More than the sum of all the parts

for discussion

Improving the whole system with

Crisis Resolution and Home Treatment

June 2003

MORE THAN THE SUM OF ALL THE PARTS

Improving the whole system with Crisis Resolution and Home Treatment

JUNE 2003

CONTENTS

WHAT PEOPLE ARE SAYING ABOUT CRISIS RESOLUTION AND HOME TREATMENT...

"...they gave me a lot time, a feeling of being important, and I never felt alone"

A service user

"...there was always someone at the end of the phone I could rely on"

A carer

"...I have never worked in a team with such high morale"

A crisis team member of staff

"...I can't imagine how sector teams coped without the crisis team"

A new sector consultant

"...probably the most cost-effective investment made in mental health in a decade"

A PCT chief executive

"...the positive effects on the whole system of care are unprecedented"

A mental health trust chief executive

"...It is a shame you had just come up with this approach. In the past hospital admission was the only solution. Those stays were very long, and as you have no stimulation with your normal life, practical things, you quickly vegetate. For the staff it's their job and they see very little improvement. For the patient it is frustrating, for families it is harrowing, for single parents it is no solution. It causes more problems. Because of no or little family support both my children ended up in care. This time my son was around me all of the time. I recovered quicker by having to care for him and also if you receive benefits these stop after six weeks. So you go home to a pile of debt and the anxiety of debts and Social Services reviews and in six months' time you are back in hospital. Thank you for asking my views. Hats off to you, because it (Crisis Resolution and Home Treatment) is a brilliant care package."

A service user

EXECUTIVE   SUMMARY

Crisis Resolution and Home Treatment (CRHT) is the term that will be used throughout this document because it is the one, among several alternatives, used in the Department of Health Policy Implementation Guidance.

There is growing evidence that CRHT is the component of the National Service Framework and NHS Plan that is having the earliest and greatest impact on service quality, effectiveness and efficiency. The benefits are not limited to managing crises but may affect the whole system of care for the better. There are benefits for staff as well from the separation of emergency from other kinds of clinical work.

The four papers contained in this discussion document deal with very practical aspects of delivery. They are intended to provoke discussion preparatory to action by primary care trust commissioners and all those involved in providing mental health services.

BUILDING THE WHOLE SYSTEM OF CARE
by Peter Kennedy, Eleanor Lane, Colin Williams, Martin Brown

Introduction

Much has been written about **service models** that are the component parts of a comprehensive mental health service within the National Service Framework and NHS Plan. Here we address building a model of **the whole system**. It reflects the accumulated experience of members of the Northern Centre for Mental Health on how best to go about staging and sequencing new developments. It considers how each part of the service needs to alter its activities and relationships as new service components are added. **Care co-ordination** is not in most people's experience working well now. The fully developed new mental health service will have more teams and more interfaces with even greater potential for discontinuities of care. An over-riding consideration, therefore, is how to achieve with each new stage of development progressively better user experiences of journeys through the whole system of care.

We do not believe that a better mental health service can be built without **professional role changes**. Hence, we give as much attention to the careful staging of developments in professional roles as to new service developments. The changes in professional practice must be good for staff as well as for patients if the right people are to be recruited.

Figure 1 is a **summary of the key steps** in an order that we believe is important for building a whole system of care that really works. The reasons for this are developed in the subsequent text. However, the paper is not a rigid plan but rather a template on which to encourage debate.
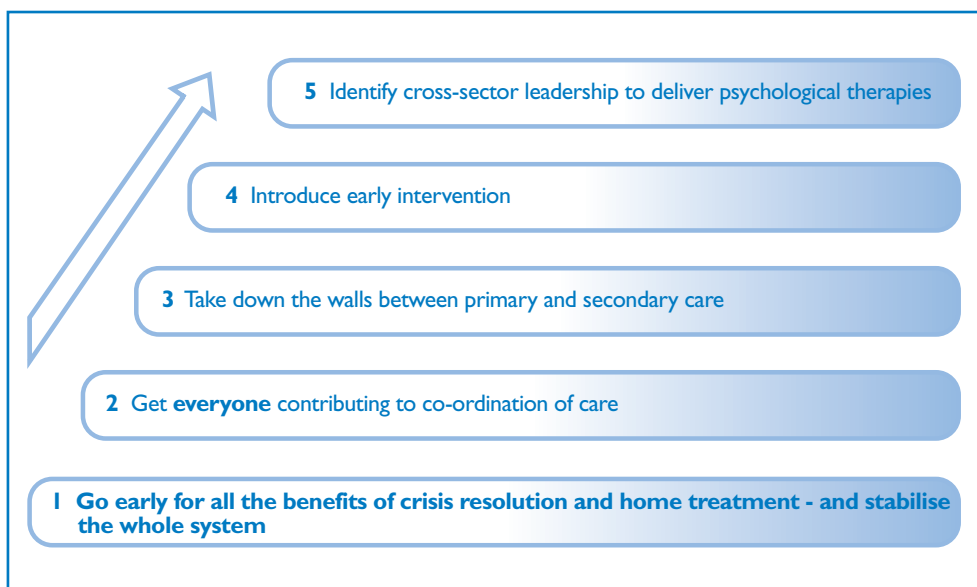

Figure 1:
Steps in building the whole system

5 Identify cross-sector leadership to deliver psychological therapies

4 Introduce early intervention

3 Take down the walls between primary and secondary care

2 Get **everyone** contributing to co-ordination of care

1 Go early for all the benefits of crisis resolution and home treatment - and stabilise the whole system

Step 1: Go early for all the benefits of Crisis Resolution and Home Treatment

Four factors make CRHT a must for early implementation in building the whole new system of care:

- It produces a major quality benefit for patients by reducing the need for compulsory admission by around 30%.

- It relieves dangerous overcrowding in the acute in-patient wards and eliminates the need for out of area admissions with reduction of admissions by around 30%.
- It reduces the pressure on key professional staff who are currently struggling to combine booked clinics and meetings with the less predictable and rising demand to deal with emergencies.
- In both urban and rural populations the introduction of CRHT can achieve these benefits within months and begin to stabilise the whole system.

Improving performance of other teams

When the CRHT is established, GPs and their primary care teams will have a simple choice of two alternatives: to refer to the CRHT any patient in crisis for whom there seems to be no alternative to admission; to refer to the CMHT all other patients.   Relieved of the burden of responding to unpredictable demands of seriously ill patients in crisis and the all too time consuming task of finding a bed, CMHT professionals can take further steps in better organising routine and planned work with patients. If not already in place the dialogue should start with primary care teams to agree a single portal of entry to the CMHT. Methods of allocating referrals to CMHT members should be worked out sensitively to current workloads of individuals and the special skills that they have to offer.

In-patient teams with reducing admissions and bed occupancies can now start organising the admission process better and further developing their treatment and discharge programmes. With fewer short stay and avoidable admissions, in-patient teams can give priority to their training needs especially for dealing with dual diagnosis patients. Policy has recently been clarified making these patients the responsibility of 'mainstream' adult mental health services. Since they account for around half of acutely ill patients in hospital there is a requirement for all in-patient teams to develop expertise in dealing with the drug and alcohol abuse aspects of their care.

Crisis Resolution Home Treatment can be the lynch-pin that stabilises the whole system. It relieves everyone else of the responsibility for higher risk unpredictable emergencies and allows them to work more effectively.

With the wisdom of hindsight most people say that if they were to start again implementing the National Service Framework they would not have started with Assertive Outreach. But Assertive Outreach teams have arrived in most cities. What often needs to be made clearer is how Assertive Outreach fits into the whole system.

Figure 2 (page 6) illustrates how CRHT and Assertive Outreach fit into the whole system. Because it is the CMHT that will be supporting most people with severe mental illness for most of the time, it is we think the CMHT which should be regarded as the centre of the secondary care mental health service.

