

Monitoring Community Mental Health Team Caseloads: a systematic audit of practitioner caseloads using a criterion-based audit tool

John Butler BSc(Jt Hons), RMN, MSc, PGDipHE, ILTM

Consultant Nurse (Acute Mental Health), Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

CASELOAD AUDIT

Introduction:

'Good caseload management and supervision processes are critical to maintaining effective practice. Each mental health provider will need to ensure, and be able to demonstrate, that staff in care coordinator roles are maintaining caseloads of suitable sizes with individuals who have active needs and that support and clinical supervision is provided.' (DH 1999: 23)

This recommendation has been echoed within the Trust's county-wide Care Programme Approach Policy (CPA):

'Individual caseloads of each Care Coordinator will be subject to ongoing monitoring through the established processes of caseload supervision and audit activity. For mental health services, present service specifications emphasise the need for prioritising care to those most in need (i.e. people with severe mental health problems) (DH 1995). An example of a caseload management tool is given. There should be parity in caseload complexity and volume across the teams and the professional groups who manage care. Each agency is responsible for implementing an effective process for the provision of caseload, clinical and/or management supervision.....' (BLCT 2003: 15).

Monitoring caseloads is a complex issue, as limiting such activity to simple numbers of clients on caseloads is potentially misleading of actual workload and does not recognise the many other important activities that are undertaken by practitioners – for example: therapeutic group work; weekly review meetings / case conferences; formal CPA meetings; service development initiatives; offering training; fulfilling significant administrative requirements; and, travel.

In 2000 & 2001, the local community mental health service piloted the use of a criterion-based caseload monitoring tool based upon a thermometer weighting system, which involves giving service users a weighted rating based upon CPA-related criteria (McDermott & Reid 1999, Butler 2001).

Advancing Practice in Bedfordshire 2005: 2 (3)

As part of the CMHT (Community Mental Health Team) review process, it was agreed to monitor and audit caseloads using an adapted version of this tool, with the aims of: reviewing the level of service-user need across caseloads, matching this with resources, and facilitating service planning and quality improvement by ensuring safe, manageable workloads (Briedel 1993).

Method:

Each qualified mental health practitioner in each CMHT was asked to conduct an audit of their current caseload using an adapted version of the caseload monitoring tool (see appendix for excerpts of audit tool), recording their ratings for each weighted criterion on a specially devised audit data collection record-form. An instruction sheet was written for practitioners to guide their use of the audit tool.

Practitioners were then asked to validate their caseload audit data with their Lead CMHN (Community Mental Health Nurse), Senior Practitioner or Team Manager.

Use of this audit tool requires the practitioner to assess each service-user on their caseload against seven CPA-related criteria (risk, relapse pattern, needs, support, engagement & compliance, contact, and CPA coordination). Each criterion is weighted from 1 – 5, in accordance with specific service-user descriptors. After weighting each criterion, a decision is then made in allocating 1 – 5 weighting points to the service-user – which is most usually the average of weightings for all seven criteria. Completed for each service-user on the practitioner's caseload, this provides an overall caseload profile.

In addition to the above, the CMHT Review Group requested the collection of additional data items: total contact time, total travel time and total administration time for each

service-user, in minutes per month; and, the type of service ideally required for the service-user, using definitions from Department of Health Policy Implementation Guides (DH 2001, DH 2002).

Although data collection was initially planned for September 2004, audit data was collected and returned from end September – December 2004. Audit data was forwarded to the author for analysis and reporting.

Findings:

A summary of some of the key findings of this audit are presented below. In addition, a summary of caseload data relating to specific CMHTs was returned to the team managers, highlighting further specific analysis.

