

8 Crisis management in the community

Alan Rosen

“Paradoxically, if you survive them, it’s in the bad conditions that you learn most about yourself.”

— Tim McCartney-Snape, mountaineer
(quoted in the *Weekend Australian*, 18–19 May 1996)

“CRISIS” was first used as a specific term in psychiatry by Gerald Caplan^{1,2} after considering earlier evidence that survivors of severe trauma, such as those in Lindemann’s study of the “Cocoanut Grove” nightclub fire in Boston in 1942, had much better outcomes if they received immediate psychiatric help.³ A “crisis” was seen as a brief non-illness response to severe stress, and “crisis intervention” emerged to detect maladaptive responses to crises and to convert them into effective coping and learning experiences.

Caplan’s concept of crisis was influenced by the theories of his time. It relied on concepts of disease rather than health, and on mechanistic theories from Freud and General Systems Theory regarding “homeostasis” and “equilibrium”. But these limitations were far outweighed by Caplan’s contribution in emphasising the importance of preventive care, achieving mastery of the crisis, the social, cultural and material “supplies” necessary to avoid or resolve a crisis, and his pioneering advocacy of a community mental health approach.^{1,2,4}

What is a crisis?

Caplan’s^{1,2} classic definition of crisis is an upset in the person’s steady state provoked when an individual finds an obstacle to important life goals. This obstacle seems insurmountable, at least for a good while, by use of customary methods of problem solving.

A crisis is a period of transition in the life of the individual, family or group, presenting individuals with a turning point in their lives, which may be seen as a challenge or a threat, a “make or break” new possibility or risk, a gain or a loss, or both simultaneously. Most crises are part of the normal range of life experiences that most people can expect, and most people will recover from crisis without professional intervention. However, there are crises outside the bounds of a person’s everyday experience or coping resources which may require expert help to achieve recovery.

Types of crisis

Developmental crises: These are the transitions between the stages of life that we all go through. These major times of transition are often marked by “rites of passage” at clearly defined moments (e.g., those surrounding being born, becoming adult, getting married, becoming an



When things get out of hand ... shark attack and an overwhelming wave ...

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Synopsis

- ▶ A psychological crisis is a brief, non-illness response to severe stress. When maladaptive responses to crisis are detected, crisis intervention is employed to achieve a more adaptive resolution and a more effective learning experience.
- ▶ Psychiatric services cannot provide the entire range of crisis interventions required in our society. As communities, we should be encouraged to “look after our own” partly through a network of formal and informal crisis support structures. These should be carefully distinguished from emergency services.
- ▶ General practitioners and others in a good position to do crisis intervention require higher levels of awareness of and training in its uses, with support from specialty services.
- ▶ Crises can precipitate or be a consequence of mental illness. There is strong evidence that more specialised 24-hour crisis response services are needed for individuals with mental illness and their families.
- ▶ Evidence is emerging for the importance of early detection and intervention for young people who may be developing signs of mental illness or suicidal intention for the first time, which may manifest as a life crisis.
- ▶ If there is a potential or existing mental illness, good outcomes are more likely to result from good teamwork between general practitioners, other clinicians and specialist mental health services.

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elder, or dying). They are crises because they can be periods of severe and prolonged stress, as described by Tyhurst, another pioneer in this field,⁵ particularly if there is insufficient guidance and support to prevent getting stuck while in transit.⁶ In small-scale cultures, there is a sense of continuity and retained value in transitioning from before birth to beyond death (e.g., becoming an ancestral resource). In Western societies, rites of passage between these stages have become blurred, the extended kinship networks they depend upon for clear expression have become scattered, the cultural value ascribed to such transitions varies with occupational and economic status, and events surrounding birth and death tend to be experienced as clinical termini.⁶

Situational crises: Sometimes called “accidental crises”, these are more culture- and situation-specific (e.g., loss of job, income and/or home, accident or

burglary, or loss through separation or divorce).