Members of the CRHT, Assertive Outreach, and ward teams need to be involved in agreeing protocols for transferring patients to and from the CMHT. But the CMHT, we suggest, should take the lead and monitor patient journeys across the whole system.   The CMHT appears to be the natural hub of secondary care in an urban service with several distinct teams for specialist functions, and even more obviously so in rural areas where these functions are incorporated into generic community teams.
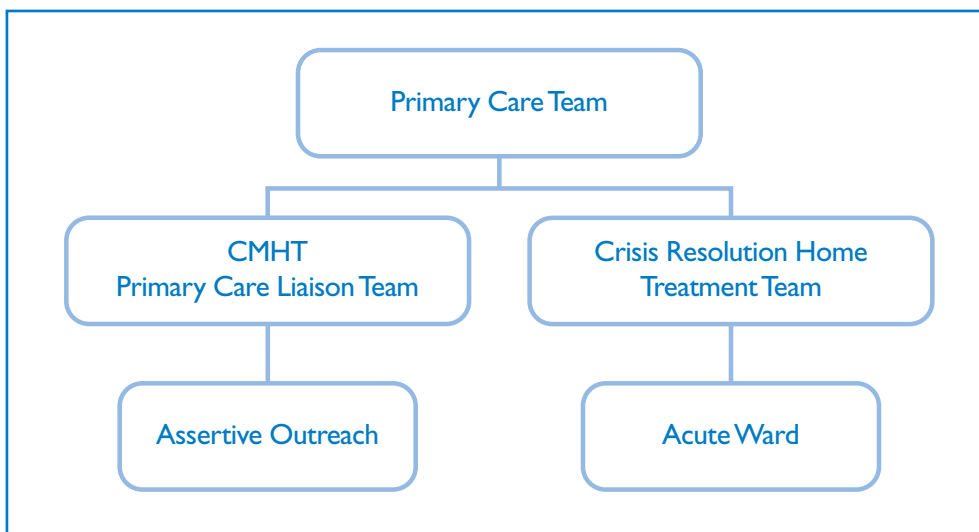
Professional role adjustments

Consultant psychiatrists will need to agree with their trust boards and professional colleagues an appropriate re-definition of medical officer responsibility for patients referred to the CMHT but not seen, or not seen regularly by the consultant. Other professionals in the CMHT will need to have agreed the limits of their clinical autonomy and how to seek review of a patient with a consultant or other senior professional.

With one general psychiatrist taking consultant responsibility for the CRHT the first step will have been taken towards sub-specialisation within general psychiatry. Now will be the time to start considering the wider implications of sub-specialisation within general psychiatry which may have more profound significance later.

The question of handovers from one consultant and team to another will need to be addressed in detail, as will the ways of quickly resolving differences in opinion about diagnosis and treatment. Many ward teams are encountering real problems in developing coherent programmes of care because several consultants with limited availability and differing approaches admit to the same ward. Discussion might begin here on the prospects of fewer consultants per ward, or even a full time consultant in-patient specialist. The full time in-patient specialist consultant role has been successful in other countries, proving to be better for both patients and professionals.

Step 2: Get everyone contributing to co-ordination of care

Co-ordination of care has often not worked well in a simpler system with fewer teams and interfaces. There is widespread cynicism that the care programme approach (CPA) is a paper exercise. Serious incident enquiries continue to reveal failures in continuity as the root cause. With more teams and more interfaces, along with more specialisation of professionals, the problem could get worse. No one has the right answer, but there are three principle components of the problem which are:

- An enormously complex system that cannot work unless everyone in it understands it and plays their part.

Key points
Box No.1
Contingent opportunities

- *Single point of referral to CMHT*

- *Better work distribution in CMHT*

- *Reduced bed occupacy*

- *Assertive Outreach in clearer context*

- *Consultant role development*

- A culture that has not yet adequately incorporated the value of seeing the service through the eyes of the user.
- Lack of measurement and effective processes to raise performance.

Does every mental health service induct and regularly update all members of staff on how the whole system of care works? Is every member of staff tested on their knowledge of the values conventions and rules that apply, and their particular responsibilities for ensuring patients' journeys through the system are safely and smoothly managed? If not then we are operating a system as complex as the road transport system without anyone needing to understand the Highway Code or have a driving test!

What data are collected and presented to tell everyone how the whole system is performing and where there needs to be improvement? What structures and processes are designed specifically to deal with inter-departmental/team/specialty problems and discontinuities experienced by patients? We have commonly encountered intense frustration amongst professionals who see obvious continuity problems recurring, and remaining unresolved as festering boundary disputes.

The values and principles tried and tested in 'collaboratives' need to be incorporated into every day management style and clinical practice: they are summarised in Box 2. Professionals from all parts of the system dispense with rivalries and differences when helped to focus on the user's journey and experience. When problem solving is bottom-up and incremental a 'can do' confidence develops and the system of care does improve. If all concerned have taken part in deciding that the right things are measured the information will sustain and encourage further improvements.

Management style has to support bottom-up driven change, value ideas from the front-line, unblock obstacles and allow some risk-taking. **It is recommended that the co-ordination of care challenge is addressed as a major programme of organisational development along these lines.**

This programme could also address a separate but not unrelated problem - that of increasing professional isolation in an increasing number of discrete teams and departments. Nurses, doctors and social workers complain that if their work is confined to one part of the system, they will be isolated from professional developments in other parts of the system. They will lack support and counsel from same discipline colleagues on difficult clinical problems.

Structure and process for care co-ordination

Some kind of clinical governance forum is required bringing together professionals from each of the component teams, wards and departments through which patients may pass. User vetted information on what patients have experienced in their journeys through care should be the focus of discussion. Multi-professional, multi-team problem solving and measured performance should be the product. Meetings must be regular, well attended, with well prepared agendas and good information. There is a real issue here about clinical staff having protected time for this crucially important clinical governance work. The requirement must be addressed in commissioning mental health services.

Key points
Box No.2
Values and principles of 'Collaboratives'

- *Focus on patient journey*

- *All disciplines*

- *"Bottom-up" problem solving*

- *Incremental cycles of improvement*

- *Measured progress to targets*

- *Supportive management context*

The clinical governance forum has to have a rapid and effective process, up to trust board level if necessary, to resolve differences between senior professionals and managers in the best interests of patients. Hence, close engagement with the work of the care co-ordination forum is required of chief officers in health and social services.

A particular concern has been expressed about more specialisation by general psychiatrists and continuity of care. What happens if the in-patient consultant has a *Leaders have to exemplify and strongly advocate the values of co-operation, and the supremacy of patients' experiences of their journeys through the whole system.* different diagnosis and care plan from the consultant who takes over the care of the patient in the CMHT or the Crisis Resolution and Home Treatment team? Well, surely it is in the interests of patients that any differences between individual consultants over diagnosis are open for discussion in such a forum to achieve consistency and safety in therapeutic approach.

Step 3: Take down the walls between primary and secondary care

When the CMHT has devolved work to the crisis team and the Assertive Outreach team, a more detailed review of its working relationships with primary care teams will be needed. There will be enthusiasm from primary care professionals and managers who have made their two highest priorities in the mental health field: developing joint working with CMHTs and; better organisation and delivery of talking therapies.

This work on CMHT relationships with primary care teams will build on earlier work on the single portal of entry to secondary care, faster access times, allocation of work within the CMHT, and redefining the consultant psychiatrist's role (see page 4). But now there should be the time and opportunity to look jointly at what secondary care does best and what primary care does best for people with mental health problems.

The dichotomy that has opened up over many years, whereby the secondary care team attempts to look after all the needs of those with severe mental illness, may not be ideal. Research shows that the physical health needs of this group are not being dealt with satisfactorily and champions of contemporary notions of 'recovery' argue that the secondary care system may hold onto individuals too long and limit their potential. On the other hand, some less severe neurotic disorders might benefit greatly from short term interventions by secondary care professionals if these were more available. Some people with mild personality disorders can make great demands on GPs' time and tax other health and social services resources without benefit, but a specialist member of a CMHT may be capable of setting limits and containing their unrealistic demands.

It will not just be in the new Care Trusts that working relationships with social workers will benefit from joint review. Social Services personnel can help health teams achieve better engagement with Housing and Social Security Departments, as well as with the plethora of non-statutory voluntary organisations that contribute to mental health. These essential parts of the mental health system have often been poorly integrated. The potential for greater efficiency, effectiveness and increased capacity may be considerable.

