

## Practice paper

# Making progress in mental healthcare: the Crisis Resolution and Home Treatment Service for Leicestershire County

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### ABSTRACT

There has been a rapid expansion of crisis resolution and home treatment (CRHT) teams round the country. Recent study has shown that these have led to significant reductions in hospital admission rates. However, to date there does not appear to be any literature discussing the roles and function of such teams, how they were set up and exactly what sorts of services and treatments they provide. This paper discusses the implementation of the Leicestershire County CRHT operational model, its main functions and infrastructure. It explains what consti-

tutes home treatment, as well as the role of the link nurse in facilitating early discharge from hospital. It also presents a discussion about the ways in which members of black and other minority ethnic (BME) groups may benefit from having a discreet accessible psychiatric service 24 hours a day, seven days a week within the privacy of their own homes.

**Keywords:** adult mental health, community care, crisis, crisis resolution, home treatment, rapid response

## Introduction

The National Service Framework (NSF) for Mental Health (Department of Health, 1999) established various standards for mental healthcare provision. These included mental health promotion, primary care, access, services for individuals with severe enduring mental health problems, meeting the needs of informal carers and reducing suicide rates. The most recent edition of this framework has emphasised, amongst other areas, care for individuals with 'long-term mental disorders, setting out a new model of mental health care in primary care' (Appleby, 2004, p. 2). This document also considers ways of reducing social exclusion; future work on services for inpatients, individuals from minority ethnic groups and people with dual diagnosis; and the provision of 'psychological therapies' (Appleby, 2004, p. 2). The NSF underpins the Department of Health's proposal to establish assertive outreach teams, currently 220 in total, and crisis resolution and home treatment (CRHT) teams, currently 335 in total, for all areas of the country (Department of Health, 1999). This proposal is supported

by the service specifications outlined in the Mental Health Policy Implementation Guide (Department of Health, 2000, 2001) which specify that, by 2008, every client who requires them will have access to comprehensive community, hospital and primary mental health services, with round-the-clock crisis resolution and assertive outreach services.

This paper provides an account of the type of services and care provided by CRHTs in one area of the UK. The Leicestershire Partnership NHS Trust is committed to the development of new services to meet local priorities and delivery plans, in conjunction with national targets, and the integration of health and social care (Leicestershire, Northamptonshire and Rutland Strategic Health Authority, 2003; Davis, 2004). This commitment includes mental health services and this paper begins by explaining how CRHTs were established and the types of clients for whom the services were intended. The Leicestershire teams operate using a specific model, and audit data indicate that they are having a positive effect in reducing

hospital admissions. The benefits of CHRTs are discussed, with reference to enabling service users who are members of black and other minority groups to gain the help and support they need.

## Rationale for Leicestershire County CRHT

Leicestershire County CRHT was established because of the desire of service users and service providers to make home treatment available as a viable and consistent alternative to hospital admission (Minghella *et al*, 2002; Northern Centre for Mental Health, 2003). The CHRT teams aim to:

- reduce the number of inappropriate admissions to inpatient units, thereby improving the quality of care to the service users that are admitted
- effectively streamline access to psychiatric services where admission is being considered
- increase the presence of out-of-hours community psychiatric services in recognition of need.

During the first six months of operation, the Leicester City team showed a 30% reduction in acute psychiatry admission rates (Colman and Lange, 2004). This accords with evidence supporting the case for the establishment of CRHT teams around the country, with a substantial body of randomised controlled trials demonstrating that the majority of individuals with severe mental health problems can be cared for by community-focused services with outcomes equal to, or better than, inpatient care (Brimblecombe *et al*, 2003; Johnson *et al*, 2005). However, others argue that the NSF for Mental Health (Department of Health, 1999) has been overly prescriptive in its imperative to set up these services. The body of evidence supporting the case for CRHT services originated mainly from the USA (Brimblecombe, 2003) and Australia (Rosen, 1998) resulting in some scepticism as to whether these services will be effective in the UK (Johnson *et al*, 2005). Notwithstanding, reports from around the UK and the Department of Health suggest that the introduction of CRHT services has led to reductions in admission rates (Department of Health, 2004a, 2004b; Glover *et al*, 2006).

