

The Care Programme Approach: comment on 'Time for frank talking'

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After seven years of circulars, monitoring, conferences and discussion, frank talking about the CPA may still be welcome, but proposals to CPA coordinators and members of community mental health teams (CMHTs) to revise the procedures implemented by trusts are less likely to be. The previous paper (Burns & Leibowitz) identified a number of difficulties that have accompanied the implementation of the Care Programme Approach, particularly confusion related to care and case management. The CPA was introduced in response to the Spokes Inquiry (Spokes, 1988) as a therapeutic strategy to ensure that a coordinated safety-net of care for people with severe mental illness (SMI) was put in place in every district. Identification of those with SMI means that the approach includes all those accepted by mental health services; those with SMI need a coordinated multidisciplinary response. The CPA Audit Tool developed by the College Research Unit for the National Health Service Executive (NHSE) and disseminated to all districts in 1995/96 may be valuable in reassessing CPA implementation.

US case-management experience is difficult to interpret in the UK where primary care and sectorisation are much more strongly developed. Burns & Leibowitz suggest that the brokerage model appears to have been adopted by UK social services departments in mental health settings, but this is at least debatable. There have been some notably disastrous attempts at the use of such a model, as described in the *Lancet* editorial cited, but few social services departments (at least outside London) have followed, with most being much more sensible. The original *Care Assessment and Management Guidance: Manager's Guide* (Department of Health Social Services Inspectorate, 1992) stressed the necessity to be flexible in differentiating between purchasing and providing in mental health settings. Although there might be some advantage in separating the functions, it would often be appropriate for the same individual to assess need and provide some of the required services.

North Battersea CMHT are making a brave attempt to implement the CPA in their own

service, but in so doing may confuse others as the concept, if not the practice, of using a tiered approach to implementation for all patients accepted is now well established in most services. The definition of tiers varies, but a simple example would be the use of three tiers: level 3 – those on the supervision register; level 2 – those who are regularly reviewed by a multidisciplinary group; level 1 – those receiving care from one or two mental health professionals. Developing arbitrary and inevitably idiosyncratic definitions such as "less than three months or eight contacts" for "eligibility for the CPA", rather than all patients accepted by a mental health service, has proved difficult to apply when tried in some areas. Where it is developed and agreed by the group using the definition, as here, it may work for their service. 'Minimal CPA' is a clumsy term, but was introduced to counteract the tendency by some managers to impose multidisciplinary review on all patients; it simply refers to the screening process necessary whereby a key worker identifies if, or when, a patient is becoming severely mentally ill and requires a multidisciplinary response. Suggesting a routine review interval for patients of six months fails to allow for the flexibility needed in clinical practice – some patients need more, some less. Similarly, many patients value attending their multidisciplinary review, while others do not – shouldn't the choice be theirs? If the review is confined to those involved with their care (and students/trainees with their consent), it is less intimidating and more cost-effective.

Finally, the review of the current literature relevant to the CPA cites Tyrer *et al* (1995) as not encouraging – possibly they say this because time in hospital increases with introduction of the CPA. However, contact with patients increases substantially which is perhaps more pertinent and important for the longer term. As this study was of the implementation of the CPA, attempts to find appropriate social placements for 'revolving door' patients would be expected to increase admission periods. Other qualitative reviews of the introduction of the CPA (e.g. Social

& Community Planning Research, 1993; Boughton & Duvall, 1994; McCarthy *et al*, 1995; Schneider *et al*, 1993) have provided a balanced commentary on implementation in a wide variety of districts and settings. It may be hard to believe that a government policy was intended to be clinically sensible and simply disseminate good practice in health and social care assessment, care planning, and collaboration between users, carers and professionals, but there is at least some evidence that this was the case.

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