Acute psychiatric care: approaches to increasing the range of services and improving access and quality of care

Sonia Johnson[1,2], Christian Dalton-Locke[1], John Baker[3], Charlotte Hanlon[4,5], Tatiana Taylor Salisbury[4], Matt Fossey[6], Karen Newbigging[7,8], Sarah E. Carr[9], Jennifer Hensel[10], Giuseppe Carrà[11], Urs Hepp[12], Constanza Caneo[13], Justin J. Needle[14], Brynmor Lloyd-Evans[1]

[1]Division of Psychiatry, University College London, London, UK; [2]Camden and Islington NHS Foundation Trust, London, UK; [3]School of Healthcare, University of Leeds, Leeds, UK; [4]Centre for Global Mental Health, Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK; [5]Department of Psychiatry, School of Medicine, and Centre for Innovative Drug Development and Therapeutic Trials for Africa, College of Health Sciences, Addis Ababa University, Addis Ababa, Ethiopia; [6]Faculty of Health, Education, Medicine and Social Care, Anglia Ruskin University, Chelmsford, UK; [7]Department of Psychiatry, University of Oxford, Oxford, UK; [8]Institute for Mental Health, University of Birmingham, Birmingham, UK; [9]Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK; [10]Department of Psychiatry, University of Manitoba, Winnipeg, MB, Canada; [11]Department of Medicine and Surgery, University of Milano Bicocca, Milan, Italy; [12]Integrated Psychiatric Services Winterthur, Zürcher Unterland, Winterthur, Switzerland; [13]Departamento de Psiquiatría, Facultad de Medicina, Pontificia Universidad Católica de Chile, Santiago, Chile; [14]Centre for Health Services Research, School of Health Sciences, City, University of London, London, UK

Acute services for mental health crises are very important to service users and their supporters, and consume a substantial share of mental health resources in many countries. However, acute care is often unpopular and sometimes coercive, and the evidence on which models are best for patient experience and outcomes remains surprisingly limited, in part reflecting challenges in conducting studies with people in crisis. Evidence on best approaches to initial assessment and immediate management is particularly lacking, but some innovative models involving extended assessment, brief interventions, and diversifying settings and strategies for providing support are potentially helpful. Acute wards continue to be central in the intensive treatment phase following a crisis, but new approaches need to be developed, evaluated and implemented to reducing coercion, addressing trauma, diversifying treatments and the inpatient workforce, and making decision-making and care collaborative. Intensive home treatment services, acute day units, and community crisis services have supporting evidence in diverting some service users from hospital admission: a greater understanding of how best to implement them in a wide range of contexts and what works best for which service users would be valuable. Approaches to crisis management in the voluntary sector are more flexible and informal: such services have potential to complement and provide valuable learning for statutory sector services, especially for groups who tend to be underserved or disengaged. Such approaches often involve staff with personal experience of mental health crises, who have important potential roles in improving quality of acute care across sectors. Large gaps exist in many low- and middle-income countries, fuelled by poor access to quality mental health care. Responses need to build on a foundation of existing community responses and contextually relevant evidence. The necessity of moving outside formal systems in low-resource settings may lead to wider learning from locally embedded strategies.

Key words: Acute care, mental health crises, inpatient psychiatric wards, emergency departments, crisis houses, acute day units, crisis resolution and home treatment teams, intensive home treatment

(World Psychiatry 2022;21:220–236)

Acute mental health care, including acute inpatient wards and services that manage mental health crises in emergency departments and in the community, consumes a large proportion of the resources dedicated to mental health in many countries[1]. However, it continues to be often unpopular, is sometimes experienced as traumatic or coercive, and shows little evidence of resulting in sustained improvements in outcomes.

Nonetheless, ready access to crisis response remains of high importance in the eyes of many service users, carers, clinicians and referrers to mental health services. Thus, innovations that result in better experiences and outcomes and more efficient use of resources have high potential for overall impact. In this paper, we take stock of current service models and their evidence base and identify innovations with promise for the future.

We begin by considering initial response to the acute crisis, including assessment, triage and initial care planning. We then discuss the settings in which intensive intervention to resolve the crisis is delivered. Finally, we offer some cross-cutting perspectives on crisis care delivery, focusing on contributions from the voluntary sector; the role of service users and peer workers in designing, leading and delivering crisis services; remote delivery of crisis care; and crisis prevention.

Regarding geographical scope, it is not feasible to take a truly worldwide perspective on acute mental health care. However, while the majority of the authors of this paper are based in the UK, and thus tend to draw especially on examples from the National Health Service (NHS) of that country, we also include authors from several other countries, and conclude with a section that focuses on low- and middle-income countries (LMICs) where specialized forms of crisis service are not present.

We focus primarily on services for adults of working age rather than on specialized models for children and adolescents or older adults. Distinct crisis services for these latter groups are relatively uncommon in most countries, and the extent to which the services we discuss in this paper also serve them varies greatly.

Service design and development should be rooted in evidence, and we would have preferred to focus primarily on interventions and service models for which evidence is robust. However, practical and ethical challenges in recruiting participants who are experiencing a mental health crisis have hampered research in this field[2], so that the evidence base is far from proportionate to the importance of acute mental health care. We therefore include not only approaches and models that are root-

ed in evidence of reasonable quality, but also others that appear of sufficient potential value for robust evaluation to be needed.

ASSESSMENT AND IMMEDIATE MANAGEMENT OF THE CRISIS

Mental health presentations in the emergency department of the general hospital

For many people experiencing an acute mental health problem, attending the emergency department (ED) of a local general hospital is the default option in a crisis[3], and in some mental health systems primary care referrals may be directed to this setting. Despite efforts to develop alternatives, mental health presentations to the ED have been reported to be on the rise across the US[4], Australia[5] and England[6]. Attendances are reported to have risen again following a dip during the early phases of the COVID-19 pandemic[7,8].

A review of evidence from seven countries[9] found that the most common mental health presentations to EDs are self-harm, suicide attempt, suicide ideation, depression and schizophrenia, with mental health crises making up around 4% of all ED presentations.

Despite these high levels of use, EDs are often reported to be poor environments for mental health care. They tend to be hectic and may expose service users to long waiting times and distressing sights and sounds. Assessments take place in a very different and more institutional environment from service users' usual social context, and ED assessment has been reported to be more likely to result in hospital admission than when similar crises are assessed elsewhere[10].

ED staff may not have the training required for working effectively and empathically with people in mental health crisis[11]. Negative attitudes towards people with mental health presentations have frequently been reported[12], especially towards those who present on multiple occasions following self-harm and who may have a "personality disorder" diagnosis[13].

The quality and volume of research investigating the effectiveness of different approaches to improving mental health assessment and treatment at EDs does not match what is needed. Challenges include the highly diverse nature of tasks undertaken in EDs, and more widely in general hospitals where a liaison psychiatry model is employed; lack of high-quality routine data; difficulties with linking general hospital and mental health provider data sources; and difficulty selecting appropriate outcome measures to reflect brief contacts[14].

