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What is This?

A crisis recovery model for adolescents with severe mental health problems

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Abstract
A model of intervention at the interface and for the in-patient phase for adolescents with severe mental health crises was developed to reduce length of stay while maintaining quality of service consonant with the 'recovery model'. The model is described, and discussed in the context of the limited literature on both crisis intervention with adolescents and families, and 'recovery' in this age-group. The model may be suitable also for use by community teams dealing with adolescents in crisis.

Keywords
Adolescents, in-patient, crisis intervention, length of stay, 'recovery'

Introduction

In these cash-strapped times, commissioners and providers alike are looking for models of service that will reduce dependency on beds and lengths of stay. The New Beginning crisis recovery model was developed in response to the specification, from our commissioning consortium, that 80% of all admissions should be for a duration of less than 42 days on average.

Our model of intervention starts from the premise that most people with even severe mental health problems can be sustained in their local communities within their naturally evolved support networks – the particular attributes of the person and their circumstances elicit support which is congruent with their needs over time. They can, and should, have specialist interventions in their local community to help reduce their distress and disorder. It is less frightening and less stigmatising, and ultimately better, to cope and recover at home, rather than living in a psychiatric unit. Hospitalisation adds levels of complexity to the recovery process (e.g. inpatient group dynamics, separation from family and social networks, reduced stoicism, a regimented lifestyle, etc.) and a further transitional stage to adapt to – that of disrupting reliable and useful relationships with in-patient staff and peers to return to the family and community. This has been cogently argued by

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Darwish and colleagues (2006). However, for some young people, admission to psychiatric hospital as part of the process of recovery is inevitable. In those cases it makes sense, psychologically and economically, to keep the in-patient segment of this process as short as possible, while working intensively with the community services to promote stable rehabilitation.

However, brevity of the process should not come at the expense of ethical, good quality practice. The 'recovery model' of care has been advocated widely (Department of Health (DoH), 2001a) for the effective, humane, progressive treatment of mental health problems (Roberts & Wolfson, 2004). The fundamental principle in the 'recovery model' is helping patients to take ownership of, and become experts in, managing their own (self-defined) difficulties to enhance their resilience (DoH, 2001b). This involves respectful collaborative encounters between patient and professional, in which the professional is seen as a resource that the patient can use in their adjustment and in the achievement of the goals the patient sets for their recovery. We were committed to these principles in developing our service.

Historical and policy contexts, and the available literature

In 1999 the Department of Health commissioned the National In-patient Child and Adolescent Psychiatry Study (NICAPS) to audit the provision of psychiatric inpatient services for young people across the United Kingdom. Worrall et al. (2001) identified a lack of emergency beds and facilities, insufficient number of beds overall, poor provision for severe or high-risk cases, and poor liaison with other services. NICAPS found that two-thirds of all the adolescent units in the UK provided no emergency admission service, and that the average length of hospital stay of those admitted to a 'general adolescent unit' was 104 days with a very wide range (O'Herlihy et al., 2001, p. 49).

In its first two years the Snowsfield Adolescent Unit, the first NHS in-patient service in inner London to provide an all-hours emergency admission service, achieved a mean length of stay of 51 days (median 33) with a range of 23 days to nearly a year, and reasonable outcomes (Corrigall & Mitchell, 2002). This showed that emergency admission for adolescents and short lengths of stay were achievable.

The Royal College of Psychiatrists has emphasised the inadvisability of admissions of young people to adult beds (RCP, 2002). Subsequently the National Service Framework for Children, Young People and Maternity Services (the Children's NSF) (DoH, 2004) recommended the availability of emergency beds for adolescents with serious mental health problems, such that no adolescent under 18 need be admitted to an adult bed. This is now enshrined within the Mental Health Act amendments of 2007 (England and Wales), and strongly supported in the Royal College of Psychiatrists' Child and Adolescent Faculty Report on emergency care (2006).

In adult psychiatry, much has been written about crisis intervention for those with mental illness (for example, Joy et al., 2006), but little attention has been paid to crisis intervention in child and adolescent psychiatry since Caplan's (1964 and 1989) seminal work describing crisis and social systems intervention. There is even less literature on crisis hospital admission in this age group, other than the paper by Piersma and Van Wingen (1988) describing the development of their hospital-based crisis service for adolescents. Stelzer (1990) described a model of continuous care in the provision of crisis intervention with young people, partly based on social systems theory, and Ottino (1999) described a psychoanalytic-orientated crisis intervention approach for the short-term inpatient management of older self-harming adolescents. An effective solution-focused crisis intervention hospital programme (similar to ours) is described by Vaughn et al. (1996), but this was mainly used for adult patients.