Complex crises: These are not part of our everyday experience or shared accumulated knowledge, so we find them harder to cope with. They include:

- **Severe trauma**, such as violent personal assault, natural or man-made disasters, often directly involving and affecting both individuals and their immediate and extended support network, observers and helpers.^{3,7,8}
- **Crisis associated with severe mental illness**, which can increase both the number of crises a person experiences and sensitivity to a crisis. Reciprocally, the stress of crises can precipitate episodes of mental illness in those who are already vulnerable. Post-traumatic stress syndromes similar to those resulting from a disaster have been reported in some individuals⁹ after emergency treatment of acute episodes of mental illness.

Developmental, situational and complex crises may overlap, and one may lead to the other (e.g., a train driver distracted by being in crisis may make an error, causing a disaster).

Contention in the crisis literature

Controversy still surrounds the concept of crisis. The term defies consistent definition, and “crisis theory” is just that: mainly theoretical speculation based on descriptive accounts, with the cultural and clinical concepts of crisis deriving from seemingly different fields of inquiry.

A personal crisis is not a clinical disorder. However, a severe or protracted response to crisis may lead to one (e.g., major depression, or, more commonly, an “adjustment disorder”,¹⁰ defined as the development of clinically significant emotional or behavioural symptoms in response to an identifiable psychosocial stressor). Adjustment disorder should be distinguished from bereavement and other non-pathological reactions to crises which do not lead to marked distress in excess of what is expected, and which do not cause significant or lasting impairment in social or occupational functioning. Stress is not a synonym for crisis¹¹ as all people face stress as part of the human condition. By no means all stressful experiences produce crises and the same type of stressor may be

1 Stages of crisis

Stage I: Mounting tension

- habitual problem solving responses in an attempt to maintain the person’s steady state.

Stage II: Plateau of disorganisation

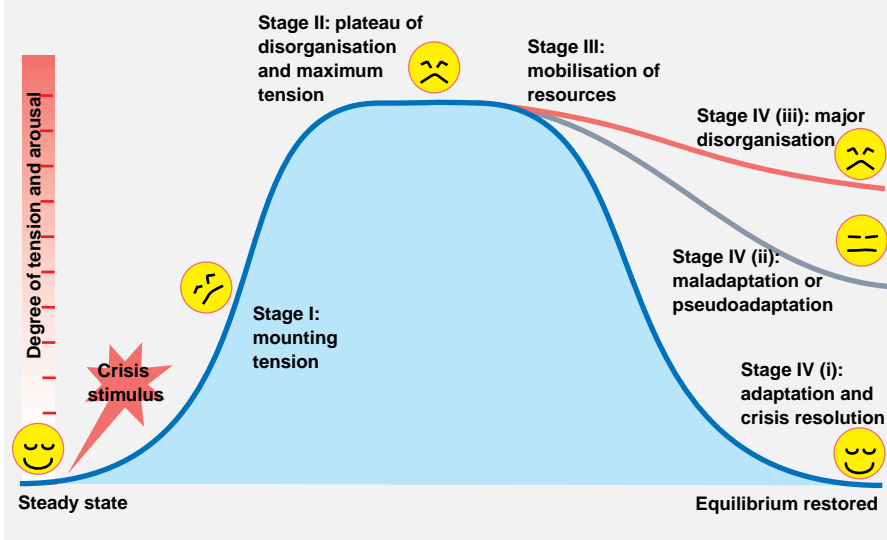
- feeling anxious and ineffectual, “at sea”, “chaotic” or “going mad”
- repetitive abortive attempts at problem solving
- stereotyped responses (like “hitting your head against a brick wall”)
- increased dependence and ventilation needs

Stage III: Mobilisation of all internal and external resources

- maximum arousal, heightened suggestibility, increasing vulnerability to good or poor advice.
- emergency methods or creative, novel solutions may be attempted, resulting in a range of possible outcomes:

Stage IV: Adaptation or maladaptation

- (i) Crisis resolution: Adaptation to new circumstances. Stability and steady state restored at equal or higher level (most common outcome)
- (ii) Maladaptation: Superficial “closure” or reactivation of past crises¹⁵ or recurrent medical symptoms and treatments¹⁶
- (iii) Major disorganisation: Crisis may precipitate psychotic episodes or affective disorders if vulnerable.^{3,17}



linked to crises, or even clinical disorders, in some but not in others.