An international systematic review of models for mental health care in EDs found just 17 relevant studies, relating only to Australia, Canada, UK and US[15]. Mental health staff may be integrated into the ED team, supporting it with patient assessment and triage. A psychiatric liaison service may work across the ED and the general hospital as a whole. Agreements of various forms may be established between the ED and a psychiatric service within the same hospital, so that the latter can provide input to ED patients on referral. Finally, as discussed further below, mental health EDs may be located away from the general hospital. A variety of benefits have been reported for these models, mostly related to service use measures such as waiting times, restraints, or unplanned departures from the ED department. Most studies do not include clinical or patient-reported outcomes.

Whichever model is employed, a challenge in the ED is ensuring that, within the brief period of a crisis assessment, a warm and supportive therapeutic relationship is rapidly established, to avoid traumatic and coercive experiences of care and create a context for collaborative decision-making about next steps[16,17]. More research focused on clinical communication, therapeutic relationship, and approaches to assessment in mental health crises in the ED would be valuable.

Models offering extended assessment and diversion following ED attendance

An international data synthesis found that studies varied greatly regarding proportion of ED attenders admitted to hospital[9]. Efforts to reduce this and to improve the quality of initial assessment following an ED attendance have resulted in service models that extend the period of mental health assessment in an environment intended to be more calming and conducive to good quality mental health care than the ED.

A range of such approaches has been developed and described internationally. Psychiatric emergency services (PES; for which other names include comprehensive psychiatric emergency program, CPEP; and emergency psychiatric assessment, treatment and healing, EmPATH) are widespread in the US, where emergency psychiatry is a distinct subspecialty, and in Canada. They are linked to one or more EDs[18] and staffed by multidisciplinary psychiatric teams, including mental health nurses and psychiatrists (available on-call if not on-site), usually providing 24-hour access.

Unlike the standard ED approach of triage and transfer, PES have extra capability to observe and provide intensive treatment, typically for a period of up to 24 hours, aiming to stabilize the crisis within this time and reduce the need for admission. Routine data on the impact of a PES serving a large area of California and linked to several EDs indicated that it substantially reduced both ED waiting times and admission rates[19].

Similar models are reported in other countries. For example, in Australia, a behavioural assessment unit with six beds within an ED in Melbourne was designed to provide a calming environment, mental health assessment and observation, aiming to discharge home within 24 hours. A before-after comparison indicated reductions in ED delays and restrictive interventions[20].

Psychiatric decision units have been established in a small number of centres in the UK[21] and are accessed via psychiatric liaison teams in the ED. They offer a stay of between 12 and 72 hours, providing recliner chairs rather than beds (subject to some criticism[22]) and aiming to ensure a calming environment, psychosocial assessment, brief interventions, and onward referrals. In general, although there are promising reports of impacts on service use, substantial evaluations of extended assessment and triage services following ED attendance are so far lacking, and impacts on

patient experience need to be better understood.

A further model that may be linked to the ED is the brief admission ward where, rather than a full-scale hospital admission, initial admission is to a ward in which intensive assessment and treatment planning takes place within a strict time limit, characteristically a few days. Several early trials of this model suggested rather modest benefits[23], although they were conducted in contexts where intensive crisis alternatives were generally unavailable. A more recent UK version of this model did not find an impact on length of stay[24], and we are not aware of substantial recent evaluations of triage or short stay wards linked to EDs or of a recent comprehensive literature synthesis.

Assessment centres outside the general hospital

Crisis assessment services may also be situated away from the general hospital in freestanding centres, within community mental health service premises, or co-located with specialist psychiatric hospitals. Evidence is lacking regarding which locations are best and for whom. Notwithstanding the ED disadvantages discussed above, links between acute mental and physical health care are important (for example, following self-harm, and for people with both physical and mental health problems, or who present with functional somatic and neurological symptoms).

Thus, even in mental health systems where referrals from primary care and self-presentations are directed elsewhere, as in many European countries, mental health care is still needed in EDs. Integrating this with general hospital and mental health care systems effectively, and achieving continuity of care between acute and continuing care services, is a complex task presenting different challenges in each national system[25].

In the 1960s and 1970s, community mental health assessment centres, often called emergency clinics, were an important innovation in some countries, including the US and UK. These services provided walk-in assessment, triage and sometimes brief treatment, often informed by the crisis intervention theory[26], which regards a crisis not as a manifestation of mental health problems but as a general human response to severe psychosocial stressors, presenting challenges but also opportunities for growth. Similar models later emerged especially in the Netherlands, Italy[27], and German-speaking countries, although investigation of their activities suggested that they tended not to focus on people with severe mental health problems[28,29].

Today, there are numerous international examples of mental health crisis assessment centres, some of which employ conventional models of clinical assessment and intervention not dissimilar to ED services, while others are more innovative in offering alternative models. The PES discussed above may be located away from general hospital premises, even though they retain close links with EDs. Such services may also be established to prevent people in crisis being referred directly for assessment to psychiatric wards, which has been observed to be associated with high rates of admission. In Switzerland, for example, establishing a unit for clinical decision-making to assess referrals rather than referring directly to wards was reported to have reduced unnecessary admissions and costs[30].

Overcrowding in EDs and infection control considerations during the COVID-19 pandemic have resulted in some countries in further development of crisis assessment centres outside hospital. For example, a survey in England found that mental health providers in 80% of areas had established an alternative to their local EDs for mental health assessments, most often on a site where other mental health services were delivered[31]. Psychiatrists reported that these often provided a better environment than EDs for mental health care, but had very limited capacity for providing physical health interventions. Concerns were raised that removing mental health professionals from EDs may increase stigma among acute hospital staff and negatively affect care for the many people with both physical and mental health problems. An Italian service system has been described[32] in which the community mental health centre, already used as a setting for some crisis assessment, shifted its focus towards greater crisis care provision during the pandemic.

Crisis centres in the community may also aim to provide a more clearly distinct alternative to standard clinical approaches. For example, a model that has emerged in England over the past decade is the "crisis café", sometimes referred to as "safe havens" or "sanctuaries"[33]. These services provide walk-in assessment, support and triage for people experiencing a mental health crisis. They are designed to provide a less formal and clinical environment, and are usually delivered by the voluntary sector with staff who do not have formal mental health professional qualifications, although they often have considerable relevant experience. Some are also staffed by peer support workers and a few are led by people with lived experience of mental health problems (e.g., the Well-bean Crisis Café in Leeds, England). They are usually open outside typical working hours (evenings and weekends), when other forms of support may not be available, and are located separately from any other health service.