## Setting up Leicestershire County CRHT

The County CRHT service became operational on 30 December 2004, following a month of training to prepare the team for the service. Team membership

represented a wide variety of clinical experience, expertise and professional and academic background. Training incorporated role-plays of possible crisis scenarios and mental state assessments, followed by the creation of management plans, as if the situations were real. The length and required number of staff per shift were agreed. There were also opportunities to network with other voluntary and statutory organisations, to explore what services they provided and processes of referral. A recording system was devised and included the initial care programme approach (CPA) assessment schedule, risk assessment and risk management plans (adapted from Morgan, 2000), care plan, record of daily intervention and partnership plan which is a tool to help patients recognise their own strengths and weaknesses and devise a recovery/relapse prevention plan. The team adopted a collaborative approach in the setting up process, and this gave an element of individual ownership of the service.

## Leicestershire County CRHT model

The service is aimed at people aged 16–65 years, and those over the age of 65 with a functional illness, such as depression, anxiety, severe agitation, and who were experiencing a serious mental health problem with an acute crisis of such severity, that, without the involvement of the CRHT team, hospitalisation would be necessary (Department of Health, 2001). The crises that may warrant the use of the CRHT are wide and varied. There may be a breakdown in normal coping mechanisms, a significant deterioration in mood with suicidal ideation, an increase in psychotic symptoms, deterioration in social performance and increasing concern from others. Such a crisis may be developmental in that the patient already has a mental health problem in which crisis develops over a period of time and the mood/presentation deteriorates. Crises may also be situational; for example, people with or without existing mental health problems may react to certain experiences such as the loss of a job, an accident or separation from relationships (see Boxes 1 and 2). Finally, crises may develop as a result of severe trauma such as sudden loss or bereavement or assault (Rosen, 1998). There may be significant risk factors for the client or others, which would warrant the client being seen within 24 hours (Northern Centre for Mental Health, 2003). Using the operational model, CRHT teams can provide rapid assessment and a range of psychotherapeutic interventions as an alternative to inpatient care. Boxes 3–6 outline the main features of the operational model, and Boxes 1 and 2 illustrate possible scenarios where the CRHT may become involved.

**Box 1 Developmental crisis**

Margaret (pseudonym) is a 45-year-old artist, divorced with two grown-up children. She has a long history of paranoid schizophrenia and has been maintained well in the community for many years. However, recently Margaret noticed that she was putting on weight and thought that her antipsychotic medication was responsible for this. She subsequently stopped taking her medication and this led to a rapid deterioration in her mental state. Margaret presented to her general practitioner (GP) as extremely paranoid about her neighbours, and thought that they were out to harm her, in the absence of any real evidence that this was the case. She was convinced that her thoughts were real and was preparing to retaliate against her neighbours. Without the CRHT, the only option would have been to admit Margaret. The CRHT can implement a treatment plan within the privacy of her own home, whereby Margaret's medication concordance can be monitored and risk and mental state assessed, causing minimum disruption to her home and family life. Home treatment may involve daily home visits to start off with, to provide practical advice and guidance on managing her days and time and to allow her the opportunity to ventilate any anxieties/worries about her illness/medication. Once the acute stage is over, further CRHT involvement may include a support, time and recovery (STR) worker taking her out to do some shopping, assisting her in preparing food and helping her access local facilities and activities. At this stage if she does not have a community psychiatric nurse (CPN), the CRHT may request a referral to the community mental health team for Margaret to be considered for allocation to a CPN for longer-term community monitoring.

**Box 2 Situational crisis**

Ali (pseudonym), a 28-year-old man with a wife and a small child, is a keen Leicester City supporter. He has no previous psychiatric history. However, he suddenly took an overdose following the bankruptcy of his business because he considered himself to be a failure and that he had let his family down. He was found by his wife in an unconscious state and taken to the emergency department by ambulance. At assessment, he appeared to be low in mood with further expressed intentions of self-harm. In the absence of the CRHT service, the only option would have been to admit this man to hospital to maintain his safety and commence on medication if needed. The CRHT service can prevent hospital admission by providing support and treatment at home through a combination of home visits and telephone contact. The range of psychotherapeutic interventions may include providing information, guidance and practical advice on anxiety management, relaxation techniques, sleep hygiene, healthy diet intake, ways of managing and structuring days with balanced activities, effective time management, managing negative thoughts, dealing with intrusive thoughts of wanting to harm himself, together with 24-hour telephone support for both him and his family. There are psychiatrists in the team who can review Ali for medication. Crisis workers can also refer Ali on to other services. In this case, it may be appropriate to refer Ali for debt management advice and counselling to help him come to terms with the changes in his life.

