Care programming and service change in a psychiatric sector

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The effects of service expansion and change (including joint working with social services) following the provision of a community mental health centre and the introduction of care management were examined by auditing service activity. Data were collected on service provision to 20 randomly selected patients who met the local criteria for care management, and also on the general level of service activity as judged by service contacts for all disciplines. Compared to the baseline period, face to face contact with care-managed patients increased six-fold. There were more home contacts, a wider range of professional contacts occurred, and a greater variety of types of treatment provided. A substantial (though not statistically significant) reduction in day hospital attendance was seen over the period studied. The number of service contacts for non-care-managed patients also rose. The introduction of care management was simplified by changes in service organisation. Increased resources were needed to both implement care management and provide an adequate service to the remainder of patients. Both aspects of the service functioned efficiently in parallel.

The health service strategy to systematise and unify the planning and delivery of care to all those with mental illness seen by clinicians (The Care Programme Approach, *Caring for People*, Department of Health, 1990) has been developed from, and includes as one aspect, the idea of applying targeted coordination of care to those with more severe illness (Onyett, 1992).

These policies are the latest in a long series of attempts to bolster care in the community (Bennett, 1991). These are related to closure of, and reduced provision of, in-patient psychiatric beds, and the general impetus, the 'drive to the community' (Bennett, 1991), of social psychiatry (Onyett, 1992). Against this background, the service changes that are described and evaluated in the present study took place.

These developments were:

(a) The opening of a community mental health centre (CMHC).
(b) The provision of 'acute' services for self-referrals and urgent referrals from general practitioners (GPs) in the CMHC.
(c) The commencement of 'care management'.
(d) The institution of specialised types of community care (with the emphasis on carers and home-based where possible) for those with long-term mental health problems.
(e) The beginning of 'joint service' work involving both health and social services.

The most telling factor in provoking service change was the decision to provide funding for the CMHC, and the staff to work in it. That decision was made when it was seen that the imminent closure of the large district mental hospital, St Augustine's (near Canterbury), could be used to provide capital for services in some of the distant communities (in this case, the Island of Sheppey) which it served.

Although the shape of the service was to a large extent determined purely by the physical reality of the CMHC, the service provided from it was planned with the primary aim of providing better services for those most in need of them.

There were a number of pragmatic considerations. Although the policies in *Caring for People* (Department of Health, 1990) were meant to address the problems of providing a service for the more severely ill, in essence, they only described a protocol for more systematic monitoring of long-term care. However, there seemed to be no reason why such procedures in themselves would increase actual care provision.

Those with severe long-term mental illness, particularly schizophrenia, were known to be both considerably distressed by their ongoing acute symptoms (Melzer *et al*, 1991) and have very inadequate ranges of service provided for them (Salokangos *et al*, 1991). However, models of the type of service to provide for this level of problems among its client group were well described from an empirical standpoint (Isaacs & Bebbington, 1991, Onyett, 1992), both as regards acute interventions and long-term continuing care.

It seemed pointless to assess needs *en masse* when no hope of meeting them was there. For this reason, those involved in care management opted to use it as the basis for providing an

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increased range of services, with an increased level of face to face contact, and with as many contacts as possible involving the family.

Those not acquainted with the issues of continuing care, case management, family counselling and interventions, home-based treatments and outreach took it upon themselves to gain the skills necessary.

The question of joint service working was approached from a purely practical standpoint, it was likely to benefit those (and their families) who were at present underserved.

However, the health services had to provide a generally available service for those who were already on case-loads and new contacts. Most of the resources (community mental health nurses (CMHNs), in particular) were at this time being devoted to such a service, the demand being GP led. This demand would undoubtedly continue. The provision of the CMHC might in fact increase this demand purely because of the increased availability and visibility of the service. We were aware that these factors could compromise the care of those with more severe illness (Sayce *et al*, 1991).

It appeared that the interests of both groups of patients could be best served by differentiating the service into two more specialised separate components. The main thrust of staff deployment and activity would be toward the more severely ill. This would centre around those who were to be care managed, but in order to emphasise the active and intervention-oriented aspects, the group involved with this work would be called the 'care management/rehabilitation' team. These staff would work side-by-side with social services.

This side of the team would concentrate on services for long-term and severe mental illness. A named keyworker, or their deputy, would be always available during normal working hours (the CMHC switchboard was manned 09.00–17.00) for patients or relatives, or other professionals. When necessary, a 'rapid response' to the home would be made.