Some centres have developed intensive community care and outreach services for young people in order to *prevent* admission. Evans et al. (2001) undertook a randomised controlled trial of three types of home-based crisis interventions and also considered mental health outcomes in relation to clinical profiles. Ingram and Tacchi (2004) described management by the Crisis Assessment and Treatment Services (CATS) for children and young people presenting in crisis in Newcastle. Intervention is rapid; it includes home-based treatment as an alternative to admission and has led to lower rates of inpatient bed occupancy. Similarly, Darwish et al. (2006) report on the development and philosophy of the Community Intensive Therapy Team (CITT) in South Wales, which offers an intensive home-based therapeutic intervention for Child and Adolescent Mental Health Services (CAMHS) patients with complex difficulties who might otherwise be referred for inpatient admission. Singer (2005) describes his work in America with the Child and Adolescent Psychiatric Emergency (CAPE) team providing a mobile crisis response, applying Roberts's (1991 and 2000) seven-stage model of crisis intervention. A special issue of *Child and Adolescent Psychiatric Clinics of North America* (2003) is dedicated to articles on working with young people and their families presenting in crisis to the Emergency Department.

About New Beginning

New Beginning is a sub-regional acute adolescent unit in London. Its intake is limited to young people aged 13 to 18 whose GP is part of one of the five PCTs that constitute the North Central London health sector (total population 1.18 million, of whom close to 60,000 were of secondary school age, according to government statistics in January 2008). Before New Beginning was set up, there were no acute NHS adolescent beds in the sector. Referrals were made to a variety of private providers, some at a considerable distance from the families' homes.

The number of beds required for the sector was determined empirically by average number of referrals to private sector in-patient units in the three previous years. Twelve beds were thought to be sufficient for the sector, providing that the average length of stay for 80% of the patients could be kept below 42 days. (The joint commissioning/provider project team predicted that roughly 20% of the intake would require longer in-patient stays because of resistance to treatment or social/housing problems delaying discharge.)

Important to the strategic planning was the prior establishment of specialised community adolescent teams in each of the PCTs to be served, following the lead of the Service for Adolescents in Enfield (SAFE), (Kaplan et al., 2002), set up in 1995 by the consultant psychiatrist appointed to lead the development of New Beginning.

Meeting the challenge

To meet the challenge of developing a brief but high quality in-patient service, we extended Bruggen's work on in-patient care (Bruggen & O'Brien, 1987; Bruggen et al., 1973) and integrated *systemic theory* (e.g. Watzlawick et al., 1967), *solution-oriented brief therapy* (e.g. Miller et al., 1996; George et al., 1999), *motivational interviewing* (e.g. Miller & Rolnick, 2002) and *performance coaching* (e.g. Egan, 2006; Whitmore, 2002) to generate a short-term goal-directed approach consistent with the 'recovery model' of care. Our model of intervention was short-listed for the Department of Health-supported Medical Futures Innovation Award in 2005.

New Beginning opened in September 2003. In the five years between April 2004 and March 2009, 421 young people were admitted. We have always maintained an average length of stay below

that required by our contract with commissioners – 26 days average for the 80% specified in the contract (42.7 days average for all, excluding the 10% whose discharge was delayed by the lack of available suitable accommodation). In spite of this relatively short length of stay, our CGAS change scores are in line with other in-patient units (Green et al., 2001). In a survey of 100 consecutive patients between April 2008 and August 2009, the Children's Global Assessment Scale (CGAS) changes between admission and discharge were 32 to 48 for psychotic patients and 40 to 52 for 'suicidal' patients, with 25% achieving this in a stay of less than 14 days. A snapshot of 'consumer' satisfaction conducted about halfway through the survey period was favourable. This represented most of the young people the assistant psychologist could interview on the day of their discharge (17 out of about 50), 11 of the 17 sets of parents/carers, and about half of the referrers (*N*=25) who replied to our questionnaire. Inadvertent sampling bias cannot be ruled out, of course, but the summated satisfaction scores (Satisfaction with Services Questionnaire, CORC data set) for young people, parents and referrers in this survey were all well above 80% (11 positive statements summated and dichotomised, both as True [certainly or partly] versus Not True or Don't Know *and* as Certainly True versus Not True).