Crisis cafés provide a source of immediate support. People in crisis can usually access them without a referral, which may prevent a crisis escalating to a point where ED attendance or admission results. The potential of these services to improve access and choice is clear, but research evaluating their effectiveness and safety is still lacking.

Community crisis assessment

High anxiety, enervating depression or cognitive disorganization may all prevent some people in mental health crisis from actively seeking and accessing help. Perceived stigma of mental health services, or previous experience of unsatisfactory treatment following help-seeking or of an unsympathetic response at hospital EDs[34], may also create barriers.

Assessment at home may be more feasible and less frightening or distressing for many. It enables evaluation of someone's living situation, current coping, and potential risks in the home. It can help clinicians to consider social precipitants of a crisis, which may otherwise be overlooked[35]. Home-based assessment may engage the

family from an early stage, helping clinicians to understand and manage a crisis[36]. For these reasons, home-based crisis assessment services have been developed as part of the community psychiatry movement, with "psychiatric first aid" multidisciplinary teams in the Netherlands in the 1930s[37,38] being an early example.

Community teams providing longer-term care may be well placed to respond to crises for people on their caseload, allowing assessment by clinicians who already know the person in crisis. Indeed, providing a 24-hour crisis response is a fidelity criterion for high-intensity assertive community treatment (ACT) teams[39]. Flexible, stepped care models have been developed internationally and can offer a prompt crisis response to new referrals, as well as longer-term care of varying intensity, to meet people's current needs. Two examples (for both of which a robust evidence base has yet to be established) are the German RECOVER programme[40] and the FACT (flexible ACT) model developed in the Netherlands[41]. However, most community mental health services are not 24-hour, or resourced or organized to respond rapidly to needs for crisis assessment across a whole community, including people not previously known to services.

Dedicated crisis resolution and home treatment teams (CRHTTs) have therefore been developed, with the sole function of providing assessment and short-term, multi-disciplinary home treatment for people during a mental health crisis. Pioneered in the US[42] and Australia[43], CRHTTs are now provided nationally in England and Norway, and in many areas across Europe, North America and Australasia[44]. Established fidelity criteria for CRHTTs include standards for ease of referral, rapid response time, a 24/7 service, assertive engagement and comprehensive initial assessment[45].

Two key challenges for community crisis assessment relate to providing a rapid response, and managing safety and risks.

Regarding rapid response, in-person assessment within four hours from referral has been adopted as a nationally audited performance indicator in England. Yet, a 2016 survey of CRHTTs in England found that target response times varied from one hour to one week, with less than half of teams routinely providing a response within four hours. Less than a third of Norwegian CRHTTs achieve good fidelity for the rapid response criterion[46]. CRHTT staff highlight the competing pressures of responding rapidly to new referrals while reliably maintaining frequent, scheduled home treatment appointments with people being offered crisis support[47].

To address this issue, a recent trend in England has been to split crisis assessment and brief crisis home treatment functions into two different teams. This split model is now provided in over a third of English health care regions[33]. Crisis assessment teams, sometimes called "first response" teams, have achieved marked improvements in service accessibility and response times in local evaluations[48], and offer a "no wrong door" point of access for people in mental health crisis of any severity. However, they risk introducing new discontinuities between assessment and treatment, with opportunities for information to be lost or people in crisis being required to tell their story multiple times to different professionals. As yet, no robust evidence compares effectiveness or users' experience of integrated CRHTTs versus split assessment and treatment teams.

Regarding safety and risk, crisis assessment at home is not suitable when someone requires urgent medical tests or treatment (for example, following an overdose or other self-harm). Escalating risks to the person in crisis or others may be harder to manage by lone clinicians in an unfamiliar home environment than in a clinical setting. A Cochrane review cautions that people with the highest risks or using drugs and alcohol were typically excluded from studies that have provided positive evaluations of CRHTTs[49].

Thorough information gathering and careful triage are therefore essential before home-based assessment is offered. 24-hour crisis phone lines staffed by trained clinicians, with links to other local or national health service helplines, may help to achieve this, and improve the accessibility of crisis support[33]. Effective system integration with police and ambulance services is required for circumstances where the need for immediate access to hospital or clinic-based care becomes apparent during a home assessment, and help from emergency services is necessary to ensure safe conveyance of the person. This is further discussed in the next section of this paper.

Practical measures to help ensure the safety of staff, such as a lone working policy with check-in and follow-up processes, alarms for staff, and team capacity to visit in pairs when indicated, are also recommended[44]. Challenges are compounded in remote areas, and the role of telepsychiatry in crises is discussed further below.

Initiatives to facilitate prompt assessment following police contact

A 2016 literature review estimated that, for around one in ten individuals, the police were involved in their pathway to mental health care[50], although, while the author searched for all English language studies, only studies from North America were found. In a Canadian city, around half of mental health-related police contacts resulted in apprehension using mental health legislation, and half of these led to a hospital admission[51]. Concerns have been reported around the world that police officers, without adequate training or support, are often acting as frontline mental health workers, potentially resulting in worse outcomes for people in mental health crisis, increased trauma and coercion, and higher numbers of unnecessary arrests[52] and escorts to hospital[53].

Various service models have been developed to improve outcomes for people in mental health crisis following contact with the police. They usually consist of police and mental health staff responding to mental health-related emergency calls together. Some successes have been reported in reducing unnecessary use of mental health legislation. For example, in Toronto, Canada, a model involving additional training and a joint response by mental health nurses and police officers was found to result in lower rates of involuntary escorts to hospital and of arrest and injury, although total numbers of escorts to hospital increased[54].

In the UK, around 70% of NHS providers now have a street triage service involving various models of joint response by police and mental health professionals, ranging from telephone liaison to (in a

few cases) 24-hour joint response[47,55]. A systematic review of co-response models found studies carried out in Australia, Canada, UK, and US[56]. There were indications that these services reduced the use of police powers to detain people under mental health legislation, and of police custody.

Feedback from both police officers and health staff working in street triage teams or similar models is generally positive[55,57], but there has been a lack of research investigating service user experiences and outcomes[56]. The research that does exist suggests that service users value responders with expertise in mental health and skills in de-escalation[54].

There are many challenges in delivering joined-up responses across different organizations with very different roles, and models which may lead to greater police involvement in management of mental health crises may prove unacceptable or have unintended negative consequences. For example, the Serenity Integrated Mentoring model (SIM), deployed in England by around half of NHS Trusts, is designed to be a concerted approach by mental health care services and the police to better supporting people who frequently use emergency services. Reports that it resulted in inappropriate diversion from health services and in approaches mainly based on enforcing boundaries have led to the #StopSIM coalition of service users campaigning against the model's deployment, supported by allies across the mental health sector [58-60], following which policy makers have required Trusts urgently to review its further use. Much of the debate has focused on the ethics of police involvement and on its lack of underpinning evidence base, exemplifying the risks of rolling out models that are not supported by robust evidence.