A separate team-within-a-team, the 'acute' team, would provide a service to those who did not necessarily require longer-term involvement, and staff a rota to provide a walk-in, self-referral service (or at the urgent request of a GP), who could see the patient there and then if this was appropriate, or if the degree of urgency was less, see as a normal appointment. This side of the service would also deal with non-urgent, 'routine', referrals. After an initial assessment, appropriate treatments would be offered.

The long-term had input from two CMHNs, though one doubled as coordinator, and both social workers and the community occupational therapist were the other permanent staff. The psychologist worked mainly with the 'acute' team, and this team had one full-time CMHN (who was also an experienced counsellor). The medical staff worked equally with both, as did the clerical and administrative staff. The duty rota was manned by all health service staff.

It would also be the task of the whole team to focus on 'care programming', initially for those being discharged from hospital, and ultimately for the generality of service contacts.

Service changes were not limited to the actual health care workers. At the time that the CMHC was opened, a day centre, providing informal leisure and social activities, moved next door. This had a membership, at this time, of 50, which had increased to 80 by the end of the period of the evaluation.

A fundamental change in social services working practices had been caused by the introduction of care management. Concentrating resources on this meant that no work would be undertaken (at least, on a routine basis) with patients who did not meet the criteria for care management implementation.

The study

The present study aims to describe and evaluate the most important aspects of the functioning of a service manipulated to facilitate better working practices with the long-term mentally ill while maintaining a general 'acute' service. The outcome measures were chosen as being those best quantifiable from available data.

The report is based on service details obtained from the case notes and computer records of a random sample of 20 patients at present being care managed, and comparing these on three, six-month periods: June–December 1992 (baseline), 1993 (intermediate, when the CMHC was operating, and staff relocated there), and 1994, when the CMHC, and care management, were fully operative.

The impact of the service changes, based on the number of patient contacts, on the level of

Table 1. Patient demographic and diagnostic characteristics

	Men	Women	Overall
Age	33.7	49.9	44.2
Number of admissions	3.2	2.3	2.6
Length of illness (years)	12.2	13.6	13.1
Diagnosis (*n*)			
Schizophrenia	5	4	9
Manic-depressive	–	1	1
Schizoaffective	1	3	4
Recurrent depression	–	4	4
Other	1	1	2

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Table 2. Changes in personnel and organisation of team[1]

Team members[2]	Site	Functioning
1992		
Consultant, 2 CMHNs	Day hospital	Hospital-based
1994		
Consultant, staff grade psychiatrist, 0.5 coordinator, 2.5 CMHNs, psychologist, occupational therapist	Community mental health centre	Community and home-based Two overlapping teams: care management (long-term) acute services (short-term)

1. 1993 was a transitional period – recruitment, redeployment and team reorganisation.
2. Health services staff only.

activity of the 'acute' services is discussed. The details of patient contacts with health services at the CMHC are entered and held on a computerised mental health information system, 'Mental Health Connection II'.

As this system was not used by social services during the period of the evaluation, details of their activities (though substantial) cannot be provided. No figures for voluntary services activities are available.

Findings

The demographics and diagnostics details of the cohort are shown in Table 1, and the relevant team structure changes are shown in Table 2.

Routine care (Table 3)

Average routine psychiatric out-patient contact levels have not changed, but the number of those seeing someone other than just the doctor alone (in this example CMHN) has risen to 17/20 from 10/20. The other three patients were care managed by other disciplines. All patients had at least two points of contact with the service.

The number of patients on medication has gone up, possibly due to increased awareness of symptoms or increased compliance. The level of communication with GPs has doubled (without counting invitations to reviews, individual service plans, or correspondence from social services). However, no GP actually attended a review. Within service documented communication has increased five-fold.

Urgent, emergency and hospital care (Table 4)

Urgent calls and urgent out-patient department appointments have declined. Urgent out-patient department appointments fell from nine and 10 in Period 1 and 2, respectively, to zero in Period 3. Emergency domiciliary visits, overdoses and casualty assessments have not changed, though the numbers are small. There has been a reduction in the numbers of admissions to the day hospital. Mean weeks of day hospital attendance (with 95% confidence intervals) for the three periods were: Period 1, 6.9 (3.1–10.7); Period 2, 2.2 (−1.4 to 5.8), Period 3, 3.1 (0.1–6.1). In-patient weeks dropped by about 25%.

Care management-related contacts and activity (Tables 5 & 6)

These tables show the ranges of treatments, services and activities being provided in the final period. These are specific treatments (behavioural, psychotherapeutic and family counselling), as well as non-specific (supportive counselling).

