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special articles

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Service innovations: an Australian approach to community care – the Northern Crisis Assessment and Treatment Team[†]

The recent White paper, *Modernising Mental Health Services*, recommended the provision of home treatment teams for acute mental illness (Department of Health, 1998). Such services are not widespread in the UK and have been the subject of recent debate (Smyth *et al*, 2000). In Australia, multi-disciplinary teams providing 24-hour community assessment and treatment of psychiatric emergencies have been in place now for over a decade, and form the cornerstone of the public mental health service.

Victoria, the second most populous state in Australia, has been at the forefront of the nationwide move towards community-based psychiatric services. In the early 1990s the State Government began to shift emphasis and funding away from the large stand-alone psychiatric hospitals towards community-based services. The large hospitals were eventually closed, and replaced by small in-patient units located in general hospitals. The in-patient base was thus reduced and funding diverted to community services managed locally by 'area mental health services'. As well as community mental health clinics, these services have also contained assertive outreach components to cater for both acute crises and chronic disability in the community.

The Northern Area Mental Health Service (NAMHS) provides psychiatric services to a total population of 225 000 in the northern suburbs of Melbourne. The catchment area includes mainly low-income households with high rates of unemployment, illicit drug use and people from non-English speaking backgrounds. Currently the 'adult' (aged 16–64) components of the service comprise an acute in-patient unit of 25 beds, two community mental health clinics (providing care management and medical care) and a crisis assessment and treatment team.

Functions of the NCATT service

The Northern Crisis Assessment and Treatment Team (NCATT) operates 24-hours a day, 7 days a week. During office hours it operates as an adult service (16–64 years) but takes all urgent referrals out of hours, regardless of age.

Triage

Referrals come from public or private mental health professionals, general practitioners (GPs), police, casualty, families, carers and patients themselves. The team assesses those who meet intake criteria (i.e. who appear to require either admission or intensive home treatment), while others are briefly counselled over the telephone or re-referred to more appropriate agencies.

Community-based assessment and treatment

Once a referral is accepted, one or two members of the team visit the patient. All urgent referrals are seen within 2 hours. A standard psychiatric history is taken and the mental state examined, with particular emphasis on social support, risk factors and suitability for home-based treatment.

If the patient is taken on for ongoing CATT care, then he or she can be visited up to twice daily (although once daily is more usual), with the frequency of visits generally being reduced to once every few days before discharge from CATT care. In addition to ongoing assessment, interventions include advice, support and psychoeducation for the patient and carers; problem-solving; dispensing (and, if necessary, supervising) medication; and the addressing of psychosocial and interpersonal difficulties.

Telephone support

Current patients and carers are encouraged to ring at any time, day or night, if in need of advice or support.

Gatekeeping

Twenty-five public sector acute adult beds exist for the NAMHS catchment area (approximately 1 bed per 9000 total population). All agencies (except the NAMHS rehabilitation services) seeking admission must first refer to NCATT for assessment. Only those patients judged unsuitable for community treatment (generally because of non-compliance, being seriously suicidal or showing very disturbed behaviour) are admitted to the ward.

Facilitation of admission

When NCATT assessment leads to a decision to admit to the in-patient unit, the team liaises with carers and ward staff as necessary. In addition, it arranges for assistance from the ambulance service or the police if escort by the NCATT itself is not appropriate.

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Early discharge management

Turnover on the in-patient unit of NAMHS is rapid (average length of stay is 14.5 days; average bed occupancy is 90.7%). In order to ensure that hospitalisation is as brief as possible, NCATT manages some patients at home in the fragile period immediately after discharge. NCATT clinicians first assess patients on the ward for suitability for home-based care. This provides a bridge between the ward and longer-term care, allowing earlier discharge than would otherwise be possible.

Referral of clients to ongoing care

The focus is on short-term intervention during the crisis phase. From the outset consideration is given to which agencies will provide most appropriate long-term care. Referrals are made promptly in order to avoid undue delay in patients being taken on by such services once NCATT involvement is no longer needed.

Structure

The service is located within a general hospital adjacent to the ward. The team is mobile and does not receive clients at this location.

Staffing comprises 12 senior registered psychiatric nurses, a psychologist, a social worker, a psychiatric registrar, a consultant psychiatrist (0.5 whole time equivalent), a service manager and an administrative officer. Medical and administrative staff work business hours Monday to Friday. The team has access to the on-call junior and consultant psychiatric staff for advice out of hours. Three clinicians are rostered for each day shift, four for each evening (3 clinicians on weekend and public holiday evenings) and one clinician works overnight (11 p.m. until 9 a.m.). One clinician per shift remains on-site and is responsible for referrals via the local Accident and Emergency (A&E) department. The overnight clinician can attend the A&E department and police stations but does not carry out any assessments in patients' homes.

Management of clients is team-based; owing to the short-term nature of the service, a keyworker system is neither feasible nor desirable. Hand-overs are conducted at the start of each shift, when the whole team can discuss current management strategies and problems. Each shift has a nominated leader who plans and coordinates the workload.

Information regarding current clients and pending business is tracked using a whiteboard. The team keeps its own patient files. As well as ensuring ease of access at all hours, dedicated NCATT files give a useful summary of past crisis presentations.

There are weekly staff meetings, when policy issues are discussed, and regular education sessions.