INTENSIVE TREATMENT FOLLOWING CRISIS

Management of crises in hospital

Despite their ubiquity in mental health care systems, there has been surprisingly little definition or discussion of the role, function and design of acute inpatient mental health wards. Bowers et al[61] provide a conceptual model of inpatient treatment. The primary admission tasks for inpatient care may include any or all of: assessment, treatment of acute illness, providing safe and highly tolerant accommodation, rehabilitation, and the resolution of personal stress.

Inpatient wards are uniquely able to enforce treatment, provide constant observation to contain risks, and tolerate behaviour which would be unmanageable or unacceptable in the community. Inpatient admission also offers respite from and space to address stressors in the person's home environment, and the potential, through 24-hour care, for providing high levels of interpersonal contact and therapeutic engagement[61].

Thus, there is clearly a role for inpatient wards in managing and supporting those who are most acutely unwell at times when community services are unable to offer a safe alternative. Nonetheless, in the context of the narrative of deinstitutionalization, acute inpatient wards tend to be seen as an expensive legacy of a past institutionalized system of care, with admission reflecting a failure of care, rather than as unique and specialist clinical services playing an important role within a balanced mental health system[62].

Internationally, bed provision is inevitably influenced by the national and regional configuration of mental health care systems[63]. In general, across Europe, there are mental health care systems with predominantly community-oriented approaches, such as those in the UK, Italy and Spain; areas with a high availability of community, residential and hospital services (mainly in Scandinavian countries); and areas where the deinstitutionalization process is still incomplete and inpatient services are the main source of care, such as in rural France, or where it is still in its very early stages, as in several Eastern European countries[64].

A recent study involving 22 high-income countries in Europe, North America and Australasia found wide variation in the extent of inpatient provision: the mean number of beds per 100,000 population was 64, with an interquartile range of 46-93[65]. Throughout Europe and elsewhere, psychiatric inpatient bed numbers have tended to decrease in recent decades, and this trend has been marked in some countries: for instance, bed numbers fell by 62% in England between 1988 and 2008[66].

Much literature on inpatient care focuses on negative patient experiences and risks. Potential iatrogenic harms include institutionalization, exacerbation of psychotic symptoms from intense social contact with others, injury or victimization from other patients, loneliness due to separation from their home environment and social network, despair and depression arising from the environment and seeing other very unwell patients, and stigmatization[61]. Women are vulnerable to sexual harassment or assault, especially in mixed-gender inpatient wards[67].

Evidence suggests that acute inpatient mental health wards are often unsafe, with high levels of intra- and international variation in levels of conflict and containment [68,69]. During inpatient care, patients may experience high levels of restrictive practices (physical and mechanical restraint, forced medication); discrimination based on ethnicity, gender or diagnosis; crime (physical or sexual assault, criminal activity, drug taking); and blanket restrictions and rules. In England, the most frequently occurring incidents in this setting involve aggression and self-harm[70].

Safety incidents are often associated with high physical, emotional and financial costs. The physical and psychological harm to the patient, which may increase length of stay as well as having a negative impact on health-related quality of life[71], is often underestimated even in those services which aspire to operate trauma-informed models, in which an aim is to avoid retraumatizing the many patients who have previously experienced significant trauma[72]. In some cases, injuries to staff may also occur, leading to costs of replacement and impacts on burnout, stress and morale[73]. The financial cost of restraint, seclusion, rapid tranquilization, and one-to-one nursing have not been examined in any depth. One incident on a ward may increase the likelihood of further incidents via a disturbed ward milieu and social contagion[74].

Negative service user and carer experiences of involuntary detention are frequently reported and are of particular concern, given the contrast between such detentions and the principles of collaboration and consent usually advocated as central underpinning values for mental health treatment[75,76].

Rates of involuntary detention in psychiatric hospitals under mental health legislation have risen in some high-income countries and fallen in others in recent decades[65]. Explanations of why this is occurring remain confused. A complex combination of societal, service-related and legal factors is probably implicated[65]. Evidence regarding the relationship of bed numbers and availability to detention rates is mixed and inconclusive[77]; however, in countries where the drive to cut inpatient beds has been strong, there are widespread concerns and perceptions that lack of bed availability has resulted in higher thresholds for admission to hospital, a greater likelihood that those who are admitted will be involuntarily detained, a higher concentration on wards of people who are very acutely unwell and whose needs are complex, and a disturbed ward milieu. These factors combine to create high risks of iatrogenic harm. Detention also tends to establish a pattern of increased risk of future detentions[78].

Inpatient admission offers rapid access to needed medication, intensive monitoring and assessment to inform medication review, and enforcement of treatment if required – all of which may be problematic in community care[61]. However, prescribing practices are reported in many settings as relying too heavily on high-dose medications, polypharmacy and supplementary as-required doses[79], and there is a dearth of evidence on effective non-pharmacological approaches to managing acute illness and violent behaviour[80]. A literature on cognitive-behavioural interventions for psychosis adapted to inpatient settings is beginning to develop and provides examples of feasible approaches for people with complex needs, but does not yet offer conclusive evidence to underpin a large scale transformation[81]. Moreover, there is a striking lack of good quality evidence to underpin inpatient care for people with a "personality disorder" diagnosis.

Recent years have seen the development of interventions designed specifically to reduce conflict and use of restrictive practices in inpatient wards. A recent systematic review[82] identified two programmes with trial evidence of effectiveness, *Safewards*[83] and *Six Core Strategies*[84], both of which now commonly inform practice[85]. These are multi-component team-level interventions, which target avoiding or mitigating potential flashpoint situations resulting from interactions between patients, staff-patient interactions, or the ward regulatory or physical environment. The need to improve therapeutic engagement and the culture of care on wards more generally has also been emphasized[86].

An umbrella review of interventions to reduce coercion in mental health services concluded that there is supporting evidence for staff training interventions[87]. However, evidence for initiatives which have tried to improve the therapeutic quality of wards, such as scheduling protected time for ward staff to engage with patients, has tended to be inconclusive. Boredom is identified as a common problem for patients on inpatient wards, but further empirical evidence is needed about its impacts and the best ways to address it[88].

Another area where practice varies internationally and where evidence to support best solutions is lacking is the location of wards. In some countries, embedding acute wards in general hospitals is seen as advantageous, offering close links with physical health care services, normalization of mental health and accessibility to local communities[89]. However, potential drawbacks include wards that have not been specifically designed for mental health patients, and lack of access to safe open space.

There is a need for better understanding of how to design healing environments that offer private space, light, access to fresh air, and attention to details relevant to recovery (e.g., making the environments autism-friendly)[90]. The identification and international dissemination of examples of good practice would be very valuable, as the nature and probably the quality of ward environments varies greatly between countries. Other questions that have yet to be fully addressed include the value of specialized wards based on diagnosis or other indicators of need, and separation by gender[91].