The community mental health nurses and social workers of seven CMHTs returned caseload data using the audit tool: *23 Community Mental Health Nurses (CMHNs); 19 Social Workers (SWs); 4 Assistant Social Workers / Community Support Workers (CSWs); and, one psychotherapist. Audit data was validated by the respective Lead CMHNs, Senior Practitioner or Team Leader / Manager.*

Caseload Size

As summarised in Table 1, the total active caseload audited represented 47 team-members and 917 service-users. The Luton CMHNs had the largest caseload sizes, two of whom had the largest caseload sizes of the whole audit sample: 49 (Luton SW CMHT) & 40 (Luton SE CMHT) service-users. The average caseload size for a full-time generic qualified mental health practitioner was 25 service-users, which was exceeded only by the CMHN Teams of the South of County CMHTs.

Approximately 40% of the service-user sample was weighted as either 4/5 or 5/5 for

CPA coordination, confirming the level of care coordination for service-users requiring enhanced CPA care. This was significantly more likely in the Bedford East CMHN Team (73%), where caseload sizes were therefore understandably smaller. However, for one of the Luton CMHNs (Luton NW CMHT) 25/35 clients were weighted as either 4/5 or 5/5 for CPA coordination.

Only 2/47 practitioners had caseloads of more than 35 clients, both of whom were Luton-based CMHNs. This represents a significant reduction in caseload sizes since a previous audit of CMHN caseloads using this caseload monitoring tool (Butler 2001).

As shown, CMHN caseloads are generally higher than Social Worker caseloads, and Luton-based CMHN caseloads are generally higher than those in other teams.

Those with particularly low caseloads are invariably either working on a part-time basis or have additional roles, whether managerial or educational roles.

Time for Client Work

As would be expected, the findings suggested that service-users being seen by those with higher caseloads receive less total contact time per month (for face to face contact, travel and administration). The average contact time was significantly greater in the Biggleswade CMHT, although this is mainly explained by the significantly greater time spent travelling to see service-users.

It is worth noting that the total time commitment to client-based work as a percentage of total available working hours was highly variable: 64% (40 – 85%) for the Luton CMHN; 59% (26 – 111% - a possible over-estimate) for the Luton Social Workers; 36% (18 – 53%) for the Dunstable CMHT-member; 61% (32 – 114% - a possible overestimate) for the Leighton

Buzzard CMHT-member; 64% (31 – 93%) for the Biggleswade CMHT-member; 45% (30 – 55%) for the Bedford East CMHN.

Team Caseload Profiles

Team Caseload Profiles were produced which highlighted the average criterion weightings for each team, with the Luton CMHTs being separated into CMHN and Social Worker Teams. This highlighted that:

- 'risk' weightings are highest for the Bedford East CMHNs & Luton Social Workers
- 'relapse' weightings are highest for the Luton Social Workers & Bedford East CMHNs
- 'complexity of need' weightings are highest for the Luton Social Workers & Leighton Buzzard CMHT
- 'support need' weightings are highest for the Bedford East CMHNs & Leighton Buzzard CMHT
- 'engagement' weightings are highest for the Luton Social Workers & Leighton Buzzard CMHT
- 'contact' weightings are highest for the Leighton Buzzard CMHT & the Luton Social Workers
- 'care coordination' weightings are highest for the Bedford East CMHNs
- overall, the caseloads for the Luton Social Workers & Leighton Buzzard CMHT were weighted most highly

Caseload Weightings

Chart 1 shows the total caseload weightings for individual practitioners within each of the teams.

In their original caseload thermometer weighting tool, McDermott & Reid (1999) suggested an upper total caseload weighting limit of 80 points per full-time CMHN caseload. This would mean that a full-time qualified mental health practitioner should not work with more than 16 'highest priority' service-users (each weighted as 5/5).

Advancing Practice in Bedfordshire 2005: 2 (3)

If this standard is applied to the caseload weightings across the teams, then 5/9 Luton CMHNs have caseloads weighted in excess of this, with one of these CMHNs having a caseload weighting of 157 points (Luton SW CMHT) – the maximum caseload weighting for this audit sample. Only 5 practitioners in the other teams have caseloads in excess of 80 points (one Luton Social Worker – the only substance use worker in this sample, one Dunstable CMHN, two Leighton Buzzard CMHNs & one Leighton Buzzard Social Worker). This raises questions about how workload is allocated in CMHTs to ensure fairness and equity, how caseload activity is routinely assessed and monitored, and how resources are allocated.