What we do (when applying the model)

We work on the premise that a stable problem becomes a crisis through disorganisation and disempowerment. This determines our set of interventions to get young people and their families beyond the crisis.

Step 1. Managing disorganisation

Young people and their families present to crisis intervention services in a distressed, confused and often antagonistic state of mind. Managing the clients' disorganisation is something that most practitioners dealing with people in crisis do intuitively, although of course some will do it better than others.

Contributing to disorganisation are the often overwhelmingly strong and confused feelings held by the families, and their inadequate or incoherent communication. We would, as most would, manage overwhelming emotion by actively engaging families and providing 'containment' (affect modulation), normalising and validating feelings, and instilling hope and trust. We improve communication by forming a nexus of dialogues, obtaining coherence through systematic questioning and clarification of meaning, and bringing perspective of scale and development, highlighting both past differences *and* future possibilities. Our attempts to reduce disorganisation and try to help the participants to think flexibly and productively occur 'meta to' other aspects of the initial interview (see Echterling et al., 2005 and Londino et al., 2003 for further discussion).

Step 2. Systemic functional analysis of the presenting problem

Understanding the presenting problem. In the conventional assessment at the point of admission to an in-patient unit, the presenting problem is located in the identified patient. In our assessment, 'the problem' is seen as embedded within the support network acting as a homeostatic system (Jackson, 1957; Watzlawick et al., 1967). Problems may become manifest when the system has not had enough time to adjust or to have sufficient resources (information or person-power) to act effectively to restore equilibrium. The deficiencies may be quantitative (e.g. more stress, less

support) or qualitative (e.g. a less empathic support worker takes over, the mother becomes depressed, etc.) (see also Pumariega & Winters, 2003; Steinberg, 1989, p. 99).

Identifying the reason(s) for admission. Young people get admitted to psychiatric in-patient units when the support systems can no longer cope with the things they are doing, not because they have a mental illness per se (Bruggen & O'Brien, 1987; see also Gutterman et al., 1993). In one example, a young man tried to cope with the fact that he was hearing voices by turning up the volume of his music system. Ultimately it was his disturbing his parents' and neighbours' sleep that led to his hospitalisation, not his experiencing auditory hallucinations. These behaviours may become intolerable because they evoke too much anxiety, distress, anger, confusion, embarrassment and/or fear in those who have a responsibility for the young person's care and ensuring their own and others' safety.

We couch the reason for admission explicitly in terms of 'who could not cope with what'. We want the young person to recognise that what they have been doing is intolerable to their carers, and that their carers' not coping is understandable and reasonable – everyone has their limit. We are pragmatic and non-judgemental about what people can and cannot put up with and manage safely.

Systemic functional analysis of change required. We look at what in the system can change to make the behaviour tolerable and safe enough, and identify the 'leverage' (Egan, 2006) available – what is at stake and for whom – that makes change not only necessary, but also desirable for each of the participants. We know of course that what is at stake for the young person is admission to a psychiatric hospital, and we know that to avoid admission or, if admitted, to be discharged safely, what the young person has to do is change the behaviour(s) that cannot be tolerated or coped with.

Whatever other systemic change is possible, this opens up an explicit and coherent line of motivation that we can work with to produce change.

Step 3. Agreeing the minimum change(s)

The minimum change (see Bruggen & O'Brien, 1987) is the smallest change(s) that can be made by the identified patients to convince those who have to cope with them back in the community that they can be safely managed out of hospital. It is 'the difference that makes a difference' (Gorrell Barnes, 1983). It recognises that small changes, especially in a crisis, make a big difference.

Who sets the minimum change? The person who sets the minimum change is the person who has the authority to say where the young person can reside. This is normally the person who has parental responsibility for the young person's safety where they live, but for young people no longer living in their family's home, it may be their social worker or hostel manager.