In contrast to crisis theory, some crisis interventions have been subjected to rigorous empirical study, demonstrating their effectiveness with specific problems (e.g., individuals and families seriously affected by mental illness).^{12,13}

Crisis intervention can no longer be seen as a unified strategy for care, as many divergent practices in different settings have developed since its origin, from walk-in clinics to mobile home intervention, but Waldron has identified a number of common features.¹⁴ These include rapid service, intense work in the short term, and a practical here-and-now therapeutic focus.

Stages of a crisis

Box 1 presents a summary of the main stages, from the pre-crisis steady state, to crisis disequilibrium, to re-establishment of a new steady state, hopefully at an equal or higher level of organisation.¹¹ It is often reported that a crisis state lasts several weeks, usually subsiding within one to two months, if successful resolution occurs.

When to intervene

Primary prevention: Strategies aimed at preventing the development of psychiatric illness altogether may be appropriate for people experiencing developmental or situational crises who have limited personal, social or cultural resources. Bereavement counselling, telephone counselling services and “How to survive Christmas” seminars¹⁸ are examples of practical primary prevention interventions in the community.

Critical incident counselling may be offered to survivors or witnesses of traumatic events and disasters to prevent emergence of protracted grief reactions or post-traumatic stress disorder (PTSD),⁸ although efficacy in preventing PTSD remains unclear.

Secondary and tertiary prevention: Secondary prevention implies that a psychological disorder has already emerged, and aims at reducing the severity, duration or the risk of recurrent relapse. Tertiary prevention is aimed at reducing the disability attendant on a disorder that is already prolonged. Indications include:

- *People with early or acute mental illness* — preventing suicide and promoting recovery for individuals whose constitutional vulnerability and life stressors may have tipped them into an episode of mental illness, which can be highly responsive to timely crisis intervention and appropriate treatment.^{9,10}
- *So-called “chronic outpatient attenders” or “chronic crisis repeaters”*, unnecessarily pejorative terms highlighting the frustration and attitudes of clinical staff towards these individuals who make frequent demands on services. It is often more economical and effective to provide intensive intervention at times of acute crisis rather than continuing unchallenging support of a long term sickness role. A significant proportion of these individuals may have been severely traumatised in childhood. Specific interventions to deal with the sequelae of past abuse are still being developed and researched.

- *Patients with severe or prolonged psychiatric disorders* presenting with an acute exacerbation that may be precipitated by or cause a situational crisis. Defusing stressors by prompt crisis management (in conjunction with timely treatment, continuity of care and psychosocial rehabilitation) may prevent the build-up of disturbing symptoms, repeated life-disrupting hospitalisations, or suicide.^{9,12,13,15,17}

Practical management of a crisis

Crisis management is the entire process of working through the crisis to the point of resolution (Box 2). It usually includes not only the activities of the individual in crisis but also the members of the person’s social network.⁴ Not all crises require crisis intervention, which is that aspect of crisis management carried out by crisis workers (e.g., clinicians, counsellors, police or chaplains).

Practical points in intervention:

- Intervention frequently involves a general practitioner and a community mental health team, possibly including a psychiatrist or inpatient unit. Negotiate early in the process to formally clarify who will coordinate it, and who will do which components of the assessment and intervention (whether general practitioner, mental health worker or psychiatrist).
- The hospital or community crisis service should carefully identify the general practitioner’s needs, especially for prompt or extra support, while the general practitioner should respond promptly to the crisis worker’s liaison calls.
- Include family or other social or cultural supports in both the assessment and the intervention if possible.
- Collaborate with the individual or family in crisis (“doing with” rather than “doing to”) to promote their “ownership” of the crisis, and learning of new coping and communication skills.
- Allow tension — allowing or even encouraging a tolerable degree of arousal, tension or dependence for a limited time is sometimes functional in promoting crisis resolution.
- The clinician’s role in a crisis can sometimes involve undoing previous inappropriate or excessive clinical interventions (e.g., inappropriate diagnoses or types of treatment, or general overmedication causing unnecessary sedation and/or other side effects).
- When referring a person in crisis to a hospital psychiatric unit, ask for a crisis assessment rather than insisting on hospital admission, as home-based community management often results in a better outcome.
- Home visits, within defined parameters of safety, should be considered for accurate assessment and review, and more direct access to all participants in the crisis.
- A small list of the most important specific goals for the crisis intervention which are realistic and achievable within a limited time frame should be agreed in advance between all participants, with a copy to each, and with an interactive process and date for review.
- If acute inpatient psychiatric care is needed, the same mental health professional(s) who engaged with the person in the community should be involved in the inpatient

2 The process of crisis assessment and intervention

Assess crisis

- Type, severity and duration
- Psychiatric or physical symptoms
- Risk of harm to self or others

Assess resources available to the person in crisis

- *Personal*: buoyancy, resilience, experience, confidence
- *Social*: family, friends, colleagues
- *Cultural*: repertoire of cultural tools or rites of passage, extended kinship system
- *Professional*: doctors, counsellors, community services. To be used when the person's other resources are insufficient for coping with the crisis. Sometimes people just need further encouragement to draw on their existing resources, and low-key monitoring of progress.

Intervention

(Most effective in Stage II of crisis — see Box 1)

Consultation

- provide ease of access and intensive support, allowing dependence in the short term
- arrange time to allow “ventilation”
- encourage patients to express their fears and concerns
- discourage evasion of the problem and assist in setting realistic goals for a solution
- encourage patients to explore possible solutions and future directions and to feel empowered to make their own decisions in their own time
- discuss and agree to a “contract” for managing the crisis — set time limits and specific goals
- avoid oversedation or premature removal of tension with medication unless symptoms are disabling or medication is indicated for a psychiatric illness — otherwise, you may perpetuate a maladaptive solution

Network

- maintain integrity of social network (involve family and friends, find substitutes for missing confidants) — this can only be done with the patient's permission
- provide counselling, education and support to the patient's partner and family as required
- if necessary, coordinate the activities of other agencies to support the patient
- provide 24-hour availability of patient support, via a rostered team or telephone service

team (if possible) to make the transition easier and to ensure consistency of the clinical management plan agreed with the individual and family.

A crisis is different from an emergency

An emergency is a life-threatening situation demanding an immediate response. A crisis is often not immediately life-threatening and the timing of the response should be such as to include all participants in the crisis and existing or potential personal supports.

Appropriate personnel to respond to an emergency are Police, Ambulance, Fire or Hospital Emergency Departments and/or State Emergency Services. Appropriate people to call in a crisis include general practitioners, community mental health professionals, community services officers, or lay crisis response organisations.

The appropriate type of early response in an emergency is life preserving: securing physical safety, removing the person from the source of danger, and defusing physical violence. In a crisis, the early response should be crisis assessment and support, defusing stress and interpersonal strife.

The use of the terms “crisis intervention” and “emergency psychiatry” are often confused by clinicians, and used interchangeably in the names and descriptions of services.¹⁷ But what difference does it make to patients and their families when they feel distressed and just know they need help now?¹⁹ In fact, they benefit by more appropriate referrals and settings for intervention when these distinctions are clearly made, while professionals are able to deliver such services more safely and effectively when they know the difference between a crisis response and an emergency response.

Sometimes there is an overlap between a crisis and an emergency. When there is any hint of a crisis turning into an emergency, it is considered a skill, not a failure, if a mental health professional or general practitioner chooses not to work alone and calls for expert advice, police assistance, or other emergency services.