As for caseload sizes, those with particularly low caseload weightings are invariably either working on a part-time basis or have additional roles, whether managerial or educational roles.

Some 46 service-users were given the highest overall case weighting (= 5/5): 10 were seen by the Luton CMHNs; 11 were seen by the Luton Social Workers; 18 were seen by the Leighton Buzzard CMHT; 1 was seen by the Dunstable CMHT; 3 were seen by the Biggleswade CMHT; and, 3 were seen by the Bedford East CMHT. Of these, 39/46 were on Social Worker caseloads, with a maximum of 7 'highest priority' service-users on any one caseload (Luton Social Worker & Leighton Buzzard Social Worker).

Caseload Risk Levels

There is considerable variation in the average risk level of individual caseloads, with risk weightings being generally higher for Social Worker caseloads.

Considering the important issue of the level of risk, effective caseload management would suggest that those practitioners who have larger caseloads would be expected to

work with service-users presenting a lower degree of risk - an hypothesis that is represented by the diagonal line in Chart 2 (to visually demonstrate this point, this line has been arbitrarily set at an average risk rating of 2/5 for a caseload of 60 service-users, although no practitioner would be expected to work with this number of service-users).

As shown, the average risk weighting (risk index) falls above the line for 13/47 practitioners. This suggests one or both of the following: either greater levels of workload for these practitioners; and / or, a comparatively reduced contact time for those service-users presenting the highest level of risk.

Service Requirements

As highlighted in Table 2, practitioners provided an indication of the type of service required by their service-users. As expected, whilst the majority appeared to be receiving care appropriately from the Acute / CMHT service, a considerable number of service-users were assessed as requiring a service from the respective continuing care (164 clients), assertive outreach (78 clients) or primary care team (50 clients).

This may highlight some issues relating to accessing the appropriate service and the need for a clear integrated pathway through and between different teams.

It should be noted that since this audit, the local Crisis Resolution and Home Treatment Teams have commenced their operational service (from December 2004).

Conclusion:

This clinical caseload audit tool represents an attempt to achieve a compromise between practical simplicity of use and the known complexity of workload issues. Nevertheless, as with any such tool, it has to be accepted that there is always a degree

of subjectivity on the part of the auditor (practitioner) and validator in agreeing weighted ratings.

As shown by the summary findings, which are supported by the more specific findings for individual teams, there is considerable variation between individual, discipline and team caseloads, which can be summarised as follows:

- a caseload sizes are greater in the Luton-based CMHTs
- b caseload sizes are greater for the South of County CMHNS
- c caseload sizes for CMHNS (especially South of County) are greater than for Social Workers
- d caseload sizes exceeded 35 service-users for only two practitioners, both of whom were Luton CMHNS, representing a significant reduction in caseload sizes since a previous audit in 2000-01 – it is worth noting that in a survey of caseloads in six South West London CMHTs (Greenwood et al 2000), the average CMHN caseload was 30.3 service-users (range = 18 – 34), whilst the average Social Worker caseload was 13.1 service-users (range = 9 – 26)
- e the average caseload size for a full-time qualified mental health practitioner = 25 service-users
- f 40% of service-users were weighted as receiving enhanced CPA care
- g 73% of service-users on Bedford East CMHN caseloads were weighted as receiving enhanced CPA care, and as their caseloads were generally lower, this suggests more effective caseload management than for other teams
- h the number of service-users receiving enhanced CPA care on individual caseloads varies from 0 – 25 service users per practitioner, which suggests that this workload should be more equitably shared
- i the number of service-users weighted as 5/5 (indicating highest priority or at greatest risk and need) on individual caseloads varies from 0 – 7 service users per practitioner, being most likely for Social Worker caseloads and suggesting the need for further attention to routine caseload monitoring, fairness in the allocation of new cases (workload) and/or the development of speciality roles for some practitioners (to engage and work with those in most need)
- j some practitioners with large caseloads have a high overall risk index, which suggests the need for reviewing and routinely monitoring caseloads, to ensure equity and safe practice
- k there is a general trend suggesting that those with higher caseloads offer less contact time to service-users, as would be expected, although this is subject to a few exceptions
- l overall, the Luton Social Workers and Leighton Buzzard CMHT caseloads were profiled as including more service-users with greater needs
- m considering McDermott & Reid's (1999) recommended maximum caseload weighting, the caseloads for 10/47 practitioners exceeded their maximum threshold of 80 weighting points, 5 of whom were Luton CMHNS, thus suggesting the need for enhanced caseload management and supervision (e.g. challenging caseloads) and/or for further resources
- n whilst 2/3rds of service-users were assessed as appropriately requiring the service of Acute / CMH Teams, the remaining 1/3rd were assessed as ideally benefiting from one of the new services (CRHT, AOT, EIS), a continuing care team or primary care, raising questions about the interface between teams