Before we can begin the negotiation, we sometimes have to resolve complex statutory and relational problems (Bruggen & Pitt-Aitkin, 1975) to distinguish authority from interest or influence. We may, for example, have to resolve differences between the father and the mother, between the social worker and her manager, or between the social worker and the foster parent/hostel manager.

Furthermore, the carer's capacity to cope may depend on the resources available and the level of support in the community. For example, the parents may be able to cope if the young person can

be tolerated in school for a substantial part of the day and/or has someone at home to keep them safe and occupied, and if there are available specialist services to provide support, therapy and risk assessment in the community. These services may wish (and are explicitly invited) to set their own minimum change criteria before they will agree to take on responsibility for the patient in the community.

The important thing, from the point of view of motivating and empowering the young person to make positive changes, is that it is clear *who has the authority to demand change* as a condition of discharge from hospital, and who influences this decision. The young person knows then whom they have to convince that they are safe enough to leave hospital and live in the community.

We respect that carers can only cope with so much, and that what and how much they can cope with varies. We help the young person to recognise this as a fact of life and come to terms with it. Of course, the carer can make it easier or more difficult for the young person to meet their minimum changes – we routinely offer family therapy to help the carer cope with more, or in a more helpful way, if they want this help. Most, of course, do.

For young people detained under the Mental Health Act, there is the intermediate step of convincing the Approved Clinician responsible for the 'section' that they can be accommodated safely in hospital without compulsion and/or are responsible enough to make informed decisions about their treatment, and will make decisions responsibly.

Specifying the minimum change. For the young person to know what s/he has to do, and for there to be no dispute about whether they have done what was required, the minimum change criteria need to be *operationally specific*. We reduce these to behaviours that either happen or not, and can be externally verified. They are specific and not global, and they are minimal – just enough to make a difference. They must be behaviours/activities that the young person can *choose* to do. For example, in one case the parents said of their suicidal son, 'he can come home when he's happier'. We got them to clarify what he would be doing if he were indeed happier (watching comedy on television with his brother, playing football with his friends). We established that while appearing to be happy may be reassuring, what they wanted ultimately was to know he would take responsibility for keeping himself safe. Their son volunteered to repeat aloud to them the coping strategies he had learned at the unit when going out and agreed to stay at home unless accompanied by a trusted friend or relative, and to come back within a specified time.

We clarify also how *persistent* and *regular* the minimum change behaviours have to be for the parent(s) to be convinced that the changes are real and likely to last. In the example above, the parents were required to specify how long their son watched television and played football for, and on how many separate occasions (leave days) he had to achieve his minimum changes for this to be reassuring of stable-enough change to allow discharge.

If the minimum changes involve other support agencies, the plan for their involvement may need to be tested out. For example, to meet their minimum change, the young person may have to attend school for a specified time or attend a session at CAMHS.

While change(s) may be formulated as doing something less often (for example, reducing obsessive hand-washing or self-harm to a frequency manageable at home), reducing behaviour is not as motivating as choosing to do something else (more acceptable) instead – doing something positive by choice. The minimum changes should be reformulated in a positive way whenever possible: for example, 'not swearing at your mother' should be reformulated as 'speaking politely and in a friendly way'. Contracting to do something positive requires visualising positive attitude and behaviour – this envisioning of a positive future without the problem is a precursor of behavioural

change within a solution-focused paradigm. Minimum change(s) may also be token: choosing activities indicative of a more positive, organised frame of mind (tidying a bedroom or looking after a pet for example).

The young person and the adult(s) responsible for setting the minimum charge are encouraged to negotiate until they agree the correct level of expectation of change (see Castro-Blanco, 2010). These agreed changes are then the basis for a contract for coaching/therapy – what the 'coach' (key worker/therapist) has to focus on to help the young person change to 'get what they want', that is, discharge. This is then formulated as an agreed Care Plan signed up to by the young person.

Minimum change examples. Case 1. A 16 year old boy with worsening OCD symptoms had worn his parents out by his needing their constant attention, pacing in their bedroom at night as he was unable to sleep for fear of recurrence of violent mental imagery, and being home all day, having withdrawn socially and therefore being unable to attend school.