The place of crisis intervention in psychiatric services

The evidence indicates that 24-hour home-visiting crisis response services should be integrated into local comprehensive services for people seriously affected by mental illnesses and their families.^{9,12,13,15,20} The potential for new learning and personal growth in this population and their families has probably been vastly underestimated, often by the clinicians involved.¹⁷ Systematic interventions to promote such new learning out of “using the crisis” of acute psychiatric episodes are being developed to reverse the potentially erosive effects of early psychosis on self-esteem, identity and related maturational tasks.^{9,19} Family problem-solving techniques aimed at acquiring new coping techniques in crisis have been shown to prevent relapses.^{20,21}

The principles of effective crisis intervention are consistent with current good practice in mental health services, regardless of the phase of care. There is evidence that people severely affected by psychiatric illnesses are much more likely to cooperate with interventions which are tailored to their individual needs, and when they feel listened to, are consulted and offered choices regarding types of proposed interventions. Cooperation is further enhanced when they and their families are provided with sufficient information and explanation, when time is taken to negotiate intervention goals, when low-key and low-dose interventions are offered (at home on their own “turf”, if possible, rather than ours) and when the traumatising effects of involuntary hospital admission and heavy sedation are avoided.^{6,9,12,13,22}

Inpatient psychiatric care is sometimes essential but should be arranged on a voluntary basis if possible.

Who should manage crises?

General practitioners, community workers, police, ministers of religion, counsellors, as well as mental health professionals, are all in a position to be involved in crisis intervention. General practitioners are particularly well placed to help people in crisis and their families.

Should all crises be referred to psychiatric services? Emphatically no, although psychiatric services are most appropriate for people in crisis who have diagnosable psychiatric illnesses and who may be suicidal.

Firstly, psychiatric services do not have the resources or mandate to handle all crises in the community. There are community services for domestic abuse, children at risk, and sexual assault crises, non-government and church organisations dealing with couple, family, existential and spiritual crises, and networks for bereavement and disaster counselling.

Secondly, many people requiring help with crises do not wish to be seen by a psychiatric service or professional, which they may perceive as stigmatising, and therefore adding to their troubles. When the crisis is not complicated by significant psychiatric symptoms, it may be managed with significantly better outcome by a general practitioner who has the person's trust and does not need to label the person with a psychiatric diagnosis.²³

Thirdly, some communal voluntary organisations run crisis hotlines (e.g., Lifeline) which may produce more timely referrals to clinical services, or care for people who would not present clinically. Whether they reduce the number of suicides is a more contentious issue. Peer-group and consumer-driven mutual support lines are developing further, via telephone "warm-lines", interactive radio, computer bulletin board chat-lines and the Internet. While these are a potential wellspring of support, they may make the caller feel more vulnerable through public exposure, and the recipients may feel helpless if their concern is ignored or abused by an anonymous caller. Arguably, basic training in crisis support and coping skills should be adopted as essential components of community and school education.¹⁴

Gaps in services

There is still a lack of child and adolescent mobile crisis services operating extended hours to augment outpatient nine-to-five mental health services for these age groups. Adolescents are at a time of developmental transition and are particularly vulnerable to crisis. Early intervention services available on a 24-hour mobile basis which are specifically designed to deal with the crises and psychiatric problems of young people, their families and peers may help to reduce the exceptionally high youth suicide rates in Australia.

Conclusion

The National Mental Health Strategy²⁴ has provided impetus to develop extended-hours mobile community psychiatric services integrated with local inpatient services in both urban and rural centres across Australia. Yet it is by no means possible, nor appropriate, for psychiatric services to provide the full range of crisis intervention services needed by our community. A broad

Case history 1: Stages of crisis and "depathologising"

History

A 36-year-old male administrative officer feared that his wife was about to leave him after four years of marriage. This was preceded by a six-year courtship, during which he had been reluctant to commit himself to getting married or having children.

He was an only child, and his mother, with whom he had had a close relationship, had died a year before his marriage. His wife told him that she had long since had enough of his expecting her to meet all his physical and emotional demands without offering her much in return. They were still childless, but she told him that he had become more like her child than her husband. He had refused counselling, despite her repeated requests, because he said he "did not believe in shrinks."