Given the above, this audit highlights the potential value of systematically using a practical caseload monitoring tool in comparing caseloads between

practitioners, disciplines and teams, in highlighting relevant issues for caseload supervision and effective caseload management. As a tool that is closely based upon CPA-related criteria, this also provides another indicator and guide for the implementation of the Care Programme Approach.

Five Key Recommendations:

- 1 All qualified mental health practitioners are strongly recommended to maintain an up-to-date (concurrent) profile of their individual caseload using a practical caseload monitoring tool, as a method to support caseload supervision, caseload management and the fair and equitable allocation of workload and resources.
- 2 Following the more recent appointment of Team Managers for all CMHTs, Team Managers are strongly recommended to ensure the implementation of both clinical supervision and caseload supervision as distinct processes for facilitating effective caseload management. This would allow caseloads and workload to be challenged in a supportive atmosphere, promoting effectiveness, the use of alternative approaches, transfer and discharge.
- 3 Team and Service Managers are recommended to agree upper caseload weighting limits for individual practitioners, which need to take account of the additional roles and responsibilities fulfilled by some practitioners. In terms of the total caseload weighting for a full-time qualified mental health practitioner, this could be set at 80 weighting points (using this caseload monitoring tool), being reduced for those with agreed additional responsibilities. If an upper limit is not agreed and set, then: the quality of care is likely to be variable across caseloads, and in some cases this may be compromised; the

team-member is likely to experience greater and possibly unacceptable levels of stress; and, there will continue to be a lack of any meaningful system for identifying caseload pressures, resource needs or any way of ensuring fairness and equity.

- 4 Team and Service Managers are recommended to review their specific team caseload data in forming more specific action-plans and considering the option of preparing a case for further resources.
- 5 It is strongly recommended that an externally validated caseload audit of the whole service is conducted on a periodic basis – the CMHT Management Team are recommended to decide upon the required frequency of service-wide caseload audits, e.g. annual or biannual, and to plan this into their service clinical audit plan.

References:

- Bedfordshire & Luton Community NHS Trust (2003) *The Care Programme Approach Policy*. Luton: BLCT
- Briedel J (1993) Why Measure Workload? *Professional Nurse* 8(6): 362-5
- Butler J (2001) *Monitoring Your Caseload: the development and pilot of an audit tool*. Luton: BLCT
- Department of Health (1999) *Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach: a policy booklet*. London: DoH
- Department of Health (2001) *The Mental Health Policy Implementation Guide*: CD-ROM Resource. London: DoH
- Department of Health (2002) *Mental Health Policy Implementation Guide: Community Mental Health Teams*. London: DoH
- Greenwood N, Chisholm B, Burns T & Harvey K (2000) Community Mental Health Team Caseloads and Diagnostic Case-Mix. *Psychiatric Bulletin* 24: 290-293
- McDermott G & Reid L (1999) Model for Integrated Mental Health Care Measures Up. *Nursing Times* 95(13): 46-47