Staffing is a further area in which there is scope for innovation to improve care. The staffing of wards remains a nurse's domain, largely providing the 24/7 care for inpatients. The approach to staffing is often constrained by budgets and custom rather than evidence, and we lack high quality research regarding safe staffing levels or optimal skill mix on inpatient wards. Clinical decision-making still tends to be dominated in most settings by psychiatrists, often via a traditional ward round model. More extensive involvement of other multidisciplinary team members such as psychologists and occupational therapists has great potential to enrich both decision-making and therapeutic environments and activities, though limited size of the specialist health professional workforce may constrain this[92]. The opportunity to further enrich the skill mix by enabling the roles of peer support workers, mental health advocates, housing officers and social workers could help heal disconnections from the community and address those key issues which precipitate and prolong admissions, such as social isolation, poverty and poor housing.

The future of acute inpatient provision requires serious attention. Services can improve, and listening to the patient voice is key to this[86,93]. There is a broader need to listen to those voices marginalized as a result of gender, ethnicity or diagnosis, including those labelled with "borderline personality disorder", who may be at most risk of receiving a poor service[94]. Achieving high quality community care and supporting people outside hospital is rightly a policy priority internationally, but it is vital that this is accompanied by sustained efforts to re-design and improve the provision of care in acute inpatient settings, rebalancing multidisciplinary teams, listening to service user voices and investing in interventions that demonstrate improvements in patient outcomes.

Home treatment

Early crisis home treatment programmes formed part of a broader deinstitutionalization movement, seeking to minimize stigma

and normalize mental health crises. In this section we discuss intensive treatment at home. We note that in many systems the same teams are offering both crisis home assessment (discussed above) and intensive home treatment.

Treatment at home from CRHTTs may reduce the perceived stigma and coercion associated with hospitalization. Because it requires negotiation and takes place on the territory of the person in crisis, it potentially reduces power imbalances and respects people's autonomy[95]. It may encourage a greater focus on interpersonal issues and involvement of the family and wider support system[34,96]. It may also avoid difficulties of transferring coping strategies and skills learnt in a hospital setting to a home environment[41].

A Cochrane Collaboration review of community crisis intervention for people with severe mental illness[49] included six trials of CRHTT-style services (and two residential community crisis services). It found evidence that CRHTTs can reduce inpatient service use, improve clinical outcomes and patients' experience of care, and reduce costs. Observational studies similarly suggest that the introduction of CRHTTs in a local area can help reduce overall mental health inpatient admissions when well-implemented[97]. A qualification to this promising evidence base is that crisis home treatment will not be suitable for people with the highest risks to self or others, and CRHTTs have not demonstrated effectiveness in averting involuntary hospital admissions[98].

CRHTTs do not originate from a highly specified theoretical model. Key characteristics of model services have included: a multi-disciplinary team; 24/7 availability and a rapid response to crises; intensive short-term home-based treatment (typically of less than six-week duration and with visits more than once a day); collaboration with families and other involved services; working with people in crisis who would otherwise be admitted to hospital, and facilitating early discharge from hospital for those who are admitted[43]. There is some empirical evidence that having a psychiatrist in the team and extended opening hours are related to CRHTT effectiveness[99]. A more highly specified CRHTT model and an accompanying fidelity scale have been developed[44], with fidelity scores shown to relate to inpatient admission rates and satisfaction with care[100], but the relative importance of individual fidelity criteria and the critical ingredients of CRHTTs have yet to be established.

Implementation of the CRHTT model has proved challenging. Model fidelity is typically low or moderate in CRHTTs in England and Norway – the two countries where it has been scaled up nationally[45,101]. Criticisms from service users and families have included poor continuity of care within CRHTT team-working, a narrow therapeutic focus on risk and medication (with a corresponding lack of other meaningful therapeutic interventions), and lack of support for or involvement of families[33,99,102,103]. CRHTT staff have highlighted difficulties in establishing role clarity for CRHTTs across the mental health system, and in joint working with inpatient services and longer-term community care teams[46].

Three initiatives may offer helpful ways to address some of these difficulties and improve the effectiveness of CRHTTs. First, a UK trial[104] showed that a service improvement programme for CRHTTs over one year, involving coaching from a senior clinician, regular fidelity assessment, and access to an online bank of practice resources, increased model fidelity and led to reductions in inpatient admissions and bed use. Second, a recent Swiss trial[105] reported that a CRHTT was able to reduce inpatient bed use, despite focusing almost exclusively on facilitating prompt hospital discharge rather than preventing admissions, which shows the importance of working closely with inpatient wards to end inpatient stays as soon as home treatment becomes a viable alternative. Third, a number of models for enhancing the involvement of families in acute mental health care have been developed, which typically include a focus on communication, language use and joint decision making[106].

Most attention internationally has been given to the open dialogue approach (ODA). ODA is a model of crisis and continuing care characterized by a rapid response to a crisis presentation, care centred around regular meetings of the whole support network of the person in crisis; and a psychologically informed approach to care facilitated by clinicians trained in family therapy. Three evaluations of ODA in Finland have reported promising findings[107], although robust trial evidence for effectiveness and transferability to other health care contexts has yet to be provided. A randomized controlled trial of an adapted ODA approach within a contemporary CRHTT context is currently in progress in England[108].

Both crisis assessment and intensive home treatment are in some service systems undertaken as functions within community mental health teams that also provide longer-term care[109,110]. This has advantages for continuity of care and therapeutic relationships. However, community teams also providing a range of other functions may struggle to deliver sufficiently intensive support and may not be well-placed to work with people not already on their caseloads.

Treatment at home may not be helpful for people who are extremely socially isolated, or for whom tensions or abusive relationships with others in the household are contributing to the crisis, or when other household members require respite from their caring roles. "Family sponsor homes" – short-term crisis placements with host families, who are trained and supported by mental health teams – have been established in the US and England[33], although practical and legal challenges have limited the implementation of this model internationally.

Acute day units

Acute day units (ADUs) typically offer programmes combining therapies, activities and social contact to people experiencing mental health crises who are close to the threshold for admission and attend several times a week for a number of weeks. Traditional names include day hospital or partial hospitalization service, but the more recent use of terms such as ADU or recovery centre reflects a concern that the term "day hospital" may have unduly institutional connotations[111].

The history of ADUs extends over most of the last century, with Moscow in the

early 1930s sometimes identified as their birthplace, prominent models established around Europe and the US before and after the Second World War, and provision expanding rapidly in many countries between the 1950s and the 1980s[112].