**Box 3 The operational model**

- A mobile community-based service
- Accessible 24 hours a day, 365 days a year
- Rapid response (all accepted referrals to be assessed within 24 hours)
- Multidisciplinary and multi-agency approach
- Crisis management, support and treatment in the least restrictive environment
- Crisis/relapse prevention

**Box 4 Sources of referral**

- Emergency department, including liaison psychiatry
- GPs, including out-of-hours doctors
- Drug/alcohol teams
- NHS Direct
- Voluntary sector
- Primary care team
- Social services
- Police/forensic services
- Consultants/community mental health teams
- Treatment and recovery service
- Early intervention team

### Box 5 Inclusion criteria

- Adults aged 16–65 years, and those over the age of 65 with a functional illness
- Evidence of acute symptoms (e.g. of schizophrenia, mania, depression)
- Breakdown of normal coping mechanisms
- Hospitalisation is being considered
- Significant risk factors, overdose, self-harm, suicidal ideas/plans
- Patient willing to accept home treatment and support

### Box 6 Exclusion criteria

(Where a client does not meet our referral criteria, they are offered telephone support at the point of contact, signposted to appropriate services and referred back to their GP.)

- Client is under 16 or over 65 years of age with an organic illness
- Does not have a county address or a GP (refer to the Leicester City CRHT Service)
- Client has a severe learning disability
- Client is presenting with mild anxiety as the only mental health problem
- Primary diagnosis of substance abuse. However, patients with dual diagnosis will be assessed
- High levels of aggression or violence that will put CRHT workers at significant risk
- Patient has an organic disorder
- Intoxicated individuals will not be assessed. However, an assessment can be offered once sober

Due to the size of the geographical area, the team is divided into two: County North and County South. Patients who are on the enhanced level of the CPA ([hyperguide.co.uk](http://hyperguide.co.uk)), and already on a fast-track system for hospital admission if crises arise, can refer themselves or be referred by mental health ward staff. Those patients already accepted for home treatment can contact the service 24 hours a day. Box 4 outlines the main sources from which the CRHT can accept referrals.

The nature of the service means that certain inclusion and exclusion criteria apply, but that does not mean that those referrals that do not meet the Leicestershire CHRT criteria for home treatment are left unsupported (see Boxes 5 and 6). Every effort is made to direct unsuitable patients to other services and, where appropriate, the team will even provide home treatment for a short period.

The system works as follows. The duty co-ordinator discusses the appropriateness of the referral with the referring source. Actual and potential risks are discussed over the phone, and an approximate time given in which the patient will be seen. The CRHT team has 24 hours within which to assess the patient from the time of referral. Once the referral has been accepted, it is then handed over to the relevant team to arrange a time for assessment. During assessment, the CPA form ([hyperguide.co.uk](http://hyperguide.co.uk); Hyperguide to the Mental Health Act, 1996) with the mental state section adapted from Gelder *et al* (1989) is completed. The risk assessment is completed using the trust risk-screening protocol first, and later the Morgan (2000) comprehensive risk assessment if required. The CRHT leaflet is given to the patient, and the team's expectations and limitations are explained. Patients are asked if they want copies of correspondence sent by the team to their GP; if so, they are asked to sign a form. The patient is then discussed at the next possible team meeting back at the office to decide on the course of home treatment in light of the presenting factors.

Home treatment can last anything from a few days to about six weeks, depending on the needs and circumstances under which the patient was referred to the CRHT. Following home treatment, a period of open contact for up to two weeks may be offered before the patient is discharged. Open contact is a period where the CRHT does not contact the patient, but the patient or their relative can contact the CRHT if there are any changes to the presentation/circumstances or deterioration in their mental health. Following discharge, the patient's GP is informed in writing with a brief summary of the presenting complaint, treatment that was provided, details of progress, details of medication and any post-discharge arrangements made by the CRHT. Once all the necessary paperwork has been completed, the file is placed for archiving.

In situations where the patient is too acutely unwell to be maintained at home, a systematic review has shown that a planned short hospital stay with community follow-up is more effective than any other mode of standard care (Johnstone and Zolese, 1999). Link worker posts have been established to support the integration and collaborative working between CRHT teams and inpatient areas. The role of the link worker is to support the client in the inpatient setting. Early discharge planning facilitates the transition from community to hospital, and then back into the community, once the patient's mental state starts to improve. This enables the client to retain the same key worker and promotes continuity of care that is client and not systems led (Northern Centre for Mental Health, 2003). Once the client is discharged from hospital, the CRHT will provide a further two weeks of home treatment to look at specific needs and interventions.