New professional roles

It is doubtful whether the *nurse gatekeeper* and *graduate worker* can come into their own and make a real contribution to the service until the more established professionals in the system have had time to review their roles and relationships. Then gatekeeper nurses can signpost individuals with particular problems to particular professionals who will now be more prepared and receptive to such referrals. Graduate workers can audit pathways of care and outcomes when there is multi-professional agreement on what is optimal. However, before embarking on appointments to either of these newer roles it will be well worth considering the alternative of investing in the kind of 'team co-ordinator' developed in Monaghan (see page 22). Fewer higher paid more experienced mental health professionals might be far more effective sign-posters and patient pathways managers.

Integrated service delivery

Two important and quite distinct aspects of the mental health service, which could benefit greatly from the closer engagement between CMHTs and primary care teams, are:

1 Early Intervention Services
2 Talking Therapies Services

Though work in both areas will undoubtedly have preceded this stage of whole system development, it will nevertheless be a good time to take stock and make larger strides forward within the better integrated primary and secondary care network.

Step 4: Introduce early intervention

There is growing concern that young people with first episode psychosis may experience very poor outcomes because there are often long delays in diagnosis, coupled with inadequate services which do not focus sufficiently on evidence based approaches. This may lead to service disengagement, high levels of relapse, high levels of involuntary admissions and serious and chronic disability. One in ten people with psychosis commit suicide.

Research is beginning to confirm experience that intervening properly and early in the course of a psychosis can prevent initial problems and improve long term outcomes and recovery.

The Department of Health now requires that all young people experiencing a first episode psychosis receive care and treatment in accordance with its Policy Implementation Guide (PIG) from 2004. This sets out explicit service development requirements to establish a first team by 2004, and a full service within the lifespan of the NSF i.e.2009. The full service is defined as a specialist service, comprising three or four teams, serving a population of around one million.

Implementing the policy requirements for 2004 necessitates preliminary scoping work to map current service provision, establish the incidence of new psychosis, and audit pathways of care. The PIG expected this work to occur in 2001/2002, with the first team set up by 2004.

Despite the somewhat prescriptive policy guidance, there is no such thing as a one size fits all Early Intervention Service. A number of local factors will need to be taken into account when designing services: morbidity, geography, population, social characteristics, and pre-existing services and the way they work.

A variety of ways are emerging to meet the needs of young people with psychosis:

1. Through primary care to specialist teams;
2. Through existing services to specialist teams;
3. Through existing pathways to generic teams with specialist support;
4. Through self referral to 'one stop shops' and Youth Inquiry Services.

All services need to address the following core components in any design:

- Early detection and assessment
- Treatment
- Care co-ordination
- Co-morbidity
- Basics(housing, money, healthcare, practical support)
- Psychosocial interventions
- Occupation
- Acute care facilities
- Service style
- Partnerships

The Sainsbury Centre for Mental Health is currently producing a workbook on setting up EI services, which will be available this autumn.

As skills and expertise in recovery are gained, other service elements will need to adjust roles and responsibilities in the light of experience.

Step 5: Cross-sectoral leadership for delivery of psychological therapies

There are psychology departments in secondary care organisations with year-long waiting times for patients not ideally selected for the special skills of clinical psychologists. Such services are often not well connected with the range of counsellors appointed by fund-holding practices during the last decade. The very large clientele in some areas provided for by Relate, Cruse, MIND and other non-statutory organisations are part of a system of care that is hardly at all integrated with statutory services in some areas. There is considerable inequity of provision. There is considerable inefficiency in routing patients with particular problems to the most appropriate therapist. Supervision and development of counsellors is haphazard. Not enough is known about the effectiveness of various talking therapies under normal service conditions. Demand for talking therapies is rising not least because of the promises made in the National Service Framework for Mental Health.

Before more resources are pumped into meeting the rising demand there is a need to rationalise current provision. Leadership of a 'managed clinical network' crossing primary/secondary/voluntary sector boundaries needs to establish:

- Referral pathways that match patient problems to the therapist most able to deal with them.
- Supervision arrangements that support and develop counsellors of all levels of experience.
- Monitoring for user satisfaction levels and outcomes.
- Training capacity for introducing new evidence based approaches.

The key issue is an absence of cross-sectoral leadership designing and developing delivery of an integrated service. This leadership must convince the voluntary sector organisations that integrated working supports and improves their performance, dispelling fears of simply dumping more work on them without additional resources.

The Northern Centre for Mental Health will soon be publishing the recommendations of a large workshop of therapists from primary and secondary health and social services, plus voluntary service providers and of course users, on improving the organisation and delivery of psychological therapies.

Steps 1 - 5: Provide the context for Learning by Doing throughout

From steps 1 - 5 staff working in the mental health field will need excellent arrangements, continuously evaluated, for learning by doing. Passive learning in old style courses and conferences has a limited place. Learning sets, bringing together people on a common frontier, to learn from each other as they implement service change, have much to recommend them. Exposure to the successes and pitfalls of others who have trodden the same path before is what they require, not idealistic presentations by people who have never done it themselves. Participative workshops and collaborative style meetings need excellent organisation. However, they can release a 'can do' energy and optimism that has been absent in many services because of too much top-down instruction and guidance.

CRHT FOR INNER CITY POPULATIONS:
THE NEWCASTLE AND NORTH TYNESIDE STORY

by Stephen Niemiec and Mary-Jane Tacchi

Introduction

The Newcastle and North Tyneside Crisis Assessment and Treatment service started in April 2000 and now covers a total adult population of 450,000 providing 24-hour a day, 365 day a year crisis assessment, resolution and home based treatment service. Referrals are received from general practitioners, accident and emergency departments, CMHTs, social service providers and other emergency services. Referrals are made by telephone and triaged by a senior clinician. This arrangement provides one point of contact for crises.

Relatives and carers are engaged at the point of assessment and the team decides on the need for admission to hospital or home based treatment. The service is multi-disciplinary and includes medicine, nursing, social work and occupational therapy.

The establishment of this service preceded the National Service Framework. Funding came from Health Action Zone monies on a recurring basis. A senior clinical project manager was appointed to set up the service (SN) who had wide experience at setting up similar services. A consultant psychiatrist with special interest in CRHTs (MJT) was recruited to the project team. Implementing CRHT with fidelity to a tried and tested model, has benefited users and carers across the whole adult mental health care system.

Figure 3
Source of referral

Source of Referral (%) April 00 - September 02
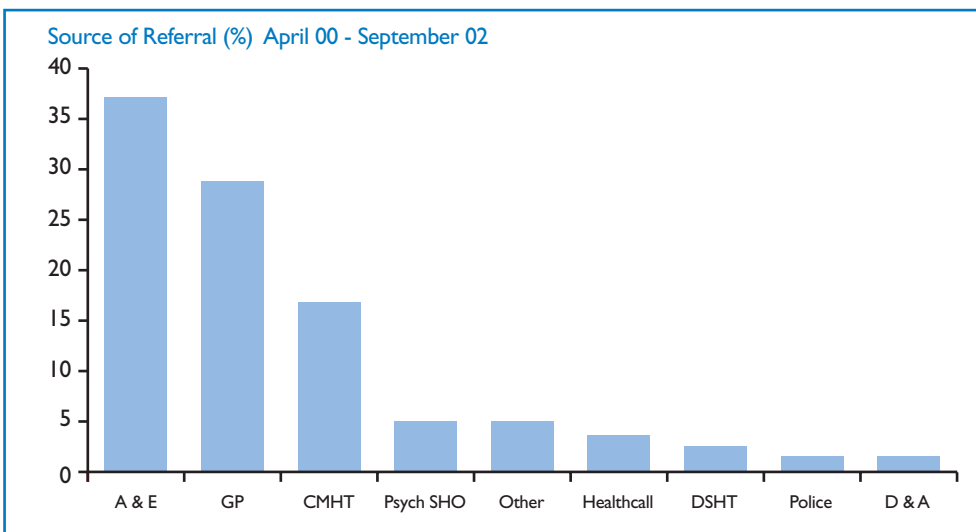
The majority of referrals come via Accident and Emergency departments and general practice. The numbers of people seen per year are approximately 1500, with a mean of 120 assessments per month. 50% of referrals are mental health service naïve individuals. We believe that provision of crisis resolution service for all the population increases appropriate access to specialist services and reduces admission numbers, bed occupancy, and waiting times for CMHTs.

Impacts

Before implementation of the CRHT there were major problems with entry into and exit from CMHTs and in-patient units. There were long waiting lists for some CMHTs, and waiting times between sector CMHTs were inconsistent.