Minimum changes
1. To sleep for eight hours on three consecutive nights (a sign he would be able to sleep, allowing his parents to rest, when at home).
2. To eat one meal in a restaurant without making tensing gestures (as a sign of social re-integration).
3. To complete one hour of schoolwork a day for three days (as a marker of improved concentration and reduced obsessive preoccupation, as well as a positive sign that he could begin gradual school reintegration and not be at home all day).
4. To spend one hour in the company of friends (as a sign of increased ability to relax and to distract himself).

Case 2. A 15 year old girl was admitted following an abrupt onset of florid psychotic symptoms with paranoia. Her mother could not cope with her 'not communicating' (she was anxious that she did not have any way to monitor her daughter's state of mind), refusing medication and not eating for four days prior to admission. Her mother was reluctant to admit her and wanted her home as soon as possible.

Minimum changes for home leave:
1. To acknowledge explicitly that she needed help.
2. To take medication without coercion for two consecutive days (as a sign of compliance, increasing trust and improving insight).
3. To give her word that she would return voluntarily to the unit after the agreed four hour period of home leave.

Minimum changes for discharge: For five consecutive days:

1. To continue to take her medication (as above).
2. To eat one meal a day (evidence of improving self-care and well-being).
3. To have a conversation with her mother for at least five minutes a day (to allow mother to gauge her daughter's state of mind).
4. To drink at least one litre of fluid a day.

In both cases above, minimum changes for discharge occurred within three weeks.

Step 4. Empowerment

Once the young person knows clearly what they have to do, our job as 'coach' is to help them choose this positively, make a commitment to the choice and then help them to be successful in achieving their goals.

Disempowerment is corrected over time by an *active coping style*: a determination to do something that will, by one's own efforts, make a difference towards achieving the desired change. This active coping style has two strands – agency and motivation.

Promoting agency. The people we encounter in crisis often feel helpless, especially if they are used to relying on others to act to put things right. We counteract this passivity in two ways: (a) with the coaching mantra 'the past does not run the future' – meaning that even though things have often gone wrong, this does not mean they always will, unless we let them (if we act and make different decisions in the present, we can make different outcomes in the future); and (b) by instilling the notion that every action involves choices about *what* to do and *how* to do it.

This is something that infuses all our joint activities with young people on the unit. We frame questions about young people's actions to indicate that, however thoughtless or impulsive the action, it required a decision (to do one thing rather than another – there are always alternatives to be weighed). We call impromptu meetings of all the young people to discuss and debate young people's choices/decisions whenever we notice things the young people are doing that concern us, but also when we notice new coping behaviour young people have chosen which we wish to highlight, reinforce and celebrate. We have a weekly 'goal setting/review group'. 'Failing' to achieve desired outcomes is connoted as an opportunity for learning (e.g. about consequences/better strategies, etc.). Staff work with the young person on what is possible and achievable, thus encouraging a sense of agency – a sense of 'I can'. Negotiation and compromise is encouraged.

What comes with the *power* to make decisions is the *responsibility* for those decisions. Interventions are directed to helping the participants make better decisions (for them) and become aware of choices they didn't know they could make. Better decisions are more efficient and effective – decisions that are more likely to get the young person what he/she wants, with fewer obstacles, complications and discomfort than other options. To do this, the participants are required to appraise the *consequences* of their decisions for themselves and for others, and in relation to achieving their goals. Actions are then *outcome-determined* – a co-constructed cost-benefit analysis will determine, *on balance*, which consequences, and therefore which decisions and actions, they prefer. The consequences are not merely the first consequences, but the extrapolated consequences further down the chain of causality, projected into the future. (When faced with difficult, irresponsible, self-destructive or resistant behaviour on the ward, our first question to the young person will often be 'what is the outcome you want from this?', with the second being 'how will what you are choosing to do right now help you get what you want/get discharged?')

We acknowledge frankly that all decisions come with risks. Thus, we help young people make risk management plans to help limit the risk, and thereby make a decision which may initially have seemed too risky worth considering. A necessary part of risk management is getting away from 'all-or-none' thinking and identifying small changes – steps towards the desired goal, of which carry a low penalty for failure in and of itself. Any failure should not produce catastrophic demoralisation, a giving up, but should instead allow another attempt to succeed, perhaps with a modification of the

method of progression (trying something different) or merely with more will, determination and energy.