## Crisis house for social crisis

The provision of a crisis house is a vital asset to the CRHT because sometimes it becomes necessary to remove someone from their immediate environment to a place of safety and sanctuary (Perkins and Repper, 1996). The aim of having a crisis house is, in part, to offer an alternative to an acute admission ward. Residents, known as 'guests', receive intensive interventions from resident therapists (Berke, 2003). The intention is to promote dialogue, insight and healthy relationships in order for clients to gain greater independence and integration in society (Felices, 2005, p. 33). The Leicestershire CRHT team has access to three beds provided by Leicestershire social services for social crisis such as domestic violence, the threat of harm from family members or others, unsafe housing that may contribute to poor coping, and so on. In other parts of the country, crisis houses have been provided by voluntary organisations and are often based on therapeutic community principles. Examples include The Arbour Association in London, which has a crisis house and other places for longer-term care.

## Leicestershire CRHT team composition

The Leicestershire CRHT service operates within a multidisciplinary and multi-agency framework and in

partnership with service users. All team members are based in the same office, which helps to ensure that continuity of care is maintained, good networks are developed and referrals to the appropriate services are made, once the involvement of the CRHT service ceases. There can be a great deal of subjectivity about what constitutes a crisis, both in terms of the circumstances leading to the referral and the outcome of the assessments by individual practitioners, but an element of acute symptomatology needs to be evident at the time of assessment. Team members work in pairs when carrying out assessments. Usually a mental health practitioner and a STR worker (Department of Health, 2003; Foley, 2005) or a service user development worker (SUDW) work together. This is to ensure that a diversity of experiences and knowledge leads to the eventual formulation of the treatment plan for the presenting problem. Both the STR workers and SUDW focus directly on the needs of the service users, working across boundaries of care, organisation and role. They provide support, practical advice and guidance, give time to patients and their families by being there to listen to their concerns or worries, and promote their recovery through anxiety management, relaxation, sleep hygiene and relapse prevention work (Uddin *et al*, 2006). The team composition is summarised in Table 1.

**Table 1** CHRT team composition

County North	County South
	Service manager
	Team manager
	Senior nurse practitioner (Band 7)
Associate specialist psychiatrist	Professor of psychiatry (lead clinician)
4 Team co-ordinators (Band 7)	4 Team co-ordinators (Band 7)
1 Approved social worker (ASW)	1 Social worker
5 Mental health practitioners (Band 6)	5 Mental health practitioners (Band 6)
	1 Occupational therapist
2 Link workers (Band 6)	2 Link workers (Band 6)
4 Mental health practitioners (Band 5)	2 Mental health practitioners (Band 5)
7 Support time recovery workers (Band 3)	5 Support time recovery workers (Band 3)
3 Service user development workers	2 Service user development workers
	Head of administration
	5 Administrative and clerical staff

## Impact on hospital admission rates

During 2005, the target for the CHRT was to receive 947 referrals. The team actually received 1957 referrals, of which 1547 patients were assessed and treated at home (see Figure 1). The remaining 410 referrals were triaged and considered inappropriate for the CHRT. Between 1 January and 31 August 2006, the CHRT received 1081 referrals, of which 1057 patients were assessed and home treated and 24 were triaged but considered inappropriate for the service. Table 2 and Figure 2 demonstrate the impact of the Leicestershire CRHT service on reducing the admission rates to acute mental health units.