The average number of health service staff contacts (this includes all disciplines) has increased from a baseline figure of 11.5 per patient (though only half saw anyone other than the doctor) to 29, over the relevant periods. One patient only did not have a review, or an ISP update, in the six months studied. However, this person had the highest overall time in contact

Table 3. Routine care

	Period		
	1	2	3
Psychiatric out-patient department	105 (17/20)	91 (16/20)	105 (17/20)
Number of CMHN contacts	113 (10/20)	120 (10/20)	232 (17/20)
Medication reviews	28 (16/17)	34 (16/17)	28 (14/19)
Number on medication	17/20	17/20	19/20
Letters to GP	36 (17/20)	57 (17/20)	73 (17/20)
Other correspondence	8 (6/20)	15 (10/20)	41 (11/20)

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Table 4. Urgent, emergency and hospital care

	Period		
	1	2	3
Domiciliary visits	1	5	2
Urgent calls	11	9	4
Overdoses	1	1	2
Casualty	2	2	1
In-patient weeks			
weeks	31	24	23
n	5	5	3
Day hospital			
weeks	140	38	62
n	11	5	5

with the service. This statistic itself clearly makes review relevant.

Community occupational therapist CMHN activity in the team

The tables of care management generated contacts and activities relate mainly to the community occupational therapist and CMHN (they also include psychology contacts). Both occupational therapist and CMHN functioned as care managers (three patients by community occupational therapist, eight by CMHN), otherwise occupational therapist involvement was decided by the necessity of specific occupational therapist skills (assessment, activities, occupation, etc). These two staff undertook group activities

Table 5. Care management generated contacts

	n
Treatments	
Behavioural	3
Psychologist	3
Family counselling	5
Family support	4
Family therapy	1
Symptom-directed counselling	7
Supportive counselling	5
Working to individual service plan	5
Non-specific support	5
Services	
Discussion of individual service plan	5
Finance/benefits	4
Housing	6
Community carer	8
Other (e.g. new placement)	5
Activities/groups	
Relaxation	6
Confidence building group	4
Work-related	5
Hobbies group	5
Women's support	1
Other (i.e. social)	3
Young persons group	3

Table 6. Care management-related activity (June–December 1994)

	Total	Mean	Range
Number of contacts	555	29	4–77
Time in contact (hours)	464.5	24.5	2.5–82
Home contacts (16/20)	108	6.7	1–32
Time in contact (home), hours	94	5.9	0.25–31
Family treatments in home (6/20), hours	26.5	4.4	1–5

(e.g. anxiety management), often jointly, and also family work (education, counselling and therapy).

Social services activities

There were many similarities between the activities of care managers from both services, in the areas of assessing general needs, discussing benefits, proving support, discuss housing issues and encouraging socialisation. However, the policy was to allocate a care manager to patients with specific therapeutic needs who had some relevant clinical skills, for instance, in family therapy. Although social workers might participate in running various groups, the primary responsibility for example the hobbies group was with the occupational therapist. Social workers did engage in counselling regarding the impact of symptoms on patients' lives but the team clinical psychologist and the continuing

Table 7. Team activity around the period of the evaluation

	CMHN	Psychiatrist	All staff
1993 consultations			
May	58	75	146
June	85	77	160
July	77	101	220
August	73	57	166
September	62	103	188
October	77	95	218
November	108	94	315
December	86	70	236
1994 consultations			
January	95	102	309
February	110	102	329
March	130	123	439
April	108	87	334
May	98	89	352
June[1]	129	78	361
July[1]	120	145	432
August[1]	146	84	353
September[1]	149	119	n/a
October[1]	123	132	346
November[1]	165	128	489
December[1]	264	82	363

1. Evaluation period.

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care psychologist conducted specific psychological interventions.

'Acute' v. 'long-term': overall community team activity (Table 7)

There was a gradual rise in overall community team activity from the opening of the CMHC in May 1993, and the total number of team consultations (see Table 7) roughly doubled in this period. The total number of consultations by the CMHNs doubled also, though these figures include care management-related activities.

In the year prior to the opening of the CMHC, about seven new patients a month were seen in the out-patient department by the psychiatrists. Immediately following the opening of the CMHC (second half of 1993) the numbers of new patients seen rose to 20 per month, though they then fell.

However, compared to the first six months of 1992 (4.5 new patients per month seen) the overall activity by the psychiatric services in 1994 had doubled, seeing an average of 10 new consultations a month throughout 1994. The comparable figures for out-patient follow-up consultations was 54 per month (first six months of 1992) and 100 per month (all 1994).