The evidence base for ADUs is arguably the most robust for any admission alternative. The authors of a Cochrane review concluded that around one in five of those otherwise admitted to an acute psychiatric ward could successfully be treated in an ADU setting, with similar clinical and social outcomes[113]. The most recent UK trial showed greater service satisfaction and symptom improvement for ADU service users[114], but new trial evidence has been lacking worldwide over the past 15 years, so that it cannot be assumed that such findings would be replicated in contemporary service systems which tend to have high thresholds for hospital admission and other approaches, such as CRHTTs, providing alternatives to admission. However, a recent naturalistic study compared outcomes for ADU and CRHTT care, finding greater service satisfaction and better outcomes for depression and well-being for the ADUs[115].

Despite the robust underpinning evidence, a decline of ADU provision has been documented in the UK[116], and may have accelerated during the COVID-19 pandemic, while little new evidence has been published elsewhere in the world. Reasons for this may include a perception that the model is unduly institutional, the substantial premises required to support a comparatively small number of service users, and the rise of other admission alternatives.

Care of an ADU form may also be integrated into community mental health centres, where these are central to service provision. However, qualitative work as well as trial evidence suggests some specific advantages which may not be shared by other admission alternatives: ADUs have important potential to address loneliness, social isolation, and lack of purposeful activity, and are also a potential environment for fostering both formal and informal peer support[117]. Evidence for the importance of social connection, sense of belonging and peer support in mental health recovery is growing, and purposeful activity also has established significance for recovery. A resurgence of the ADU as the principal acute service in which these elements are a central focus would thus be timely.

Residential community crisis services

Like ADUs, crisis houses and other community residential alternatives to hospital admission have a history spanning many decades. They are characteristically services allowing a short stay of a few days to a few weeks, with 24-hour staffing and therapeutic programmes that range from relatively clinical services aiming to replicate the interventions delivered in hospital in a less coercive and institutional setting, to more radical alternatives aiming to support different ways of resolving crises and to enhance service user choice[118].

An early US example was Soteria House in California, which from 1971 to 1983 aimed to manage first and second episodes of psychosis with minimal medication in a community setting, with some reported evidence of success[119]. Subsequently, crisis houses have been described around the world in a variety of formats. In the UK, provision has been growing in recent years, with just over half of catchment areas having some access to crisis house provision in 2019[33].

The evidence underpinning the crisis house model is substantial, though not conclusive. Relatively few randomized controlled trials have been reported, reflecting the challenges of conducting such trials with people in crisis[2]. A systematic review[23] included five randomized trials and 11 non-randomized studies of community residential alternatives to admission. Services were diverse in theoretical model, content and workforce, and included 11 US, two UK and two Swiss studies. Summary conclusions were that, according to the limited available evidence, community residential alternatives show similar, or in a few cases better, clinical outcomes to hospitals, with similar or lower costs and greater service user satisfaction.

A subsequent US review[120] included "subacute" services, not necessarily 24-hour staffed but available for urgent admission with the aim of averting crisis. Equivalent or better clinical outcomes and greater user satisfaction were reported compared to acute wards, with lower costs also found in some studies.

Throughout this literature, the authors note that community acute residential services support a population overlapping with, but not the same as, acute wards, often excluding people who are assessed as posing a substantial risk of violence or who have been compulsorily detained[118]. We are aware of no randomized controlled trial of community residential alternatives to hospital in the past 10 years.

Positive reports regarding service user experiences, therapeutic relationships, and the availability of non-standard therapeutic models are prominent in the literature on crisis houses[121-124]. This, together with evidence of satisfactory outcomes and similar or lower costs compared to inpatient care, provides a justification for including community residential alternatives to inpatient acute care as a standard part of the range of services in any mental health system where choice, flexibility and cost-effectiveness are prioritized. Despite this, we are not aware of any countries where inclusion of crisis houses is a standard element in acute care, although the model is found in many countries.

The literature on residential community crisis services suggests that the models implemented are diverse[118]. While this is an impediment to drawing generalizable conclusions about their outcomes, it is a potential strength in developing a flexible crisis care system in which a range of needs are met. Needs vary greatly at the time of a mental health crisis: for example, a service user beginning to take medication following a relapse of psychosis or bipolar disorder may benefit from a crisis house that incorporates some clinical professionals and approaches, while someone experiencing escalating distress and risk of self-harm in the context of complex trauma and/or a "personality disorder" diagnosis may benefit more from a less clinical approach, in which relational care, psychotherapeutic approaches to trauma and complex emotional needs, and the support of peers might be the main elements. An optimized crisis care system might thus include multiple residential al-

ternatives offering a choice of approaches to service users and referring clinicians.

FURTHER PERSPECTIVES ON CRISIS CARE

Crisis prevention

Our primary focus in this paper is on the management of mental health crises. However, the best option is clearly to prevent such crises if at all possible, investing instead on maintaining good mental health and supporting recovery in the community[125]. A rapid evidence synthesis found that several interventions recommended by the UK National Institute for Health and Care Excellence (NICE) guidelines have some supporting evidence regarding prevention of crises and/or relapses of illness[126]. These include early intervention services for psychosis, intensive case management models, and a range of pharmacological and psychological interventions for psychosis and bipolar disorder. Investing in full implementation of such models has potential to reduce crisis care use. Beyond such clinical models, social stressors and adverse social circumstances are contributors to crises, and a comprehensive programme to reduce adversity and inequality, as well as to implement interventions for severe mental illness that are clearly evidence-based, is arguably the optimal approach to crisis prevention[125].

A wide range of approaches focus directly on preventing crises, including early warning signs monitoring and relapse prevention programmes, some in digital form, collaborative crisis plans, and advance statements or directives. Supported self-management, often incorporating relapse prevention, is a straightforward intervention that shows evidence of effects on a range of clinical and social outcomes[127], so that wide implementation appears desirable in an optimized mental health system. The time following a crisis is an obvious target for delivery of interventions to prevent further crises: a large trial of a supported self-management intervention delivered by peer support workers in sites around England found that it reduced repeat use of acute services[128].

Collaborative planning for what should happen at the time of a crisis is currently the intervention that appears most effective in preventing compulsory hospital admission, the form of acute care that it is most desirable to avoid[98]. Ideally, as advocated in the Independent Review of the Mental Health Act in England, this should include advance statements that have legal force regarding what should happen when compulsory admission is contemplated[129].

The role of the voluntary sector

In many high-income countries, the voluntary sector (including charities and community and service user groups) is increasingly playing a role in the provision of mental health support, valued for the distinctive approaches it offers and its greater focus on equalities.

Factors accelerating the contribution of the voluntary sector to crisis support include: a) recognition that the restricted focus of statutory acute mental health care results in people falling through the gaps in provision[130]; b) service user dissatisfaction with crisis support provided by secondary mental health services[131,132]; and c) disproportionately high rates of involuntary detention for people from some minority communities, and concern that their needs are not well addressed by statutory services[133].