***Key points
Box No.3
Impacts***

- *Increased choice for users and carers*

- *High user and carer satisfaction*
- *Bed occupancy down from 110 to 73%*

- *Out of area treatments down 335 per year to zero*

- *Decrease in admissions by 35 - 40%*

- *Increase in-patient staff/patient ratio*

- *Decrease in length of stay*

- *Increased access for non-urgent referrals*

In-patient facilities were over used with an mean occupancy of 110%, and frequently in excess of 120%. There were difficulties in locating in-patient beds within any locality leading to out of area referrals. Morale of staff particularly consultant general psychiatrists was low.

Service users and carers now have now more choice when deciding on location of acute treatment.

46% of people seen have been taken for home based treatment. 12% of people seen at the point of assessment are admitted. Admission rates reveal a decrease of 35% as a mean for all admissions. Figure 4 shows the effects on bed occupancy in wards.

Figure 4
In-patient Unit (percent occupancy)

In-patient Unit	1998-1999	1999-2000	2001-2001
Ward 21	97	99	73
Grange	111	81	79
Collingwood	105	102	84
Lowry	123	115	96
Gainsborough	110	104	87
Bewick	98	96	82

Who is it for?

Adults aged from 16 and upwards are included. Elderly people aged more than 65 years and not known to adult mental health service are referred to Services for Elderly.

Experience has taught us that open-contact lines to crisis services create unnecessary work, preventing those with a genuine psychiatric crisis from receiving the appropriate assistance. Even between health professionals there is no shared view of what constitutes a psychiatric crisis, therefore, all calls are Triaged telephonically. The telephone Triage number was given to GPs, CMHTs, accident and emergency departments, 999 emergency services, and social services, with the following referral criteria:

• The person presents at significant risk to themselves, to others, or that admission to hospital is being considered.
• The person needs to be seen within 24 hours.

The service also offers carers and patients accepted for home based treatment a 24-hour telephone contact number. The phone is based in the CRHT service office that is manned at all times.

Assessment

Assessment is usually carried out by two clinicians within two hours of referral. Two clinicians attend for reasons of safety and because there is instant comparing of opinions. Following assessment and engagement, a risk management plan and the care package is negotiated with the patient and relatives or carers. Medication can usually be started at this point with approval

of the team-dedicated psychiatrist. Medical reviews can be conducted at the first contact but are usually conducted on the second visit.

Following any immediate steps in risk containment, the first contact clinicians present their formulation to the team at the next shift hand-over meeting which occurs twice a day. At least one of the consultants is present during Monday to Friday. A full bio-psychosocial work-up is presented with precipitating, predisposing and maintaining factors of the existing crisis. Through multi-disciplinary discussion facilitated by one of the consultants, the team agrees to a treatment plan to offer to the patient and carers.

Length, frequency and purposes of visits is planned and regularly reviewed. Level of contact is titrated to the level of distress and nature of the clinical issue. Patients with high levels of distress combined with major risk can be visited up to three times a day for medication adherence, monitoring, psychosocial support and problem solving or pure practical support. The levels of support, intervention and direct engagement with health professionals are considerably greater than many patients receive in most acute wards.

The CRHT team's phone number is given to relatives and to patients to call the CRHT team should the need arise. Withdrawal of intense contact is subject to as much scrutiny as initial engagement.
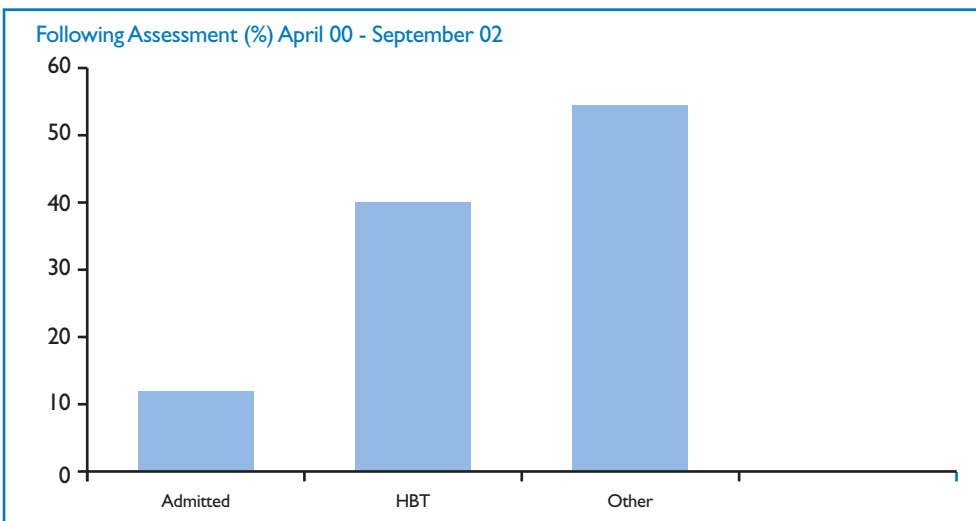

Following Assessment (%) April 00 - September 02
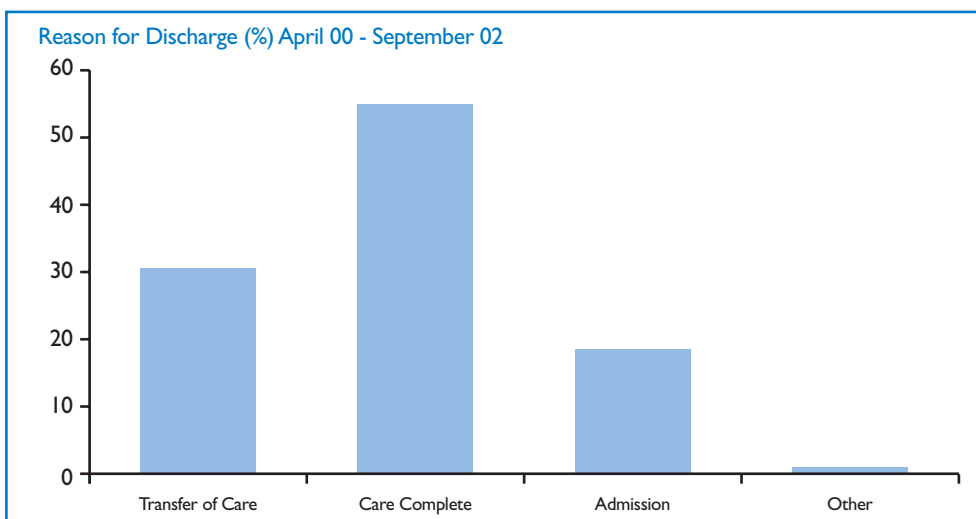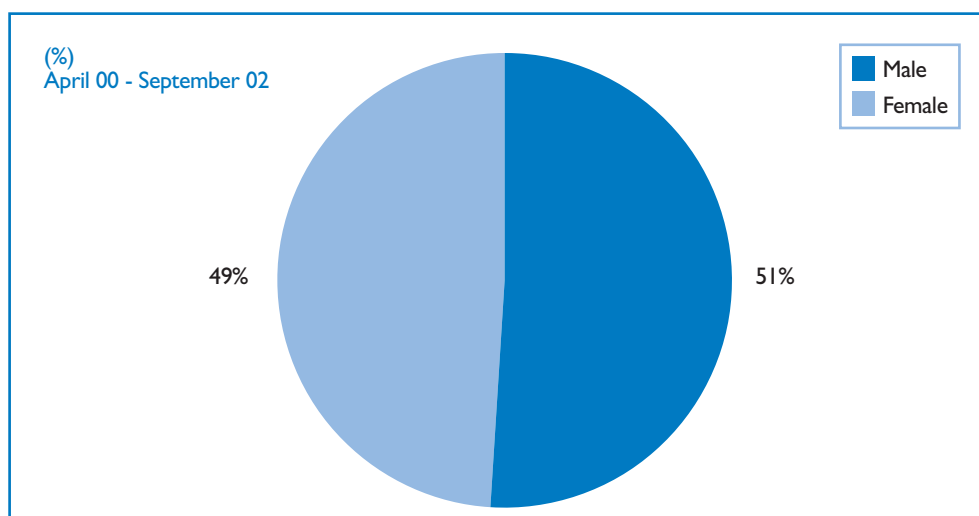
Figure 5
Disposal following assessment

Reason for Discharge (%) April 00 - September 02

Figure 6
Reason for discharge

Male and female
comparison of discharge

(%)
April 00 - September 02

Male
Female

49%   51%

Interventions

A wide range of interventions are available to patients and their relatives/carers ranging from assistance with simple tasks, to psycho-social interventions, problem solving, family therapy and psycho-education to more specialised therapies such as, cognitive behaviour therapy, solution focused brief psychotherapy. Biological treatments play a significant part in treatment and underline the necessity for having multi-disciplinary team membership.