The CMHNs had been able to make an increase in the number of new assessments undertaken from 14 per month in the second half of 1993 (prior to their team restructuring, and an increase of staff from 2 to 2.5 whole time equivalents) to 24 per month in the second half of 1994.

The service output has increased by >100% for all activities (all CMHN contacts) and >50% as regards acute assessments.

Face to face contact with the service

During the baseline period, any patient was seen (on average) six times by the psychiatrist and, if they were seen by the CMHN, an additional 12 times. This would have been roughly 15 minutes for each contact, that is, an average of 4.5 hours for those seen by the doctor alone, in face to face contact. The average time in contact with the services has increased to 24.5 hours each. A large proportion of this activity is home based and/or family oriented.

Comment

In the old style service, whether a patient with severe long-term illness saw anyone other than the doctor was determined by whether they were receiving medication by long-acting injection or not. This meant that virtually no patient with a diagnosis other than schizophrenia ever saw any other health service professional than the doctor, except in a crisis situation.

Contact with patients' families was by and large restricted to that possible during consultations, and counselling of patients and their families was likewise limited. This can be contrasted with the range of treatments, services and activities now provided for this group of patients across all diagnostic categories (half the patients described have diagnoses other than schizophrenia). This is still not a vast level of input (clearly much less than would be provided by a day hospital), but it is a four-fold increase on the part of the health services.

How well services are matched to needs, and what level of overprovision or wastage is occurring, is of course relevant. On the other hand, there are still many service gaps, and we are still not able to state categorically that quality of life has improved.

The service changes have been quite complex. There is no doubt that no major changes in team structure are necessary solely in order to implement care management (Kingdon, 1994). However, the question remains as to whether the assessment and review processes of care management can ensure more effective care delivery, if they cannot provide any worthwhile change in the amount or quality of care provided.

The type of service attempted by us is not as intensive as "assertive community treatment – an interdisciplinary team-oriented approach (which) provides field-based, individualized, direct treatment and rehabilitation services to a limited set of patients" (Santos *et al*, 1995), nor was it an attempt to provide a substitute for hospital care such as the Daily Living Programme (Muijen *et al*, 1992). The value of these kind of 'assertive outreach' programmes for the highly vulnerable is clear, but the effects, or effectiveness, of community care in other guises, or current policies to implement it, are not so clear (Marshall, 1996).

Although there may be some debate as to whether a service such as ours, with less restrictive criteria for response, may be wasteful of the skills of those trained in mental health care (Gournay & Brooking, 1994) in practice, the psychiatric service must be able to serve the needs of those across the spectrum of mental illness. We would argue that the balance has at least been shifted in the right direction.

On the other hand, the introduction of care management has led to a contraction of social services' role in mental health care, in that they can no longer cater for patients with less severe illness. Many of these patients would benefit from 'traditional' social work input and contact. Some of these cases are probably being dealt with, by default, by services such as our 'acute' service.

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Writing letters to patients

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Recent changes in the law and mental health policy have forced psychiatrists and other mental health professionals to review the traditional cloak of secrecy that surrounds record keeping and letter writing. This paper establishes what proportion of patients attending a psychiatric out-patient clinic are interested in receiving letters from their psychiatrist. Those who are interested tend to be better educated, whereas those who are not interested are much more likely to have an ICD-10 diagnosis of schizophrenia. Overall, there appear to be high levels of satisfaction with the nature of the letters received. The significance of these findings is discussed in relation to the difficulty of engaging people with the most severe and enduring forms of mental health problems as active participants in the process of care.

A recent Government paper (Department of Health, 1996) emphasises the importance of patient involvement in decision-making processes about treatment. Everyone agrees that psychiatric patients should be given the information necessary to understand and participate in their treatment, but there is no consensus as to the best way of achieving this. A Court of Appeal ruling in 1994 made it clear that while patients have a *prima facie* right of access to their clinical notes under the 1991 Access to Health Records Act, this may be denied under certain circumstances (Brahams, 1994). The 1991 Act triggered a flurry of papers examining the ethics of patient access (McLaren, 1991; Weil, 1993) or its practicalities (Parrott *et al*, 1988; Asch *et al*, 1991; Bernadt *et al*, 1991). This signifies a move away from the tradition of medical paternalism to a more person-centred approach to health care. However, the discussion about access to medical records, and the related issue of patient involvement in decision-making processes about treatment, is dominated by an important assumption:

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