## **Conference briefings**

## The first international conference on crisis intervention approaches in mental health\*

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Crisis intervention is seen by many as an impractical approach to mental health care practised by a small minority of isolated enthusiasts. This conference, coordinated by Dr Rao Punukollu, attracted over 400 delegates from 32 countries and more than 60 papers were presented. On hearing of the wide range of successful crisis intervention services, delegates and speakers alike were left in no doubt that crisis intervention has truly come of age.

Dr Howard Parad described the underlying principle of crisis intervention as embodied in the Chinese pictogram for "crisis" which indicates both danger and opportunity. The outcome of a psychiatric crisis may be a reinforcement of maladaptive patterns of behaviour or, through intervention, an improvement in coping mechanisms enabling better management of crises in future. He stressed the importance of capitalising on the "sensitive period" immediately following a crisis, during which individuals and families are in turmoil and consequently most able to change. To this end the response to crisis must be rapid with the individual seen and treated as part of a system involving family and significant others. He described brief focused crisis therapy, emphasising the need to concentrate on those with significant psychiatric problems, rather than the "worried well".

In the USA, where crisis theory originates, crisis teams are relatively well established. However, they often struggle to relate to numerous differently-funded mental health projects and, in a system where no single professional or team carries ultimate responsibility for a patient, crisis teams may be left "holding" patients for a very long time. In contrast, Professor Leonard Stein described the integrated comprehensive service which he has developed in Madison, Wisconsin. The emphasis here is on long-

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term psychiatric problems and one central authority is responsible for planning, operating and funding the service. With the help of mobile community teams, crisis homes and group homes, bed usage has been cut by 75%.

A similar change is taking place in Australia, as described by Dr John Hoult whose model is based on that of Professor Stein. New teams are being established regularly and 60% of New South Wales is now covered by a crisis service. Other speakers described crisis work in the UK, Canada, the USSR, Belgium, Japan, Denmark, Israel, the Netherlands and Sweden.

Clearly crisis intervention theory is now applied to a large range of clinical problems and is used in an enormous variety of setting. This was perhaps best illustrated by a lecture given by Dr Lawrence Ratna entitled 'Crisis intervention - where is it contraindicated?' In this illuminating talk he started with a list of patient groups not traditionally associated with crisis work, such as addicts, the elderly, the suicidal and the severely psychiatrically disturbed. He then proceeded to give examples where crisis theory had been used successfully in each of these "forbidden" areas. The range of applications was emphasised by speakers who described interventions with the hallucinated patient, in bereavement, in disaster situations and in management of the psychological distress of AIDS. The practice of crisis theory is clearly adapting to meet the needs of our times.

The conference confirmed that crisis intervention is established as an effective approach to the management and prevention of psychiatric illness. The future holds the promise of further international conferences (Amsterdam in April 1991, in collaboration with the International Emergency Psychiatry Association, and Hyderabad in February 1992) and the application of a crisis-orientated approach in many more services.