Reclaiming the care programme approach

David Kingdon

Eight years on, the care programme approach (CPA) remains controversial. The principle of providing coordinated community care as defined by the CPA, a safety net of care, is accepted, but its application continues to divide services rather than uniting them. Psychiatrists and other mental health staff complain of two specific problems. First, excessive paperwork and second, being made responsible for the actions of patients over whom they have, at best, limited influence (Kendell & Pearce, 1997).

The bureaucracy that has developed in some trusts, ostensibly because of the CPA, is overwhelming. Why has a clinical system been subverted to such an extent? The only additional information required by the CPA is the name of the keyworker and whether the patient is 'severely mentally ill'; the most practical definition of which is "requires multi-disciplinary review" (Nottingham Healthcare Trust's Care Programme Approach policy, 1998, available from the author upon request). A good psychiatric history has always included 'health and social care assessment' (although the CPA was introduced partly because the social element was sometimes being overlooked). A formulation should contain a 'care plan'. Working cooperatively with other professionals and regular review of patients is nothing new – just good clinical practice.

However, information about service use has been poor for many years and was worsened by the demise of the Mental Health Enquiry in 1986 and the case registers subsequently. Körner returns have never fully replaced case registers, and certainly not bettered them as intended. The CPA has been used as an excuse to make clinical staff provide data, which, in many instances, should be a clerical function. But clerical staff have been reduced, or not introduced, because of ill-considered policies on administration in the health service. Some services have even developed parallel systems collecting demographic and other data through patient administration systems and identical information 'for CPA'. Computer systems should have helped but, as yet, have rarely done so, failing to produce useful or reliable information for clinicians or anyone else. Other requirements have been latched on to the CPA (needs assessment procedures, risk assessment protocols, Health of the Nation Outcome Scales), which are not intrinsically part of the CPA. They may be appropriate in their own right but need separate consideration and training. Bulky CPA policies which aim to achieve too much without getting fundamentals right, confuse and overwhelm staff.

The CPA does mean that coordinating care for individual patients is the responsibility of named individuals, keyworkers, and no longer just the responsible medical officer. But this does not mean that all risk involving the patient can be predicted, let alone prevented. Guidance from the Department of Health (1994) has subsequently specified that "assessment of risk is, at best, an inexact science". However, a process which defines good practice can be protective, provided that the guidelines produced are clinically appropriate and effective (Tyrer *et al*, 1995). There is protection in obtaining the support of a multi-disciplinary group who document decisions and a coordinated plan of action where significant risks exist (e.g. with dual diagnosis or borderline personality disordered patients).

Clinicians need to reclaim the CPA as good clinical practice, shorn of the other elements that have impeded its implementation. The CPA provides a framework for systematically implementing such good practice but it is not a panacea for the ills of mental health services. CPA can highlight areas of unmet needs and resource inadequacies but cannot be expected, alone, to remedy them all.

References

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David Kingdon, *Medical Director, Nottingham Healthcare NHS Trust, Duncan MacMillan House, Porchester Road, Nottingham NG3 6AA*