

Care Programme Approach: first you have to prove you are ill

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The Care Programme Approach (CPA) was introduced in England in 1993 to co-ordinate the care of patients with mental health disorders.¹ Its aim was to ensure that there was a full assessment of the patient's needs, that a care co-ordinator would see that the care was delivered, regular checks would be carried out to review progress, there would be collaboration between health and social services, and that patients (or the term used to 'demedicalise' them in psychosocial Newspeak² namely, 'service users') and carers (they also use the service) would have a greater say in the written management plan. Targets were set.

What has happened since? Prior to this I recall that most psychiatrists carried out full assessment needs, regular checks reviewed progress (outpatients), social services were involved when necessary, and patients and their families were nearly always involved in the discussion of after-care, when appropriate. Despite the condescending manner in which patients and carers were treated by the hierarchy, i.e. they would not understand the difference between social services management and other after-care, it was always quite clear to doctors that patients had no difficulty with the concepts of medical intervention (investigations, diagnosis, treatment), psychological therapies, and social help (housing, work, family, finances).

Rather than simplifying the process we now have two tiers of CPA, namely, standard and enhanced. Where the patient has 'complex needs' or is a 'complicated case' then you are in the enhanced bracket. For the rest – back to the General Practitioner (GP)! Not enough resources apparently. Not ill enough more likely. Remember – you have to have a severe and enduring mental health disorder – nothing else counts. Nowadays the GP is expected to be a specialist in mental health and run a risk assessment on every 'psychiatric' patient. The GP is frowned upon by the 'experts in living' should he/she for example, dare refer a mild or moderately (yes - those descriptions again!) ill patient to the Mental Health Services. Because there is no bottomless pit of money, the scenario was changed in 2008 so that those receiving only standard CPA were no longer entitled to it. However, not to appear callous and indifferent to the plight of those suffering from 'less severe' mental health problems, the usual lip service was paid to patients, assuring them that they should be respected and

supported, and that their carers be also recognised as having 'needs'. All the buzz words were put in place again – integrated care pathways, working together, reviews about the reviews, good practice, better training, and so forth. Now there is the Supervised Community Treatment Order, (whether you like it or not) and those subject to the new 'order' will be entitled to the 'new' CPA. Wonderful in theory.

So what happens to a patient who is not on CPA? We are informed that such patients should still be open to secondary mental health services, should continue to receive clinical support, that reviews should take place regularly, and a social assessment should be available under the new guidance to local authorities FACS (Fair Access to Care Services), readily available on the Internet. The truth of the matter is that only those patients on enhanced CPA will receive immediate support, the rest will have to jump through the usual hurdles to prove they have a severe, enduring mental illness (enduring is not enough) in order to gain access to NHS 'support' facilities. Some patients are seen as more deserving than others, for example, those admitted to hospital under the Mental Health Act (voluntary admission may count against you), current or potential risk (theoretically, any patient with a mental health disorder, which seems to defeat the purpose of the exercise) or the presence of a dual diagnosis (depression with alcoholism, or is it the other way round?). Anyway, if in doubt, the patient is entitled to a formal reassessment CPA and may be admitted to the 'new' CPA list. If all fails, the patient (remember, one with severe, enduring mental health symptoms) may make a complaint to the local authority or even hire a lawyer.

What is the true state of affairs? To begin with, many patients have enduring mental health problems which are not severe, are not life-threatening, and despite the hardship and drudgery endured, manage to trundle through work, relationships, and family life. Years of talking therapies or psychotropic medication, indeed both, may have only taken the edge off their symptoms. Often symptoms resurge and require alterations or adjustments in medication; sometimes a different psychological approach needs to be considered. Such patients are best left to the fountain of all wisdom, the GP, so it seems. Rather akin to telling the GP to treat for example, a 'minor' cardiac problem (say, palpitations) because the 'specialist unit' only deals with

severe arrhythmias, severe pain, severe disability, 'severe everything'. It is unfair to expect GPs to make informed decisions concerning psychotropic medication (no more than they should about adjusting chemotherapy drugs) and most would be familiar only with specific therapies such as Cognitive Behavioural Therapy (CBT) or Anger Management, where appropriate. The type of patients described here comprise the majority of those seen in outpatients, yet there is now a growing trend to discharge such patients back to the GP, because he/she is not 'care co-ordinated' on enhanced CPA. The burden is on the GP. It does not seem to have registered with politicians or management (doctors included) that chronic schizophrenia is not the same as chronic gastro-oesophageal reflux.

The trend now is for the setting up of Community Clinics (the patient does not necessarily get to see a doctor) where 'all the other psychiatric problems' are dealt with. The traditional psychiatric outpatient department is to be abolished, unless of course, GPs do something about this torrid state of affairs now. It could only happen in Psychiatry which seems to me a specialty doomed to oblivion. Family doctors are becoming increasingly irritated by a system or discipline (Psychiatry especially) which seems to ignore their concerns and is more preoccupied with targets (nothing has changed) and outcomes (back to the GP). Even referrals from GPs, who want a medical opinion, are filtered in order to weed out those not worthy to enter the hallowed walls of the Mental Health Institution. Those patients who 'know the system' or who are vociferous and make complaints ('I know my rights') get to be seen by the Great and Good. Lesser mortals, usually those with serious mental illnesses, do not make any undue demands and are

therefore often forgotten or fall by the wayside. A patient with bipolar disorder on lithium is discharged back to a GP who is unsure whether or not the medication needs 'fine tuning' at times, should be discontinued, or reinstated were compliance is a problem in one heading for a relapse. As a corollary of that, I am sure most hospital doctors would not know what the acronym ABVD means in the chemotherapy treatment of Hodgkin's disease. Adjusting psychotropic medication is not quite the same as adjusting an antihypertension regime. Unfortunately, if the patient needs to be referred back into the system the whole Kafkaesque scenario begins again.

A medical colleague once bemoaned to me that psychiatrists are totally out of touch with Medicine. Alas, it seems they are also now out of touch with their medical colleagues.

Competing Interests

None declared

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