In many cases (especially in the context of crisis), the young person will not be aware of the choices they have, perhaps because of limited experience, ambition, imagination or information about alternatives, or previous failure through deficiencies in necessary skills. We explore possibilities and try to extend their appraisal of their options and the skills and resources they already have available but have not employed, or not employed effectively. In accordance with our solution focus, we elucidate this by helping the young person (or parent) identify *exceptions* to the rule(s) about when the problem happens (i.e. when it *doesn't* happen), and identify their part in the 'problem' *not* happening then (de Shazer, 1988). We also encourage creativity through the adage 'if what you're doing doesn't work, try something different'. Einstein is said to have described madness as doing the same thing and expecting a different outcome.

New problem-solving skills may be learned. It will be for the young person, who needs these skills to expand their repertoire of coping and improve their chances of success, to *choose* to learn these new ways of doing (or thinking about) things. This also applies to our and their relationship with medication whenever possible – we tell them about other young people whose similar problems were ameliorated by taking medication, and connote medication as an option they can choose, on trial, to see if it will work for them. Taking medication then, as a way of coping, is made an active, responsible choice, rather than something they are made to do. This, we believe, also improves compliance.

Enhancing motivation. Some young people are not sure what they want or are reluctant to make active choices. Some are intentionally self-destructive in their choices.

Although we may use motivational interviewing in all cases, in these cases it has special value. Motivational questioning often includes asking

- what are the advantages of (your behaviour/circumstances) not changing?
- what are the *dis*advantages of change?
- what are the advantages of change – why is the desired change a good thing?
- what's in it for you (if things do change/if you change what you're doing)?
- who has most to gain and most to lose from change? And in which way?
- is solving the problem in a small way, or in small steps, better than not solving the problem at all?

Positive motivation is enhanced by our relentless enthusiasm for helping the young person achieve their goals, and by helping to formulate the goals in as advantageous and attractive way as possible (see also Egan, 2006, pp. 235–239). 'Coaching' is used (in our daily 'community meeting', in weekly 'goal-setting groups' and in 'key-work' sessions) to maintain *commitment* to the goals they have set, and to stay active and positive.

Discussion

There is nothing in the world literature on the 'recovery model' applied to adolescents, and yet the respect and autonomy that the 'model' espouses is especially attractive to adolescents and pertinently congruent with their developmental tasks. Although we assume that many services would

see themselves as conforming to the tenets of 'recovery', our service has recovery at its core. At New Beginning, staff are facilitators and 'contracted in' coaches to help young people achieve their goals. This requires, and engenders, empowerment through responsibility and active decision-making. The patients' power is in being effective – in knowing that, in co-creating their preferred futures and being the agents of their success, they carry this power within themselves. This in turn inspires realistic hope for a better future and resilience born from a personal growth experience, acquiring skills they have *chosen* to learn.

Some young people's home and educational environments are not conducive to recovery at the point of admission, and brief and focused interventions are needed to make these settings more favourable for recovery and adjustment and ensure that carer relationships and other social factors in the community setting do not aggravate the mental health problems of the young person in a way which would extend their stay in hospital or act as a disincentive to recovery.

For pragmatic reasons, young people sometimes stay longer than we would ideally wish them to. We recognise that a balance needs to be struck between brevity of stay and relapse pre-emption. A limiting factor is often the meagre mental health, special education and social care resources, relative to need, available to the community teams to support intensive rehabilitation. Thus we work, in most cases, to achieve improvements beyond the immediate crisis and do extended bridging work with the receiving community team(s) to allow them to take on patients with what are still considerable difficulties (the average discharge CGAS is about 50).

However, the motivational model we have created does not work to achieve a short length of stay for everyone. Some young people do not want to be discharged. Compared to their usual home environment, the adolescent unit may be less bleak and oppressive, may provide containment, boundaries and affectionate interactions absent in their home environment, may be more convivial (with other young people who accept them even with their quirks), and for some may provide relief from abuse which they are not yet ready to disclose, but from which they wish to be free. In some cases, a refusal to return home is used in the service of punishing the parent(s). We work with these dynamics in family therapy sessions, but in some cases we require Social Services' involvement.

For some young people who have experienced traumatic loss and have disorganised attachments, a 'magical/idealised' attachment (transference) to a powerful, caring member of staff becomes an impediment to working to be discharged. In these cases, home leave and discharge are perversely incentivised. Other motivational strategies and enticements to recovery have to be put in place. We have in some cases contracted for an admission to a medium-stay placement, and invited the receiving units to set minimum changes.