The length of stay in the CRHT home treatment is usually between 4 - 6 weeks or until prior levels of functioning are obtained. First episodes in psychosis are the exception to the rule. They may stay on home treatment for up to three months before transfer.

Inter-service liaison

CMHTs and sector consultant psychiatrists are now freed up from having to respond to psychiatric crises allowing them to attend more effectively to non-emergencies and continuing care. CMHTs are now seeing more non-urgent appointments more quickly. Patients referred by CMHTs to CRHTs transfer medical responsibility to the CRHT psychiatrists. New referrals to secondary care are entered onto CPA after their first assessment by the CRHT. Regular team reviews occur twice a day and each patient is discussed in depth at least once a day.

Commitment

Prior to embarking upon any new service development it is vital to enlist the support of those who will enable the development to occur. From our point of view this has included senior management within the organisation in particular the chief executive officer and medical director, key personnel within the service, i.e. senior nurses from in-patient wards and community mental health teams and junior doctors, and service users. Various agendas may exist for those supporting the development for example the potential for closing beds or improved working conditions but the prime aim is to improve the quality of service for patient in crisis.

Fidelity of model

There is much to be gained in learning from those who have gone before. CRHTs in the states of Victoria and New South Wales, Newcastle and North Tyneside, and other sites in the UK such as North Birmingham, Camden, and North Islington operate with:

- 24-hour availability
- Mobility
- Gate keeping function for in-patient beds
- Multi-disciplinary working

In addition the Newcastle and North Tyneside CRHT service undertook bed management for the Adult Acute MHS and 24 hour manned shifts because of the population size and the demand upon crisis services after hours. We also appointed permanent adult psychiatrists, and a consultant nurse to provide consistent and expert consultant advice.

In going around the country and speaking with many Trusts we have found much variation in the set up of crisis services with the result that clinical and service opportunities are not realised to the full extent that a fidelity service would offer. We would strongly recommend to services considering CRHT development to follow existing fidelity models that demonstrate success. The absence of any one component in Box No.4 leads to a decrease in positive impacts, and service incoherence.

Project manager

In order to effect such a major service change a full time project manager is mandatory. In our case for a period of one year although possibly for less in a smaller organisation. It is not possible for someone to manage such a change in two sessions per week on top of a full time job. Ideally the project manager should have experience in working in such teams but if not be able to put the theory into practice and hold a clear vision of the proposed service will. In our experience the project manager needs to be very influential and able to tackle obstacles and threats to the development. They must also have the qualities of good leadership, organisational skills and diplomacy.

Selling the idea

It is common in an organisation to hear that there has been a new development and some people are unaware of it. In our experience selling the idea to all of those who will be involved is a long and painstaking task but extremely useful in the long run. We identified all stakeholders, i.e. anyone who would be potentially involved with the crisis service including the constituent parts of the mental health service, primary care, Accident and Emergency departments, the police, Social Services, the voluntary sector and user and carer organisations.

We organised different types of meetings either in small groups or larger events where key personnel were invited. We sent out written information and provided laminated cards detailing how to refer for all of those who would be referring to the service. The idea was to sell the idea of a new service outlining the potential benefits but also to manage and discuss concerns and fears.

Key points
Box No.4
Essential elements for fidelity service

- *24 hours a day, 365 days a year*

- *Gate-keeps all admissions to in-patient units*

- *Multi-disciplinary team*

- *Mobile*

- *Stay involved until the crisis is over*

Without these conditions, crisis resolution services cannot deliver the desired clinical and service impacts.

Employing staff

Much of the training of staff occurs after appointment however certain qualities were looked for in the appointment process. We were interested in people who were prepared to accept a different model of service delivery, were prepared to take more responsibility for their own decisions and were not locked into a blame culture, i.e. covering their own backs with decisions that they made. We looked for people with cognitive flexibility and the ability to problem solve.

Many of the staff came from within the organisation and there must be management of drain of these staff members from other parts of the service. Inevitably this will depend upon the ability to attract to the post being vacated, but can be helped by appointing the staff to the CRHT service in phases and trying to appoint from outside when appropriate.

Staff training

We would recommend a month long training programme for all staff if they have not worked in such teams before. We designed a specific training package where we covered four main areas:

1. The models of Crisis Resolution and Home Treatment, the evidence for this and our experience.
2. Assessment skills in particular history taking, note keeping, mental state examination, recognition of psychiatric and organic conditions, drug and alcohol history taking, formulation skills and risk assessment.
3. Triage training on how to manage calls and what would constitute an appropriate referral and the generation of alternatives for those referrals not thought to be appropriate.
4. Home based treatment and the adaptation of psychological therapies and psychosocial interventions for brief intervention at home, the effects and side effects of medication, the particular risks for managing people in the community and practical support in the home for patients and carers.

Training took place over the course of one month and involved ourselves and local experts using didactic teaching, experiential learning and role play.

Supervision

Clinical supervision and consultation occurs twice daily in the CRHT Service. First thing in the morning work from overnight is handed over to the team and the work set for the day. In the afternoon both dayshifts and consultants meet to discuss new assessments in detail and patients receiving home based treatment. There is also 24-hour access to a consultant psychiatrist for clinical consultation. In the beginning all assessments were discussed at the time of assessment with the consultants. This was to ensure the quality of the assessments and decision making and safety of risk taking but also allowed the clinician to learn assessment and decision making skills quickly. As the clinicians gained confidence it was no longer necessary to discuss all of the assessments at the time of assessment although they are discussed daily in the handover.

When it came to the on-call supervision of the CRHT Service there was some

discussion about the suitability of giving clinical supervision to nursing staff by specialist registrars and consultants. This in fact occurs in all parts of the service and is a demonstration of people's anxiety when a service is delivered in a slightly different way. We would suggest that rather than talking about supervision we talk about clinical consultation so that when a patient is seen by the CRHT they can ring up to consult with the registrar or consultant on-call as to the best outcome.

Evaluation

As a new service it is vital to decide upon what data would be recorded for what purpose. Evaluating various aspects of the service is necessary and the collection of data has not only allowed evaluation of the impact of the service and comparison with other parts of the service but will be used for other research projects for the future.

Before starting we decided upon various key performance indicators that are collected and reviewed on a monthly basis and this way we can make a response to this evaluation when necessary.

Management of change

In the implementation of any new service there may be opposition. We found that often this was secondary to a part of the organisation taking a very narrow view, feeling under threat and in need of protecting itself. A broader view of the organisation is encouraged to prevent this occurring. Some of the opposition was secondary to lack of understanding of the aims and impacts of the service development and was only solved by the demonstration of the benefits of the service. Some of the opposition is secondary to a fear of change per se and is not directly related to the particular service development and has to be managed by discussion and demonstration of effectiveness.

Consultant psychiatrists

Within the Mental Health Trust, consultant psychiatrists are a very influential and powerful group and it is vital to gain support from this body early on. If possible it is extremely advantageous to have a psychiatrist as part of the project team prior to implementation of the service.

Our experience was that having an 'insider', i.e. a consultant who had worked in the service for a number of years was extremely useful. The other consultants could identify with this person as understanding their perspective. Within the consultant body there are certain topics that are always broached when talking about development of crisis services which are discussed below.

Risk

The idea that a seriously ill patient will not be admitted is a concern. The point has to be made that no one is kept out of hospital if admission is thought to be the best outcome. However many people can be adequately managed with the support of family or carers, the CRHT service and the 24-hour carer's telephone line from CRHTs. It must be stated that no unnecessary risks are taken. Until the development of the CRHTs there had not been real alternatives to hospital admission and the alternatives that did exist were not able to

manage seriously disturbed patients. The reluctance, therefore, of psychiatrists to use home based treatment at first can be understood. Keeping people at home who are seriously unwell is a departure from the teaching that most have experienced and it does require experience of the success of such treatment to be able to accept it.