The distinctive contribution of voluntary sector services results from the way they work, whom they work with, and their roles within local communities[134-136]. Their foundations are often in grassroots organizations and activism, and they tend to be "underpinned by an ethos of informality, promoting accessibility, using relational-based approaches, and valuing self-organization and service-user-defined outcomes"[130]. Hierarchies are often flat, and service user, volunteer and staff roles may overlap. They are thus potentially better placed to meet the needs of marginalized groups, and of those who are either unable to access or mistrust mainstream health services, such as people from racialized communities[137], homeless people, or those excluded because of complexity of difficulties or diagnoses such as "borderline personality disorder" (although coverage of marginalized communities may be uneven).

For example, Hutchinson et al[138] found that men using not-for-profit mental health services in London were more often unemployed and had more unmet needs than local users of public mental health services. Those using the voluntary sector service cited wanting to escape "the system", with levels of dissatisfaction with public sector mental health services reported to be particularly high among Black Caribbean participants.

Among the models discussed above, crisis cafés/safe havens and crisis houses have developed predominantly in the not-for-profit sector. Distinctive characteristics of their intended approaches[130,139] can include: a positive stance on mental health; a holistic understanding of crises that locates them in the biographical, social and relational context of people's lives; space and time for people to speak about their distress; a safe, calm and welcoming environment and relational safety; informality and a light touch in terms of assessment and note-keeping; greater autonomy, choice and responsibility for clients; strong therapeutic and peer relationships; enabling people to maintain their connections to "normal life" and the community; and a less stigmatizing and less clinical approach, with providers of care including peer support workers and volunteers embedded in local communities.

Types of help offered by such crisis services include emotional support and individual and group therapy; peer support and mentoring; social and therapeutic activities; programmes to better manage mental health; advocacy; and liaison with and signposting to both public sector and other not-for-profit organizations. Thus, mental health crisis management often sits alongside services that can support recovery and enable people to deal with financial, housing and social issues.

As well as these specific crisis support services, many other not-for-profit organizations play a role in crisis support, crisis prevention, recovery, and addressing inequalities in access and support. These include those supporting particular groups at risk of poor mental health – for example, members

of the lesbian, gay, bisexual, transgender and queer (LGBTQ) community, those who are deaf, communities from specific ethnic or refugee backgrounds – and those responding to life crises such as bereavement, rape or homelessness[130].

The research literature on the contribution of not-for-profit and community organizations remains relatively scant internationally, and stronger evidence regarding their roles in local systems, experiences and outcomes would be very valuable. Reported advantages suggest that approaches developed in some not-for-profit crisis services have potential to address the problems with accessibility, acceptability, equality, and appropriateness to specific communities often reported in public mental health services[33,125]. A case can thus be made both that this sector should be recognized and incorporated within a comprehensive crisis system, and that it provides a model for rethinking dominant models of crisis care to ensure a response that is accessible, acceptable and appropriate for all members of the local population[130].

The contribution of service user-led and co-produced initiatives, and of peer support

Change to crisis and acute services has been a consistent focus for action in the mental health service user (or consumer) movement for many decades[140]. In the 1970s, activists in the UK demanded rights-based reform of the conditions and treatment in psychiatric hospitals[141]. Later, in the context of "community care", user-led organizations established themselves as sources of mutual support, patient advocacy and forums for campaigning and involvement work[142]. Informal peer support naturally occurred when people with mental health problems came together, and mental health service user groups went on to develop more organized forms of peer support, including for people experiencing mental health crises and acute distress[143].

Since their inception in grassroots service user groups, organized versions of one-to-one and group peer support have become influential for crisis and acute services across the UK, US, Canada, New Zealand and Australia[144]. For example, "intentional peer support" defines crisis as "emotional and psychological pain" and peer support as being with another who has experienced similar pain in a relationship of trust and "mutual empowerment"[145]. This model has been introduced into acute inpatient environments in the UK[146], and small-scale qualitative studies show that patients can find it helpful in providing person-centred emotional and practical support and in modelling hope[147]. Research into the implementation and effectiveness of peer support in crisis and acute services is ongoing globally[148] and, while some study findings on discharge and readmission to acute care seem promising[128], a robust evidence base is still needed[149,150].

As originally conceived, peer support is rooted in a set of values and principles[144] which can sometimes conflict with clinical environments and treatments associated with acute services, such as seclusion and restraint[151]. Mental health service users, their organizations and allies have worked to establish a set of principles and principles-based approaches for delivering peer support services in mainstream mental health services, including inpatient and crisis care[152]. Recent research into the formalization of peer support in UK mental health services suggests that "we need to pay attention to the values underpinning peer support… [and] to resist the replication… of a para-clinical model of peer support"[153], whereby peer support workers become just another kind of non-professional staff making up numbers in clinical teams. Some are concerned that the professionalization of peer support could undermine its values and authentic practice, and might negatively affect user-led and community groups that have established their own forms of crisis peer support outside the psychiatric system[154].

An international consortium of peer support leaders agreed that present and future peer support innovations should adhere to values and principles rooted in maintaining "role integrity", and in civil rights, social justice, and responsiveness to local cultural world views[155]. These principles should apply whether crisis services are located within public mental health systems (such as Open Dialogue[156]) or beyond them in independent user-led projects, such as the Leeds Survivor Led Crisis Service (LSLCS).

LSLCS is notable as an independent organization offering an alternative to hospitalization and statutory crisis care underpinned by principles and values of peer support[157]. A social return on investment (SROI) analysis for the service estimated that the "SROI ratio for LSLCS lies within the range of £4.00 to £6.50 of social value generated for every £1 invested"[158].

The future challenge is to sustain and develop a diversity of values-based, innovative and responsive peer support services for people in crisis and acute states. This is likely to expand further into the digital and online space for crisis prevention and recovery support[159]. Research into implementation, development and effectiveness using a range of methodologies is needed to ensure that a robust evidence base is built on current and emerging forms of peer support, both within and beyond mainstream services.

Other essential considerations for service planning in the future include the benefits of a co-production approach and of service user leadership. Given frequently negative service user views regarding mainstream acute services, such approaches have potentially much to offer across the acute care system.

Remote acute care delivery

Most literature on telepsychiatry focuses on videoconferencing, seen as the preferred substitute for in-person interactions, but rapid and wide accessibility suggests that there is a significant role for telephone support in crises. Voluntary sector organizations have a long history of providing such mental health support, and have been found to deal with suicidal callers as effectively as professionals[160]. The use of mental health hotlines has increased greatly in the early stages of the COVID-19 pandemic[161]. Telephone services may also be used in secondary mental health care as an initial contact, support and triage point: for example, all NHS Trusts in England are now required to provide a local helpline[162].