Tragically, a few of our patients have no home to go to, and often Social Services and Housing are reluctant to take on anyone under 18 who comes with a 'mental illness' label. The consequent delays often add to the young person's sense of not being wanted, and that can lead to their 'acting out', 'confirming' that they cannot be managed in the community. Once 18, they are eligible for the spectrum of supported housing resources available to adults with mental health problems.

But we are successful with many. One of the factors that we think promotes our effectiveness is the *therapeutic alliance* the model engenders, and the application of coaching which maintains 'behavioural involvement' (Shirk & Karver, 2006) in the task. Various reviews (e.g. Green, 2006; Shirk et al., 2010) demonstrate that the strength of the therapeutic alliance is the best predictor of the effectiveness of psychotherapeutic interventions. Following Bordin's (1979) and Hougaard's (1994) propositions, the New Beginning intervention model is designed to promote elements in the

'professional domain' (strengthening the patient's expectation of positive outcome, engagement and expertness – 'we can help and have helped others') and in the domain of 'task alliance' (agreement on goals and on tasks). We also aspire to enhance the 'personal alliance' with both the young person and their carers through our empathy, acceptance and authenticity, the latter especially manifested by our not claiming to be more than we are and by our being clear about power relationships, our ethical duty and the young person's legal rights. Green et al. (2001) found that alliances with patient and parent are independent, and that the intensity of admission to a psychiatric hospital may amplify this. With our model, we position ourselves both on the side of the carers, in empowering them to set the minimum changes, *and* on the side of the young person, in helping them to achieve the changes which will help them get what they want – that is, to be discharged from hospital. This, we hope, aligns the (separate) alliances of our team with the young person and with their carers (that is, reduces the usual discrepancy), thus amplifying the power of the alliance to underpin therapeutic change. As Green (2006: 431) puts it: 'It is not surprising that a treatment with essential informed consent and mutual agreement about the goals of treatment, in terms of process, range and goals, will promote more confident and motivated collaboration.' He points out this is in keeping with the strategy for preparedness in motivational interviewing (Baer & Peterson, 2002) and CBT.

Two further factors which we believe enhance our effectiveness are optimism and – perhaps related – maintaining staff morale. A well-documented study by Harding et al. (1987) showed that an optimistic attitude and higher expectation of recovery led to higher than expected rates of recovery, even in very chronic cases. The minimum change discussion, in its orientation to the future, carries with it the implicit assumption of achievable positive change, and our solution-focused coaching stance amplifies this.

In the work we do it is all too easy for staff morale to be lowered by the high intensity, fast-turnover work we undertake, discharging young people before they are fully recovered (as mentioned, the average discharge CGAS is about 50), and by the emotional impact of working a lot with very deprived young people whose hopes and resources are limited by their socio-economic adversity. Three factors in our model mitigate against poor morale, we believe. First, the coaching stance helps to buffer against demoralisation when the young person is being challenging or self-defeating, by making it clearer that the young person is choosing their own outcomes. Second, the recovery framework directs us to invest predominantly in helping patients to discover their resilience and possibilities, promoting conversations which are uplifting and inspiring. Third, the young people's having explicitly achievable goals means they usually achieve these, and this gives staff a sense of satisfaction in a job well done, even when outcomes are modest.

Conclusion

We believe that the way we manage the referral, assessment and in-patient phases of the patient's experience of a mental health crisis has advantages beyond a short length of stay, and recommend it as containing the elements of a modern approach to psychiatric management – accessibility, patient empowerment, focused intervention and the privileging of specialist care in the community (see NIMHE, 2006). If the community teams are able and willing to take on intensive rehabilitation, the model could be used to engineer ultra-short stay admissions. Although devised for an in-patient setting, we believe our model of intervention could be adapted for use by community teams to manage crises and reduce the need for in-patient admissions.

Declaration of Conflicting Interests

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Note

Following the retirement of the first author in 2010, and because of changes to the local health economy and Trust reorganisation, the unit no longer functions as a purely acute unit, and the model of service described here is no longer rigorously applied. However in the writing of this article (first drafted in 2008) we have kept the description of the operation of the model in the present tense – this should be taken to reflect the way the model was and should be applied.

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