Consultant responsibility

A lot of psychiatrists are pessimistic in wanting to know that if something goes wrong, who will be responsible? In the crisis team it must be made explicit that as soon as a person has been accepted for home based treatment, the CRHT psychiatrist takes on the responsibility until the care is handed back to the agreed psychiatrist. Explicit guidelines such as this prevent anxiety and allow smoother transition from one part of the service to another. For a patient who is well known to a psychiatrist who would like to remain involved, shared responsibility is certainly possible but it is unlikely that the sector psychiatrist will be available for twice daily handovers so the CRHT consultant takes day to day responsibility. Any decisions for change in treatment should be joint with the current team and the crisis team and disputes over management are rarely a problem in practice.

The importance of clear protocols for handing over of responsibility between consultants and teams cannot be overstated, nor the importance of communicating adequate information in each case. Any failure will sap confidence in CRHT and the new system of care.

If the CRHT service decides not to take someone on for home based treatment nor to admit the patient but rather suggests an alternative, the CRHT team is responsible for implementing this decision and for informing other parts of the service of this.

Staff safety

The issue of staff safety must be addressed especially when visiting patients at home as the environment and other people present have to be considered in this equation also. Much can be learned and transferred from in-patient nursing protocols. Protocols must be in place and the ability to assess potentially dangerous patients in Accident and Emergency is greatly appreciated. There should also be a robust tracking system in place which is used by all.

Gate-keeping

For a CRHT to gate-keep in-patient beds is vital. Consultant psychiatrists sometimes find this a difficult concept and view it as the removal of one of their rights. It must be explained and understood that gate-keeping by the CRHT is necessary in order to use the most expensive resource, i.e. the in-patient beds in the most appropriate way. It also allows consideration of alternatives to admission as a matter of course. If anyone in the service is considering admission for a patient they are required to discuss this with the CRHT triage clinician. If admission is a most appropriate solution the CRHT will identify an appropriate bed and provide bed management also. In this way the resources are managed, alternatives to admission are always considered and discussed and staff and the rest of the service gain an understanding of what CRHTs are doing.

Continuity of care

There is a fear that patients known to the service will be picked up in a crisis and experience discontinuity in their care as a result of receiving home based treatment from CRHTs. Patients presenting out of hours prior to the development of CRHTs experienced considerable discontinuity of care, seeing an SHO in Casualty who did not have access to the notes or information and would have to make a decision without being informed. There is obviously a change in care when a patient is taken on for home based treatment but this should be viewed as the same as when a CMHT patient is admitted to the ward and as long as communication remains good and notes and documents are available the improved quality of the subsequent care should outweigh the discontinuity.

Advance directives

For difficult to manage patients and those who frequently present or have complicated care plans, advance directives produced by community mental health teams are invaluable for the CRHT. Collective responsibility is therefore made when managing patients out of hours in the most appropriate and therapeutic manner and inappropriate admissions are avoided. Such advance directives improve the continuity of care for patients who frequently present out of hours.

Effect on in-patient wards

Concern is raised that because many people are not being admitted that the in-patient wards would become much more disturbed and difficult to manage. It is true that the most disturbed and at risk patients will be admitted but it is the percentage of disturbed people on the ward that will increase rather than the level of disturbance, i.e. the patients that are admitted by CRHT teams would have been admitted anyway. Unless the reduction in admissions is used as a reason to reduce ward staffing levels the nurse:patient ration will be improved to deal with these problems.

CRHT FOR RURAL AREAS: THE MONAGHAN STORY

by Peter Kennedy

Introduction

This is a brief account of how Crisis Resolution and Home Treatment have been incorporated into a comprehensive service for a rural area in the Republic of Ireland. It is based on a visit to Monaghan and discussions with senior clinicians and managers who run this service backed up with information from their monograph '*A model for a new Community Mental Health Service – the Cavan/Monaghan Project*' published in 2001.

Monaghan and Cavan have a catchment population of 106,000 distributed over a large geographical area with small towns, none bigger than 8,000. The new service is remarkable for having been designed on the basis of local health services research. It has been developed during the last few years and is now meeting the needs of patients much better than hitherto. New specialist functions like CRHT and Assertive Outreach were incorporated because the research showed that they were necessary, and not because they were dictated by any national service framework or plan.

Research based service development

The commitment of staff and users to the plan for service change was certainly helped by a thorough local analysis of what was wrong with the service.

There was a very high level of compulsory admission to hospital. Clinical review demonstrated that many patients were being admitted for whom there were better and more acceptable alternatives. There was a 15-fold variation in admission rates from local general practitioners, some of whom seemed to see compulsory psychiatric admission as the only option for drug and alcohol induced crises. Clearly there was a need for better gate-keeping to the acute wards which were consuming most of the resource and providing a poor quality of care that many patients accepted only under compulsion.

A small minority of patients (4.6%) admitted per year accounted for nearly a quarter (23%) of all admissions and nearly one fifth (18%) of total bed days occupied within the year. What became known locally as the 'whirling door syndrome' clearly reflected repetitive failure of discharge and care planning for

Figure 8
Primary relationships in rural area whole system
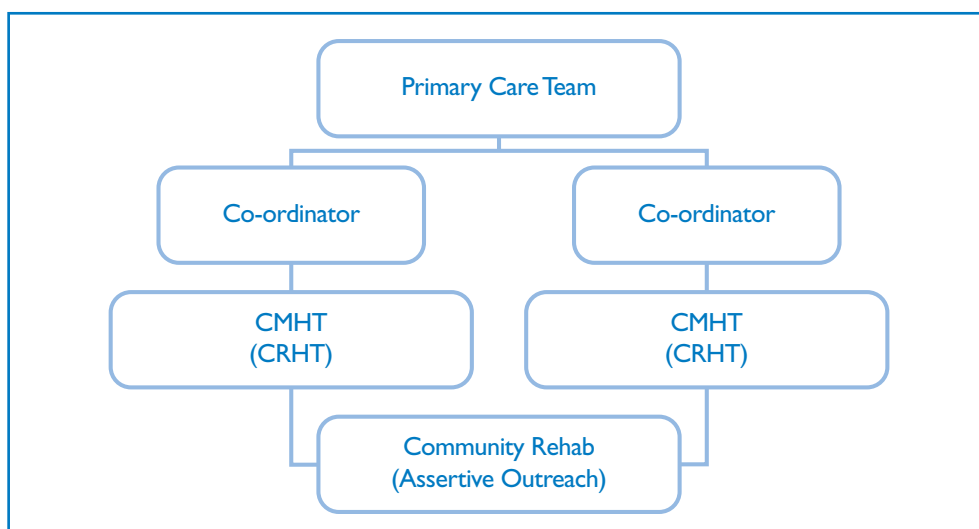
a small number of people with severe and enduring mental illness.

Figure 8 (page 21) shows in outline how the whole system has been developed with as a consequence substantial reductions in compulsory admissions, substantial reductions in re-admissions, much lower bed use, and far greater satisfaction by users, their families and general practitioners.

CRHT within the CMHT

Each CMHT covers a population of around 50,000. Previous experience with sector teams for 25,000 population proved less efficient, and were not capable of providing the required capacity for CRHT across an extended day from 9am to 9pm covering seven days a week.

Within this CMHT are six nurses plus a support worker dedicated to CRHT. As integral members of the CMHT attending all team meetings there is excellent integration between crisis and routine work. These nurses are able to respond within two hours to a crisis and offer home treatment to all those who require it across the geographical patch. The role fulfiled by the team co-ordinator is crucial to the effective working of all other members of the CMHT including its CRHT component and acute ward.