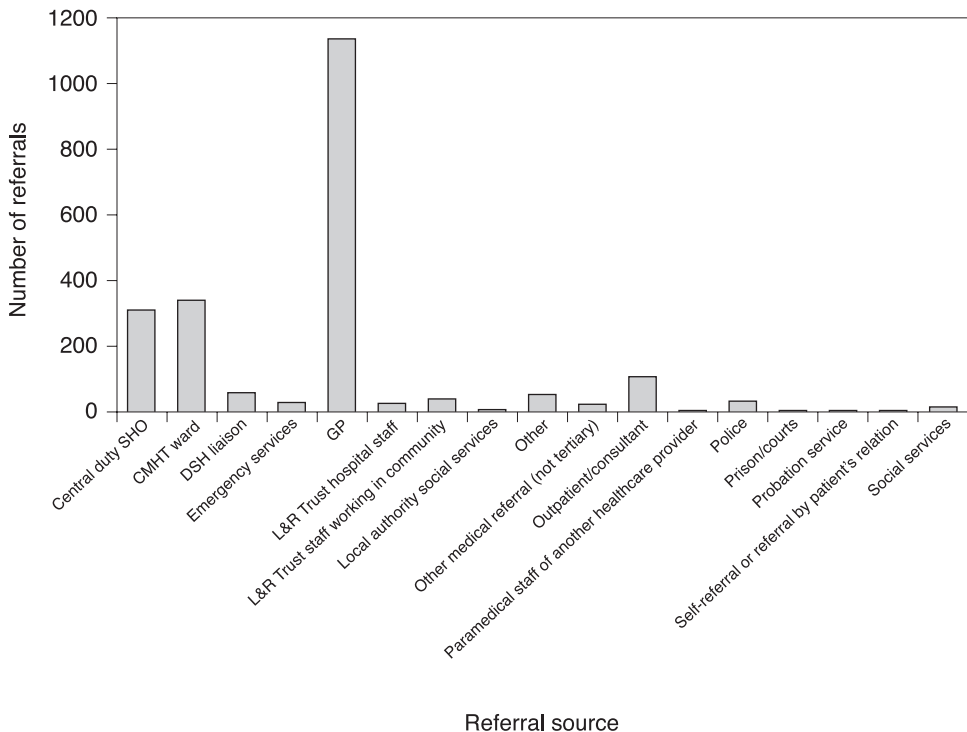
## Auditing and monitoring of standards

In July 2006 three simultaneous audits (CPA, record of daily interventions and risk assessment tools) using 150 case files were completed in order to conform to the clinical governance framework for improving quality of care and raising standards (Nicholls *et al*, 2000). The recommendations from these audits are currently being implemented and further auditing will take place in July 2007 once the necessary in-house training has been completed. Various quality improvement initiatives are being developed (see Box 7). These

include an updated patient handbook that has been devised to provide details of the service, what patients can expect, staff expectations of them together with a range of useful telephone numbers. This has been submitted for trust approval. Team members are also developing a recovery pack with various standardised training modules on anxiety management, relaxation and so on. This is to maintain consistency among all team members in how these sessions are delivered. As Leicestershire CRHT is still a relatively new service, there is a need to ensure that systems are in place so that standards are met, staff receive quality supervision and mentorship and that the service evolves in accordance with the specifications outlined in various government proposals (Department of Health, 1999, 2001, 2004a, 2004b). The SUDWs are currently surveying patient satisfaction following intervention from the service. Box 7 details some of the quality improvement initiatives currently in place.

## BME groups: the Leicestershire context

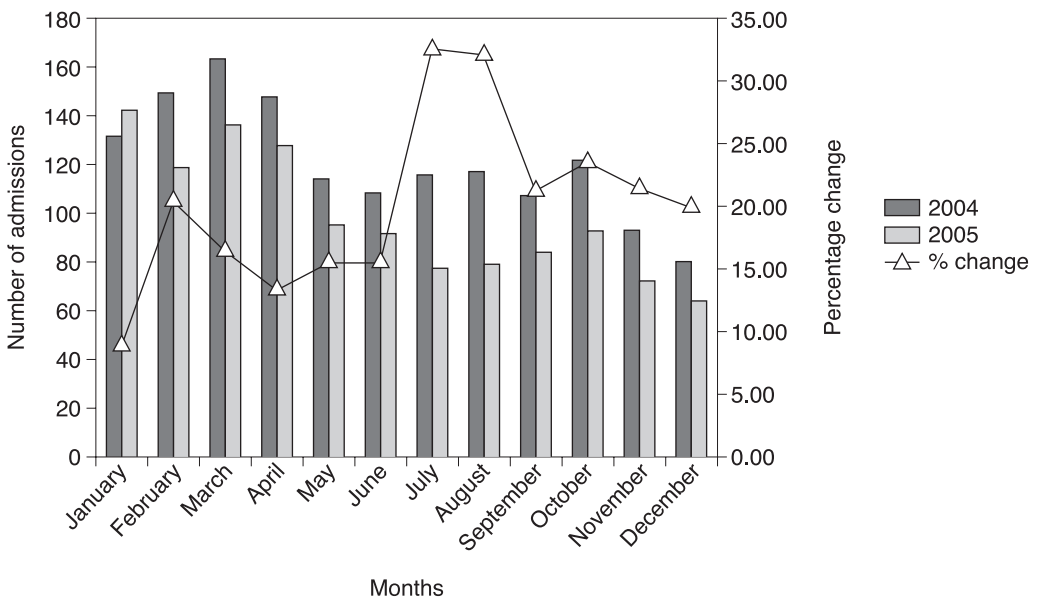
Leicestershire's population of 615 000 is forecast to increase by 4% in the next 10 years. Although the county is mostly rural, outside Leicester, nearly half of the population lives in market towns, or urban areas close to Leicester. Leicestershire is rich in the diversity of its people and its resources. The county has a long history of settlement from other parts of the world. In