Close working relationships with professionals providing long-term care both within NAMHS and beyond are essential. Patients are encouraged to continue seeing their usual clinicians (e.g. clinic workers, private psychiatrists, counsellors) while being managed by NCATT and regular communication with these agencies ensures efficient co-management. Any differences of opinion regarding appropriate care are worked through, to ensure that patients do not receive conflicting messages.

Clinical examples

The following two vignettes demonstrate how the NCATT manages common psychiatric problems.

Vignette one

Kylie is a 24-year-old single, unemployed woman with a history of childhood sexual abuse and an 8-year history of chaotic behaviour including binge drinking, drug taking, self-laceration and frequent drug overdoses. She had been admitted to a number of acute psychiatric wards for assessment. Admissions were often prolonged and involuntary owing to frequent threats of self-harm. At a case conference it was agreed that admissions were generally counter-productive and an alternative strategy was devised. One Saturday night she attended A & E while intoxicated and threatened to harm herself if she was not admitted to the psychiatric ward. Her mental state was much the same as on previous occasions. After discussion she felt able to cope at home with CATT monitoring. It was agreed that the CATT would telephone her every 4 hours for assessment and support and that she could phone the team at any time if she felt suicidal. After three calls Kylie felt that she would be able to cope and CATT withdrew. CATT contacted her keyworker and GP on Monday morning to provide hand over information.

Vignette two

Christos is an 18-year-old Greek-born apprentice plumber who was taken by his parents to his GP, with a 2-month history of social anxiety and poor concentration. The GP ascertained that he had paranoia and was hallucinating and contacted the CATT. A nurse and registrar arranged to visit Christos at his parents' home. An interpreter was provided for Christos' parents. Following a full assessment, including a neurological examination, a diagnosis of acute psychotic episode was made and an oral antipsychotic was prescribed, initially in syrup form. He was referred to the area mental health clinic and a keyworker was appointed. The CATT visited Christos at home twice daily in order to monitor his mental state and supervise his medication. A computer tomography brain scan and routine blood tests were also arranged.

After 7 days Christos refused to take his medication, and after discussion with the consultant, Christos was admitted involuntarily to the in-patient unit. He subsequently began to take his medication and after 11 days was reassessed by the CATT, who felt that he was suitable for 'early discharge management' at home. He was visited daily for the next 6 days and following a joint visit with his clinic keyworker was finally discharged to the care of the clinic.

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NCATT workload March 1999 to February 2000

For the 12 months to the end of February 2000, 4374 referrals were received, 1422 were assessed and 384 were taken on for ongoing NCATT care. The mean duration of contact for those taken on was 10.7 days (s.d. 10.9 days; range 1–72 days). Of those taken on, primary ICD–10 (World Health Organization, 1992) codes were:

(a) F10–19 (mental disorders due to psychoactive substance use): 12 (3.1%)
(b) F20–29 (schizophrenia, schizotypal and delusional disorders): 173 (45.1%)
(c) F30–39 (mood disorders): 110 (28.6%)
(d) F40–48 (neurotic, stress-related and somatoform disorders): 51 (13.3%)
(e) F60–69 (disorders of adult personality and behaviour): 20 (5.2%)
(f) Z code (no psychiatric diagnosis): 18 (4.7%)

Ensuring effective team working

Various problems can arise in the functioning of multidisciplinary community psychiatric crisis teams. Failure to maintain a clear focus can result in services being flooded by minor emotional and social problems, to the detriment of those with severe mental illness. Idiosyncratic therapeutic practices on the part of individual clinicians can undermine the team approach to care. Working at the acute, sharp end of a service is often stressful and 'professional burnout' is therefore a risk. The NCATT has generally managed to avoid such difficulties. The low percentage of referrals taken on for intensive home treatment suggests that less serious problems are being effectively filtered out. Team hand overs, which are overseen on a daily basis (Monday to Friday) by the consultant psychiatrist, help to harmonise treatment approaches.

Team morale has generally been excellent. There are several possible reasons for this. All clinicians are experienced practitioners and feel confident in their abilities to work as independent, responsible practitioners within a team. An atmosphere of mutual respect is encouraged and differences of opinion are freely expressed before consensus is reached. More formally, the team manager conducts annual confidential appraisals of all staff at which performance is evaluated and future goals identified. 'Team building' days also take place each year, where the future goals of the team are discussed.

Conclusion

The CATT model of care has facilitated the move from an institutional model of care to safe community-based care and is considered locally to have been a great success. After 8 years there are remarkably few who would advocate a return to a more traditional style of service.

References

DEPARTMENT OF HEALTH (1998) *Modernising Mental Health Services*. London: HMSO.

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

WORLD HEALTH ORGANIZATION (1992) *The ICD–10 Classification of Mental and Behavioural Disorders*. Geneva: WHO.

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Consultant advisers in every service

Summary report from the working group on the role of consultants in implementing the National Service Framework and NHS Plan

Shortly after taking up my appointment as National Director for Mental Health, I convened a working group of consultant psychiatrists to consider how to involve psychiatrists more in the current process of changing mental health services. This was in recognition of the fact that, while psychiatrists are central to modernising services, their skills and experience are insufficiently used. It is one of the most frequent complaints that I hear from clinicians.

This paper summarises the conclusions and proposals of the group. First, it proposed the appointment of a 'consultant adviser' in every local service; with dedicated time for service development, linked to National Service Framework (NSF) local implementation teams. The consultant adviser will have no managerial responsibility and will reflect the perspective of front-line clinical practice on how a local service puts current policies into

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