Table 1: Caseload Data

| CMHT | No. of staff returning caseload data | Ave. caseload for full-time generic workers (range) | Total active caseload (no. of service-users) | Total weighted as >=4/5 for CPA Coord. (% of total caseload) |
|----------------------------------|---|--|---|---|
| Luton NW CMHNs | 3 | 33 (30 – 35) | 99 | 37 (37.37%) |
| Luton SW CMHNs | 3 | 35 (27 – 49) | 105 | 41 (39.05%) |
| Luton SE CMHNs | 3 | 36 (33 – 40) | 77 | 21 (27.27%) |
| Luton Social Workers | 7 | 19 (11 – 28) | 140 | 47 (33.57%) |
| Dunstable CMHT | 8 | 27 (21-34) (CMHNs) 21 (SWs) | 98 (CMHNs) 53 (SWs) 10 (CSW) | 41 (25.47%) |
| Leighton Buzzard CMHT | 11 | 32 (27-35) (CMHNs) 22 (20-25) (SWs) | 96 (CMHNs) 86 (SWs) 32 (CSWs) 10 (Other) | 98 (43.75%) |
| Biggleswade CMHT | 9 | 20 (16-23) (CMHNs) | 68 (CMHNs) 32 (SWs) 9 (CSW) | 46 (42.20%) |
| Bedford East (CMHNs only) | 3 | 20 (19-21) | 52 | 38 (73.08%) |
| TOTAL | 47 CMHT members | Ave of 25 service-users per F/T generic worker | 917 service-users | 369 (40.24%) service-users weighted as >= 4/5 for CPA co-ordination |

Key:

CMHNs = community mental health nurses; SWs = social workers; CSWs = community support workers

Table 2: Which service is required?

| CMHT | Acute / CMHT | CRHT | EIS | AOT | Cont. Care | PC | Other |
|---|---------------------|--------------|-------------|--------------|-------------------|--------------|--------------|
| Luton NW CMHNs | 88 | 6 | 0 | 2 | 3 | 0 | 0 |
| Luton SW CMHNs (for 2 CMHNs only) | 30 | 2 | 0 | 1 | 13 | 10 | 0 |
| Luton SE CMHNs | 60 | 0 | 1 | 2 | 12 | 1 | 1 |
| Luton Social Workers (for 6 SWs only) | 63 | 3 | 2 | 7 | 31 | 6 | 2 |
| Dunstable | 10 | 2 | 10 | 2 | 19 | 12 | 16 |
| Leighton Buzzard | 11 | 4 | 0 | 0 | 38 | 64 | 62 |
| Biggleswade | 75 | 2 | 2 | 3 | 4 | 11 | 12 |
| Bedford East (CMHNs only) | 19 | 0 | 1 | 6 | 25 | 0 | 5 |
| TOTALS | 551 (64.4%) | 23 (2.6%) | 8 (0.9%) | 78 (8.7%) | 164 (18.3%) | 50 (5.6%) | 22 (2.5%) |
| Key: CRHT = Crisis Resolution & Home Treatment; EIS = Early Intervention Service; AOT = Assertive Outreach Team; Cont. Care = Continuing Care Team; PC = Primary Care; Other – included Mental Health for Older People, Personality Disorder Service etc... | | | | | | | |