CMHT team co-ordinator

Each CMHT has an experienced senior nurse (grading equivalent to assistant DNS or 'I' grade) who not only provides overall management and co-ordination of the CMHT but also engages closely with local General Practitioners and handles triage and access. In a rural population of 50,000 she gets to know all referring general practitioners. They are easily persuaded to use her as the single point of access and conversations develop about improving referral practices in a constructive and collaborative way. The 15-fold variation in GP referral rates has been much reduced. This team coordinator is able to judge when to bring in the CRHT nurses to avoid an admission and when to allow access to the ward. She alerts the consultant psychiatrist or junior doctor when they may be required to assist in crisis resolution. Unnecessary unpredictable demands are avoided. The team co-ordinator keeps an eye on caseloads of all members of the CMHT to make sure that work is appropriately distributed. The in-patient ward team is considered a part of the CMHT whose workload is also overseen by the team co-ordinator who controls access and monitors discharge procedures.

Instead of the 'whirling door' – community rehabilitation

Across the total population of Monaghan and Cavan there are a finite and manageable number of patients with severe and enduring mental illness who can be managed by a single specialist team. This community rehabilitation team (CRT) incorporates 11 nurses who are dedicated to Assertive Outreach. Staff providing day or residential care for these patients are an integral part of the community re-habilitation team. The close and continuous engagement with these needy patients and their families has meant the avoidance of many crises and re-admissions. Weekly meetings of each of the CMHTs are attended by

members of the community rehabilitation team to ensure effective collaboration and appropriate referrals between the two.

Addiction service

An addiction service is also provided for the whole catchment area of Monaghan and Cavan by a single specialist team. This team also liaises closely with each of the CMHTs - someone from the addiction service attends weekly CMHT meetings. As with the CMHT and its CRHT each of these specialist teams requires clinical leadership by a psychiatrist and also management by a clinically skilled team coordinator. The CRT and addiction service also have a team co-ordinator.

The relationship between the team co-ordinator and the consultant is central to successful team functioning.

The results

Compulsory certification rates in Monaghan have more than halved and are currently one third of the average national rate. The admission rate per 100,000 in the year 2000 was less than a quarter of what it had been in 1991. Occupied bed days for the County of Monaghan had been 90,000 in 1990 falling to less than 30,000 in 2000. Interestingly completed courses of ECT have fallen to one seventh of the rate they were in 1990. Since the introduction of Assertive Outreach into the community rehabilitation team in 1998 the use of long stay residential beds has halved year on year.

Acknowledgments

The Northern Centre for Mental Health is indebted to the following who gave their time and expertise to allow us to provide this brief report of their work: Dr Teresa Carey, consultant in charge of the Monaghan community rehabilitation team, Dr John Owen, consultant in charge of the Monaghan CMHT, Mrs Margaret Fleming, team co-ordinator of the Monaghan CMHT, Mr Eugene Caulfield, hospital administrator, Mr Damien Murray, chief nursing officer.

CRHT REALLY WORKS – WHAT'S STOPPING YOU?

by Peter Kennedy and Marcellino Smyth

Introduction

It is 20 years since the first positive reports of crisis resolution and home treatment services, (Fenton et al., 1979; Stein and Test, 1980; Hoult, 1986). Why has it taken so long for the idea to be adopted in Britain? Those embarking on setting up a CRHT need to understand the doubts and resistances that have inhibited spread.

One author of this paper (PK) has been visiting and studying services with CRHTs already in operation. From Camden in London to Newcastle, Barnsley in Yorkshire to Monaghan in the Republic of Ireland, and Birmingham to Bradford, CRHTs have reduced admissions by an average of 30%. They have achieved a leap forward in quality and user satisfaction by reducing compulsory orders to the same extent. Where there was over-occupancy and major problems in finding beds for those really in need, now there are always beds available. Out of area admissions have become a thing of the past. And this kind of transformation has been achieved within months of introducing a CRHT.

Such findings challenge anyone to come up with another mental health innovation in the last 20 years that has had such obvious and striking benefits. The economics are similarly impressive. A mental health trust with a £100 million turnover spends around £60 million on providing in-patientcare, at least half of which is on acute beds: it can expect to increase the efficiency of this most expensive asset by up to 30% by spending only £1 million or 1% of total turnover. What could be better value for money ?

Where is RCT evidence?

Some demand evidence from randomised controlled trials (RCTs) before accepting CRHT as an alternative to in-patient care. RCTs are at last being carried out in this country but there is a sampling problem because informed consent to randomisation is often not forthcoming from acutely psychotic patients in crisis. But who needs RCTs anyway comparing CRHT with acute in-patientcare? It is not as if acute in-patient care is a powerful standard to match or improve on. There have been no RCT evaluations of acute in-patient care. Poor conditions in wards in this country have become a major concern in recent years. The high occupancy rates have denied access to people who desperately need to be in a place of safety. There is plenty of evidence that longer stays in hospital actually harm patients.

There are more important questions about CRHTs which the second author of this paper (MS) attempts to answer here on the basis of more than a decade's experience of working in a service with a CRHT as well as keeping a close eye on international reports and developments.

Is it a genius system?

Extraordinary people with extraordinary drive and commitment sometimes achieve extraordinary service improvements. But this does not produce a service model for others because it is not repeatable. A crucial question is

whether all the benefits of CRHTs can be obtained in any service recruiting the usual calibre of staff.

Experience and commitment to acute psychiatry along with a desire to work differently within a targeted specialist team are the main characteristics of staff required to deliver CRHT. Most staff are self-selecting with a high proportion of in-patient staff who want to remain working with the same kind of patients. The expertise required in decision-making about admission rapidly develops with experience of successful home treatment for a variety of clinical and social conditions.

CRHT development has historically been led by a product champion, usually a psychiatrist. But CRHT is not a genius system. It can be replicated by any reasonably well trained mental health professionals who want to do it.

Can it work in all kinds of populations?

Doubts are expressed about whether CRHT can deliver the same benefits in very deprived populations, and whether it is practicable in dispersed rural populations. In fact, CRHT is particularly suited to deprived inner city populations, because they are compact with little travelling time and a high prevalence of severe mental illness. Unlike more affluent areas, there is little ambiguity around the needs of acute cases referred for admission.

In sparsely populated rural areas a 24 hour dedicated team is not economically or geographically feasible but some members of the generic community mental health team dedicating time to crisis work from 9am to 9pm can achieve excellent results applying the same principles. In County Monaghan, Ireland, such a team has reduced annual occupied bed days by two-thirds between 1998 and 2001.

Do CRHTs keep their staff?

People ask, is crisis work so demanding as to lead to early burn-out? Or is it so limiting that staff move on to sustain professional job satisfaction? The answer is that CRHT staff describe high satisfaction and no increase in burn-out where this has been measured (Minghella et al 1998). The reasons why nurses prefer this model is that they have a more distinct sense of their own personal contribution and influence on the outcomes for clients than in overcrowded in-patient settings.

CRHT is of necessity collaborative. Without explanation, negotiation and agreement with service users and carers it does not work. Staff relationship skills are tested and refined in difficult times in people's homes and with a lot at stake. CRHT is without institutional constraints focusing on the individual patient and professional coping with mental distress together. At best it offers a different trajectory of care, facilitating dialogue about mental illness in its widest sense from narrative, illness meanings, family context to social and biological perspectives. In North Birmingham the average length of service in CRHT is 4 years. In County Monaghan staff sickness levels have fallen from 4 - 5% to less than 1% since remodelling the service and introducing CRHT.

Are the benefits sustained?

Is it the novelty effect for both staff and patients that leads to early service improvements that dissipate over time? CRHT has been sustained for over 20 years in Madison, Wisconsin, and New South Wales. CRHT has been sustained in North Birmingham for 10 years. The benefits in terms of reduced admissions are sustained. Hoult and Smyth's analysis (in submission) of admission rates for the six years following introduction of a CRHT compared to the five years before hand, showed a sustained 50% reduction in admissions.

How does CRHT impact on the whole system of care?

A question of fundamental importance is whether CRHTs can be effective without co-operation and change across the whole system of care? What are the implications for in-patient teams ? What are the implications for the work of CMHTs? Will primary care teams notice and value the differences? How does the Assertive Outreach team relate to a CRHT?

Reduced admissions means more time on wards to develop therapeutic relationships and to deliver structured care plans. Joint working with the CRHT improves awareness by the in-patient team of pressing social and community problems, which can mean better judgement on the timing of discharge. Early discharge to CRHT support (including Mental Health Act leave arrangements) is a real option. Joint working also improves the quality of risk assessment and management.

