factors had previously been discussed with the nursing staff. Discussing them again, however, did not evoke any distress, or any sense that they were at the root of things. I then said that I had felt uncomfortable at the CPA meeting and I wondered how she felt. This opened the flood-gates, and she sobbed and described how it made her feel: mainly that her 'needs' were for love, for closeness, and for something to fill up the sense of emptiness, not the list we had written on the page.

Here is her account:

It is like it is all so simple on the form – that these things will make it all go away. It doesn't.

I'm not a *thing* to be processed  
The information it contains can be so meaningless  
It ignores the intangible things  
(like the reason why one day centre can help and a different one wouldn't and do different things for different people – getting out, providing structure, not being alone, facilities, meal)  
or things like I want a hug  
or I want someone to care.

One of my problems is that I want someone to take it all away/do something to make it better. I've tried to come to terms with the fact.

Meaningless: it ignores things like trust and understanding which take years and the right person to build up. It makes things change and fit into a mould. Set pattern of approach so it suddenly changes how you look at things.

Meaningless: trivialises the effect my problems have on my life – they may not look much on paper  
It's a mockery, I felt like I was being laughed at.

It devalues everybody involved – patient and professional.

Diagnostic labels aren't fashionable but I can be put into a level/category.

B has had a prolonged struggle, and still has difficulty in relating closely to people in a way which would enable her to find meaning and fulfilment in her life. Suicide has been an option which she has always held in reserve for a time when the struggle might become unbearable. But there have been very gradual signs of growth and change. The impending change of her primary worker was an obvious factor in how she felt on the day of the suicide attempt. It is also likely that his leaving would stir up fears about how long it would be before I retired. A further factor was that when we held the meeting, having asked her CPN about the CPA, she had a sense that we were going through the process to humour her, and were mocking her.

The last straw which triggered her behaviour, however, seems to have been the meeting itself, which she describes very clearly. She felt reduced to a thing, not a person, and she felt that her needs were reduced to trivia. A need for closeness and holding do not easily fit into the CPA form.

A common feeling in a CPA meeting is of having to get the form completed and of thinking in terms of problems and solutions, rather than of interacting with the patient. On this occasion I did not pick up the degree of distress which the patient was feeling, in spite of knowing her very

well indeed. This can be difficult enough when seeing somebody in a team meeting, but it is made more difficult when completing the necessary tasks for the CPA.

This was an aversive experience which has made me think twice (or five or six times) about what we are doing. The CPA may be here to stay, and in that case I believe it is important to be flexible about the form which the meetings take,

who attends them, who completes the requisite forms, where they are completed, and whether copies are circulated to patients. Space for accurate empathy with the patient, which is after all our most powerful therapeutic tool, must be carefully preserved.

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