**Figure 1** Main source of referrals 1 December 2004 to 31 December 2005: source of referral. SHO, senior house officer; CMHT, community mental health team; DSH, deliberate self harm.

**Table 2** Comparison of admission rates 2004/2005 and 2005/2006

Month	2004	2005	% Difference 2004 vs 2005	2006	% Difference 2005 vs 2006
January	132	143	+9.1	74	-48.25
February	150	119	-20.7	63	-47.06
March	164	137	-16.5	90	-34.30
April	148	128	-13.5	71	-44.53
May	114	96	-15.8	78	-18.75
June	109	92	-15.6	70	-23.91
July	116	78	-32.7	67	-14.10
August	117	79	-32.4	67	-15.18
September	107	84	-21.5		
October	122	93	-23.7		
November	93	73	-21.5		
December	80	64	-20.0		



**Figure 2** Comparison of admission rates 2004 vs 2005.

the early 1970s, there was immigration to Loughborough of people of Bangladeshi and Gujarati origin. More recently, there has been movement out of the city of Leicester into the smaller county areas. Slightly over half of the population of Leicester city is first-, second- or third-generation minority ethnic group (Lepton and Power, 2005; Londono, 2005).

Individuals of black or minority ethnic (BME) groups make up 7.25% of the county's population, compared with 3.4% in 1991. Of these, 5.29% are of black or Asian origin, while among the white groups, there are significant communities of Irish and Eastern European origin, as well as groups of gypsies and travellers, refugees and asylum seekers. The age of

### Box 7 Quality improvement initiatives

- Referral booklets for GPs and CRHT service leaflet for patients taken on for home treatment
- A booklet with useful numbers for patients that are assessed and not taken on for home treatment
- Patient satisfaction surveys by SUDW
- Service implementation steering group (to ensure the operational model is being implemented as specified in the policy implementation guide)
- Standard-setting group (for audit and reviews of standards)
- Monthly clinical governance forum
- Bi-monthly business meeting (all staff)
- Co-ordinators' meeting (discuss operational and management issues)
- Daily team briefings (difficulties, problems and conflicts highlighted and discussed)
- Clinical supervision (individual, team, small group, managers)
- Personal managerial supervision to personal development portfolio (PDP) and knowledge and skills framework requirements are met by individual team member

BME groups in the county is more youthful than the white British population; 1 in 14 of the BME community is of pensionable age, compared to one-fifth of the white British population. The majority of Leicestershire's population, 91.8%, was born in England, a slight reduction compared to the 1991 census. The 2001 census stated that 74% of the county's population were Christian, 2% Hindu, 0.8% Muslim, 0.8% Sikh, 0.1% Buddhist, 0.1% Jewish, 15% said they had no religion and 7% chose not to answer the question. In addition to English, more than 50 different languages are spoken in the county (Leicestershire County Council, 2005).

## Meeting the needs of BME communities

Study after study has shown that BME groups under-utilise mainstream mental health services much more than other populations (see for example Khan and Pillay, 2003; Hussain, 2004; National Institute for Mental Health in England (NIMHE), 2004a; Neale *et al*, 2005). For many BME groups, there is a stigma attached to going to an outsider to obtain treatment

for mental health problems (Neale *et al*, 2005). For South Asians in particular, the individual is commonly viewed as a reflection on the entire family, which is another reason why families may be reluctant to access mainstream mental health services (Greenwood *et al*, 2000). There may be further problems with a lack of appropriate transport to visit certain services available in the community, although this is not specific to BME clients alone. Experience of discrimination, services that are not culturally sensitive, language barriers and a general fear of approaching professionals may further lead to BME people being socially excluded (Department of Health, 2004a, 2004b; NIMHE, 2004b). In addition, the health beliefs of some BME individuals may not accord with those of mental health professionals working in statutory services (Rogers and Pilgrim, 2003).