With CRHT implementation, the work of the CMHT can be more focused and effective, relieved of disruptions that urgent referrals and crisis working creates. Keyworkers in CMHTs have the assurance that their clients in risky situations can have rapid access to more intensive support than they can provide. Earlier access to such additional input can stem deterioration which might otherwise have led to admission. An essential requirement is that CMHT staff work closely with the CRHT on transfer planning and keyworkers are quickly identified for new cases identified and treated by the CRHT. A weekly review of patients shared between CMHT and CRHT normally takes only twenty minutes, but really pays dividends in terms of joint working.

Collaboration between CRHT teams and Assertive Outreach teams should improve the latter's effectiveness. The caseload of Assertive Outreach teams by its very nature means that out of hours crisis situations will arise. CRHT, particularly with 24-hour cover, can assist the Assertive Outreach teams in these situations. The point at which additional support from CRHT teams might be requested is critical because most Assertive Outreach teams do manage their own crisis situations. But late referral at the point of admission is usually too late. Both teams should work on the 'extension principle', i.e. CRHT is viewed as an extension of Assertive Outreach rather than as a separate specialised service. The simpler the structure and process of communication the easier it is for CRHT to be able to offer help in emerging critical situations.

So, co-operation across the whole system of care is essential for the success of CRHT? It is also an opportunity for other clinical teams to improve their performance. Lack of cooperation will squander the new potential for the whole system. Primary care professionals can be delighted with the better response

to emergencies and the increased availability of CMHT staff for routine referrals.

Is professional stress increased or reduced by CRHT?

Kennedy and Griffiths (2001) found that a major contributing factor to the stress being experienced by many general psychiatrists was the struggle to cope with increasing numbers of unpredictable emergencies at the same time as managing clinics, ward rounds and other fixed sessions. Could separation of these two facets of the work of a consultant, and indeed other professionals be their salvation?

There is every indication that this is the case. From South Australia to Newcastle and Monaghan this sub-specialisation within general psychiatry and greater division of labour amongst mental health professionals is producing jobs that are more focused, more manageable, less stressful and more professionally satisfying.

What are the risks?

As yet there is no systematically collected data to answer this question adequately. Adverse incidents during home treatment ought in future to be routinely collected and monitored over time with similar incidents involving inpatients. So far there have been no high profile cases in this country blaming CRHT as causing ''another failure of community care'' and plenty of people will have been looking out for such evidence. Much research on suicide points to social isolation and rejection as the lethal factor in depression. The current state of our acute in-patient wards leaves many patients complaining of loneliness and neglect, and by virtue of the admission they are distanced from relatives and neighbours. CRHT strives to retain engagement with the individual's social group, at home, and the whole approach is person-centred.

Introducing a CRHT introduces another team and therefore more interfaces into the system of care. Serious incident inquiries often reveal failures in continuity of care due to poor collaboration between teams. It is a challenge to all teams, not just CRHTs, to reduce failures in care due to poor hand-over arrangements.

What else has inspired antipathy to CRHTs?

Smyth et al (2000) asked this question two years ago in the British Medical Journal and provoked somewhat vitriolic responses. Protheroe and Carroll (2001) were 'struck by many UK-based psychiatrists' unawareness of and hostility towards the development of crisis services with a reduced bed base and the resulting changes in working roles'. Things are changing but clinicians may still have a number of fears. Will the service be resourced by reducing beds? Is a leap of faith required to close beds first and pray that CRHT reduces admissions as promised? Even though time and time again CRHT has been shown to have early impact on admissions it is sensible to have the result delivered first with time to give confidence that it will be sustained, before proposing any bed closures and redeployment of resource.

There may be anxieties surrounding the implications for medical cover to support the out of hours service. A number of centres in implementing CRHT have invested in additional medical posts at staff grade or associate specialist grade to address this issue successfully. Another potentially divisive issue is that consultant psychiatrists have to hand over their admitting rights to the CRHT if the latter is to work. Why is that such an awful spectre? After a developmental phase when new routines of CRHT assessment of potential admissions has become established, disagreement amongst practitioners about the need for admission or the place of CRHT are quite uncommon. And being relieved of the often irritating chore of finding an emergency bed is hardly a loss to most consultants.

In conclusion

The two authors of this paper, one an enquiring sceptic, the other an experienced protagonist, after studying developing practice in this country, have reached the conclusion that it is no longer a question of whether CRHTs are effective. It is rather a question of whether the full potential of this innovation will be realised by capitalising on consequential improvements that can be made to the rest of the care system and by changing professional roles to reduce stress and improve job satisfaction. Can anyone now justify resisting changes that will avoid large numbers of patients being compelled against their will into an unsavoury and over-crowded acute ward instead of being offered the alternative of Crisis Resolution and Home Treatment?

REFERENCES

DEPARTMENT OF HEALTH (2001)
The mental health policy implementation guide.
Crisis Resolution/Home Treatment.
London.

FENTON, F.R.,TESSIER, L., STRUENING, E.L.(1979)
A comparative trial of home and psychiatric hospital care.
Archives of General Psychiatry. 36,1073-9.

HOULT, J. (1986)
Community care of the acutely mentally ill.
British Journal of Psychiatry, 149, 137-144.

KENNEDY, P. and Griffiths, H. (2001)
General psychiatrists discovering new roles for a new era.
Britisj Journal of Psychiatry, 179, 283-285.

MINGHELLA, E., FORD, R., FREEMAN, T., (1998)
Open All Hours.
Sainsbury Centre. London.

NORTH EASTERN HEALTH BOARD (EIRE) (2001)
A model for a new community health service - the Cavan Monaghan
Project.

PROTHEROE, D. and CARROLL, A. (2001)
Twenty-four hour crisis assessment and treatment teams: too radical for the
UK? Psychiatric Bulletin, 25, 416-417.

SMYTH, M.G., HOULT, J., PELOSI, A. J., et al (2000)
The home treatment enigma. Home treatment enigma and fantasies.
BMJ, 320, 305-309.

STEIN, L.I. and TEST, M.A. (1980)
Alternative to mental hospital treatment. Conceptual model, treament
program and clinical evaluation.
Archives of General Psychiatry, 37, 392-397.

OTHER PUBLICATIONS FROM THE NORTHERN CENTRE FOR MENTAL HEALTH

Seeing through walls
A report on social inclusion in practice based on the findings of the Social Inclusion Mapping Exercise
Juliet James
(May 2003)

Service User Development Worker Network
The role of the service user development worker in the North East, Yorkshire and Humberside
Bev Mills
(April 2003)

Developing the workforce
Review of Local Implementation Teams in the Northern and Yorkshire Region
Elaine Readhead and Charlie Brooker
(March 2003)

From Social Care to Social Inclusion
Changing perspectives on Mental Health amongst Social Services managers in the North East and Yorkshire & Humberside
Colin Williams
(January 2003)

Mental Health Research and Development in the North East, Yorkshire and Humberside: Report of a Scoping Project including Local and National Recommendations
Dr Jake Lyne, Dr Peter Kennedy and the IMPACT research team
(December 2002)

Assertive Outreach in the North East, Yorkshire and Humberside
Sue Clement, John Freeman, Keith Ford and John Ketteringham
(September 2002)

Avoiding the Wash Out
Developing the organisational context to increase the uptake of evidence-based practice for psychosis
Dean Repper and Professor Charlie Brooker
(July 2002)

Getting Better - Together
Reflections on the Mental Health Collaborative
Martin Dale, Kath Dempsey Jacqui Ellis, Janice O'Hare, Chris Stanbury, Yvonne Stoddart
(June 2002)

Review of the Mental Health Training Process
Elaine Readhead and Dr Ruth Briel
(July 2001)

Mapping of Current Education and Training
To Support the Implementation of the National Service Framework For
Mental Health
(January 2001)

Discussion Paper
An analysis of the concerns of Consultant General Psychiatrists about their
jobs, and of changing practices that may point towards solutions
Dr Peter Kennedy and Dr Hugh Griffiths
(September 2000)

**A competence-based 'exit profile' for pre-registration mental
health nursing**
Dennis Cross, Elaine Readhead and Martin Brown
(June 2000)

Northern Centre for
Mental Health

OUR MISSION

"To enhance the quality of life for people with mental health problems, through development activity, undertaken in partnership with service providers, commissioners, users and other key stakeholders."