Presentation

He complained to their general practitioner of increasing and unbearable tension. As he had become more anxious that his wife would leave him, he would try to reassure himself that she would not do so by clinging to her desperately, and showing her how much he needed her (Stage I: mounting tension and habitual problem solving). She responded by seeing a solicitor and setting a date for their separation. He now felt that his world was "falling apart" as he could not conceive of living without her and that he must be "going crazy" (Stage II: plateau of disorganisation and stereotyped responses). He had seen another general practitioner near his workplace who had been prescribing him daily benzodiazepines for some weeks.

Intervention

Their general practitioner set another appointment time for him later that day, when they could have an extended interview. Ventilation of his distress was encouraged. A further appointment was made for both him and his wife the next evening with the general practitioner.

In consultation with the local community mental health team, expert psychiatric and marital assessment was promptly arranged, to which, in his present state of arousal, he readily agreed (Stage III: mobilisation of resources). On specialist mental state examination, a treatable ongoing psychiatric illness was excluded. He was assured of this and was relieved.

A written set of specific time-limited goals in priority order was negotiated with the man and his wife, with copies provided for each. His previously unexpressed grief over the loss of his mother was acknowledged and further counselling was offered. The differing needs of the couple and how to meet them reciprocally were briefly explored. They both agreed to provisional postponement of their separation, while a series of couple counselling sessions was arranged and completed. A clinically supervised gradual withdrawal from benzodiazepines was arranged (Stage IV: hopefully, subtype (i): adaptation and crisis resolution).

Case history 2: Crisis intervention early in the course of a psychiatric illness

History

The parents of a 21-year-old female student consulted their family general practitioner, concerned that since breaking up with her boyfriend a few months previously she had been losing weight and attending less to her grooming. She had not been attending lectures lately, had become increasingly distant from friends and family, and had taken to isolating herself in her room. She had recently confided in her younger sister that she was receiving personal messages from songs on the radio confirming that her friends were conspiring against her. She had begun to suspect that someone was tampering with her food.

Intervention

She refused to come to see the general practitioner, so he arranged an urgent home visit that evening together with a female member of the local community mental health team. Though reluctant to talk to either of them, she agreed to a physical examination by the general practitioner, and some blood test investigations. Eventually, she also agreed to further home visits by the mental health professional, who tried to engage her patiently over a few days, gradually earning sufficient trust to take a history and to gain her agreement to bring a psychiatrist to see her and her family on a subsequent visit.

Organic illness and major depression were carefully excluded and a provisional diagnosis of early psychosis was made.

After detailed explanation to her and her family, low-dose antipsychotic medication was prescribed, further investigations were arranged via her general practitioner at her convenience, and the likelihood of a full recovery was discussed. Information sheets, further education, problem-solving and goal-setting sessions were provided for her and her family at their home. Personal counselling with the mental health worker continued, and access to group sessions with young people with similar problems was offered, focusing on the meaning to the individual of the experience of psychosis, her relationships, handling stigma ("what do I tell my family and friends?"), and returning to study or work with adequate support.

Regular clinical reviews and further prescribing were arranged on a shared care basis between the psychiatrist and the general practitioner. As there were no further symptoms or recurrence, medication was reviewed with a view to discontinuation after possible early warning signs unique to this individual had been defined together with her and her family. Further counselling was provided regarding the meaning of this episode to this individual and her family, and to help her discover what could be positively learned from this experience.

3 Useful crisis resources

Lifeline: 24-hour telephone counselling service for people suffering emotional crisis. National phone no: 131114 (cost of a local call).

National Association for Loss and Grief (NALAG): promotes community and professional education in loss and grief, and local support groups. Phone (02) 9988 3376 in New South Wales, or check the telephone directory in most States (White Pages under "Community Help: Grief Support").

Mental Health Services: See White Pages under "Community Help: Psychiatric Assistance or Mental Health Services."

network of well informed formal and informal crisis support structures is required to enable us to more effectively "look after our own".

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