Chart 1: Total Caseload Weightings

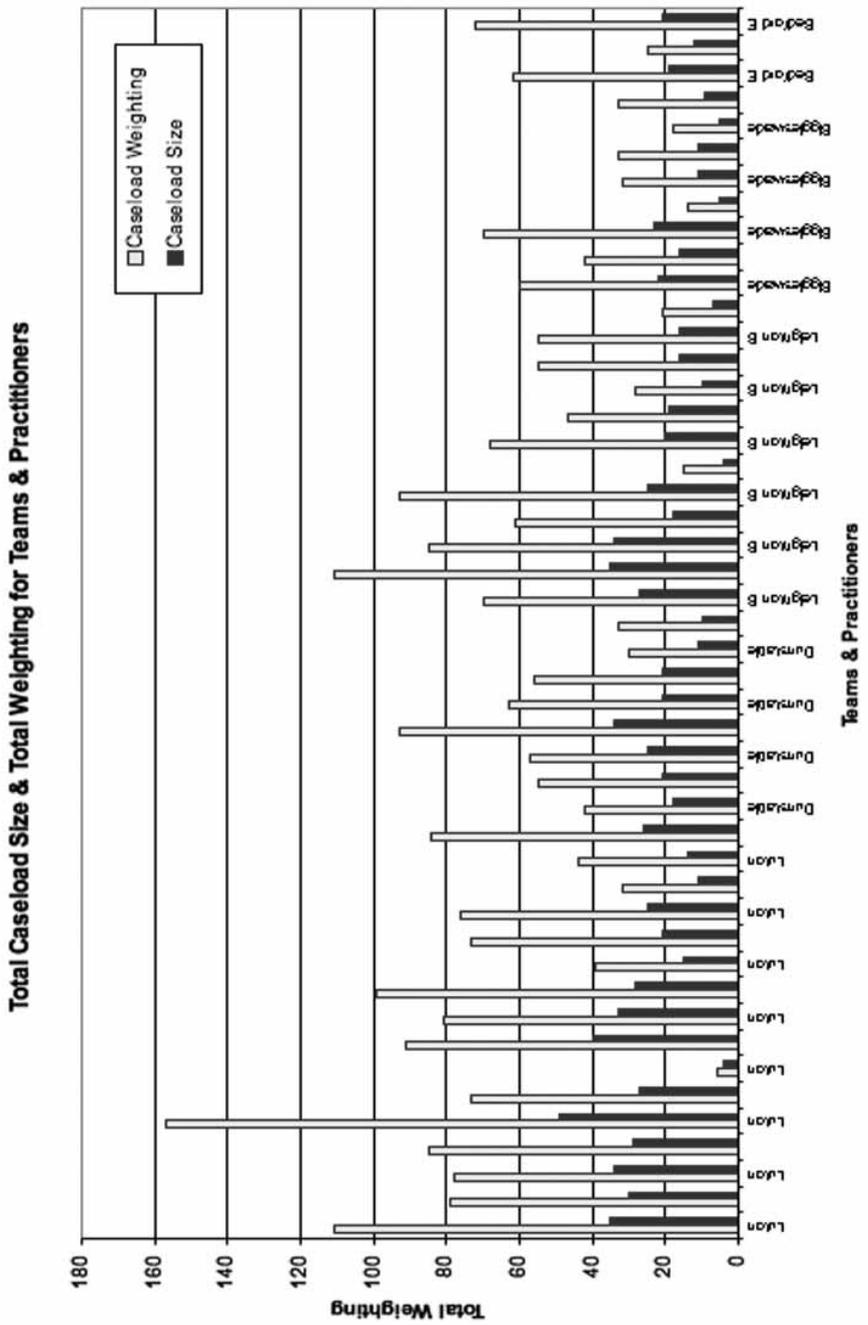
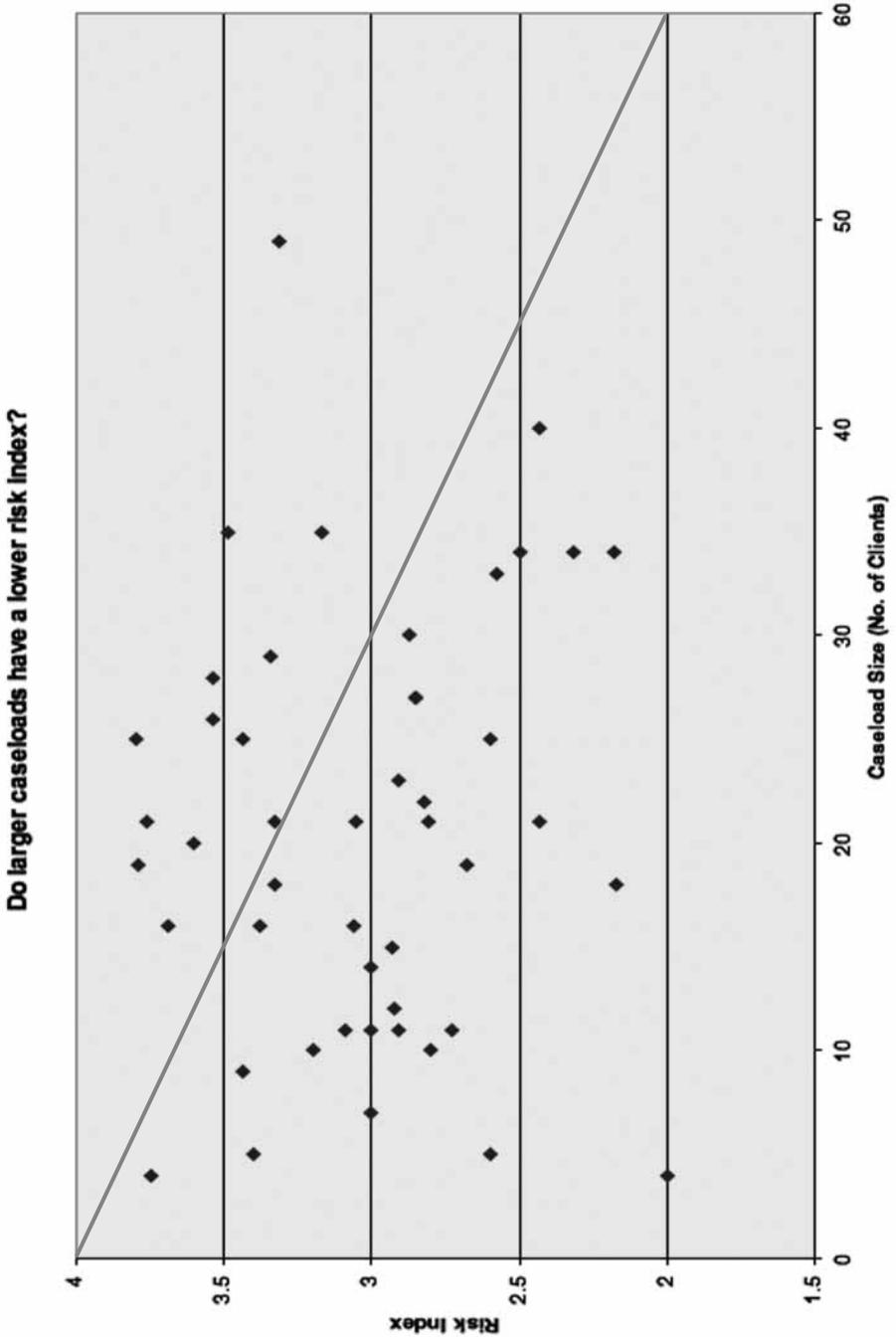


Chart 2: Average Caseload Risk Levels



Appendix: Weighted Criteria - excerpts from audit tool

| Weightings | | | | |
|--|---|---|--|--|
| 1 | 2 | 3 | 4 | 5 |
| Risk | | | | |
| very low risk, with no special precautions required | low apparent risk, which is manageable; no special precautions are required | medium or significant risk, which is currently manageable; may have an history of moderate to high risk behaviour | high apparent risk but with no immediate risk to self / others / from others; history of high risk behaviour is likely | high and imminent apparent risk AND presently a danger to self / others / from others; history of high risk behaviour is likely |
| CPA Coordination | | | | |
| requires a Standard CPA care-plan, but clinician is not the care-coordinator | requires a Standard CPA care-plan AND clinician is the care-coordinator | requires OR most likely requires an Enhanced CPA care-plan, but clinician is not the care-coordinator | requires an Enhanced CPA care-plan AND clinician is the care-coordinator; not subject to a restriction order, but may be subject to Sec. 117 | requires an Enhanced CPA care-plan AND is subject to a restriction order (Sec. 2, 3, 37, 41, Supervised Discharge, Guardianship) |