The establishment of the Leicestershire CRHT service is intended to reassure and provide an accessible service to BME communities, but relevant community groups and individuals were not involved in the setting up process. More recently, the Department of Health has stressed the importance of involving local communities in planning and developing mental health services that meet the needs of individuals from a wide variety of ethnic groups and cultures. This document sets out proposals for improving mental health services for individuals of BME groups; and for eliminating racism, inequality and lack of cultural sensitivity and cultural competence in services (Department of Health, 2005).

In relation to accessibility, apart from clients on enhanced levels of CPA, people have to be referred to the Leicestershire CHRT service by a primary health source, for example, the GP. For this reason, the service may not be perceived as being sufficiently confidential to members of the BME communities. Nevertheless, the existence of the CRHT means that a whole range of psychotherapeutic interventions can be provided in a discreet manner within the privacy of people's own homes, in line with NSF requirements (Department of Health, 2004b). It is intended that this will encourage members of the BME communities to come forward and seek help at an early stage of their mental health problems.

## New services: overlap?

There is a real danger that the CRHT will overlap unnecessarily with other services. These include community mental health teams, Psychosis Intervention and Early Recovery services (PIERS), Assertive Outreach services and Common Mental Health Problems services. Concerns about overlapping may lead to restructuring of services and reducing funds. The aims



of starting new services are always to get the best value for money and high-quality patient care (Dooher, 2005). However, in that process, there is also the danger of vital funds and resources being wasted through red tape and health service bureaucracy. At present, there are huge problems in acute hospital settings with regard to recruiting and retaining mental health nurses (Department of Health, 1992). The high levels of emotional exhaustion, dissatisfaction, understaffing and low morale have led to the migration of nurses out of hospital settings and into the community, leaving the inpatient settings understaffed and lacking in skills (Sainsbury Centre for Mental Health, 2001, 2002, 2005). The challenge that remains for the CHRT service is to deliver high-quality care but not at the expense of personal, physical and emotional wellbeing of individual team members. Current initiatives in place include an interview with a team manager following any period of time off sick, referral to the occupational health department, staff access to the trust's counselling service, regular individual and group supervision and team meetings together with discussions and feedback between clinicians, line managers and senior trust management.

## Conclusion

Mental health services are really moving forward, getting away from treating people within the confines of a psychiatric unit or hospital, to caring for people in their own homes. This gives patients autonomy, independence and the opportunity to play an integral part in their own care (Department of Health, 2004a, 2004b). The intention is that this will result in shared ownership of all aspects of care, including risk assessment and risk management (Department of Health, 1999; Ajiboye, 2004). Most importantly, caring for people experiencing a psychiatric crisis, outside the institutional setting, leads to reduction in the stigma associated with mental health problems and going into a psychiatric unit (NIMHE, 2004a, 2004b).

Of course, there are circumstances where there are no alternatives but to arrange hospital admission. Sometimes, the risk a patient presents is too high, either to themselves or to others, or their mental state has deteriorated to a level where it is considered unsafe for them to stay within their home environment. In these circumstances, home treatment is not considered a viable option.

To date, about 230 CRHT teams have been established throughout England in accordance with the specifications outlined in the NSF for Mental Health and subsequent Department of Health policy. Reports from various teams around the UK suggest that these services are having a positive impact on reducing

hospital admission rates. However, there does not appear to be any evidence suggesting a clear difference in involuntary hospitalisations, social functioning or quality of life following the establishment of the CRHT services. There is a need to devise appropriate strategies that will enable practitioners, through research and clinical audit, to evaluate aspects of local services to ensure that they are meeting both central government and local standards.

This paper has described the setting up of the Leicestershire County CRHT as well as the operational aspects of the model. The service has now been operational for two years and appears to be working well. While crisis services cannot negate the need for inpatient care, they nevertheless offer a viable alternative to hospitalisation, and encourage patients to contribute to their own recovery through taking ownership of their own care plans (NIMHE, 2005). The challenge that remains for this service is for everyone to work collaboratively with service users, agencies and the wider multiprofessional team to ensure that patients receive the best possible care.

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#### CONFLICTS OF INTEREST

None.