Telepsychiatry, predominantly using videoconferencing tools, has been used for decades to overcome geographical barriers to specialized care, particularly in rural parts of Australia and Canada, and some parts of the US[163-165]. The adoption of these services has expanded to the crisis setting to provide urgent and emergent consultation, informing care management and decisions regarding transfer to hospital[166]. For example, the Mental Health Emergency Care - Rural Access Program provides telephone and video triage and assessment for emergent psychiatric presentations across Western Australia[167,168].

Urban emergency settings characterized by variations in psychiatric coverage can also be served by a telepsychiatry liaison model. Such models have shown promise in the US and Canada to increase access to consultation, reduce wait times, decrease system costs, and improve post-ED visit outcomes[169-171]. Evidence indicates that a trained team following comprehensive safety protocols can reliably assess a wide range of presentations remotely[172,173]. This includes the assessment of suicidal behaviour, psychosis, affective symptoms, and substance use.

Virtual care is expanding rapidly, including web-based programmes and apps with potential usefulness in crisis settings. Patient-directed apps designed to help individuals cope during crises can be provided at the point of care to support post-crisis self-management and safety planning[174]. Personal videoconferencing is now emerging as a viable modality of direct care delivery, removing the need for a traditional telehealth suite and allowing assessments to take place with individuals remaining in their homes or other accessible settings. As a result, some centres are innovating and pushing the usual boundaries for crisis care delivery[175], and virtual hospital-at-home models may become a significant format for acute care in the future[176].

However, significant barriers to scaling up telemental health effectively include remuneration models, digital exclusion, inadequate privacy in many service users' homes, and perceptions that quality of care and therapeutic relationships are impaired[177]. Rigorous research is thus needed to inform future development of remote crisis care within specific health care systems[178-180].

Crisis care in low- and middle-income countries (LMICs)

In many LMICs, as well as in underserved areas of high-income countries, health services are often not the first port of call for individuals in crisis and their families. This is partly due to the limited availability and poor accessibility of mental health care. The average number of psychiatrists per one million population ranges between 0.6 in low-income countries to 20 in upper middle-income countries[1]. Even with efforts to expand access to care through integration in primary health care[1], service coverage in LMICs remains low, with only 14-22% of individuals who meet the criteria for a mental disorder receiving treatment[181]. Past experiences of poor-quality or coercive care that fails to meet prioritized needs may also deter help-seeking[182]. Only 44-50% of countries in Africa and Southeast Asia have legal protections for people requiring crisis mental health care[1], and there may be minimal enforcement.

Low community awareness about mental health, high levels of mental health stigma and, in some countries, a preference for religious and traditional healers contribute further to low levels of help-seeking from formal services[183]. In this section, we focus principally on those countries where specialized mental health services other than large psychiatric hospitals are not available, applicable to most low-income and some middle-income countries.

Crisis presentations are often not framed as mental health problems in LMICs. Community responses to mental health crises may focus on overt manifestations of a problem, including acute behavioural disturbance or distress, suicidal behaviour and self-harm, severe physical consequences (e.g., dehydration in severe depression or exhaustion linked to mania), and sudden loss of sensory or motor functions as part of conversion disorder[184]. Non-overt indicators of a mental health crisis, such as suicidal ideation, may not be prioritized for intervention.

An individual's family often drives the response to a mental health crisis, drawing on informal support from communities. Responses to acute behavioural disturbance could include involvement of the police or religious or traditional healers [185], complementary or homeopathic remedies, abandonment of the individual to the streets[186], some form of restraint[187], or emergency presentation to psychiatric services. Involvement of the police places the individual at risk of exposure to physical abuse, excessive force, restraints and detention[188]. Restraint in the context of families is often seen as a last resort in the absence of accessible and effective care[189].

Stigma and taboos associated with self-harm and suicidal behaviour may result in family concealment or punishment of the individual. Physical treatment for consequences of self-harm or suicide attempts is not usually accompanied by any form of mental health assessment or treatment.

Community responses may frame acute distress in terms of a spiritual crisis or as the understandable consequence of severe social adversities (e.g., intimate partner violence, an acute life stressor) and mobilize resources accordingly. These responses may include mediation of relationship difficulties, material supports, or providing meaning to adversity[190].

A 2015 systematic review of mental health interventions for crises in non-specialist settings in LMICs found a lack of evidence-based guidelines for crisis care[184]. Only one intervention study was identified. In a recently published guidance, the World Health Organization (WHO) set out recommendations for rights-based, recovery-oriented responses to mental health crises[191]. In developing the guidance, the WHO sought to identify case studies of good practice that were compliant with the 2006 United Nations Convention on the Rights of Persons with Disabilities, meeting five criteria (use of non-coercive practices, community inclusion, participation in care, recovery approach, respect for legal capacity). Identifying good practice case studies from LMICs was a priority, but none was found.

An integrated mental health response to crisis presentations is rare in many LMICs. Referral to specialist mental health services

may occur, but cost, inaccessibility and non-acceptability are potent barriers to uptake. Involvement of people with mental health conditions in decisions about crisis care is very limited[182]. Consequences of the existing responses include violations of human rights, prolongation of severe mental illness linked to heightened vulnerability and poorer prognosis, risk of acute physical ill-health and premature mortality, and more coercive mental health care (if accessed at all).

The WHO mental health Gap Action Programme (mhGAP) includes an intervention guide (mhGAP-IG) comprising evidence-informed algorithms for the provision of crisis care for acute psychosis or mania, suicidal behaviour or self-harm, as well as acute behavioural disturbance in the context of dementia or developmental disorders[192]. However, it does not provide clear guidance on key components of rights-based care (including supported decision-making, informed consent for treatment, and non-coercive practices) and evaluation for people with crisis presentations has been limited[193].

There have been small-scale efforts to provide alternatives to hospitalization for people in acute crisis in Somaliland[194] and Jamaica[195], but these models of care have not been rigorously evaluated and have limited potential for scalability, due to reliance on specialist mental health professionals. An adapted form of the crisis intervention team model, used widely in the US, has been piloted with law enforcement officers in Liberia, with preliminary evidence of beneficial impacts on knowledge, stigmatizing attitudes, and engagement with mental health clinicians[188].

To date, there have been two randomized controlled trials of crisis interventions for people presenting to non-specialist services after suicide attempts in LMICs[196,197]. Both trials evaluated the brief intervention and contact model, comprising an initial one-hour psychoeducation session at the time of the attempt, followed by nine phone calls over the next 18 months which assessed suicidality and support needs. The larger, multi-country trial (Brazil, China, India, Iran and Sri Lanka) demonstrated an impact of the intervention on repeat self-harm attempts and suicide, whereas the single country study (French Polynesia) showed no impact[197].

For the future, improving crisis response in LMICs will require the development and evaluation of contextually appropriate interventions, building on existing community resources and enabling community members to identify and support those in acute crisis, alongside strengthened access to mental health care and changes to policy and legislation. Building on community resources and equipping accessible individuals (e.g., peers, family members, community health workers, traditional and religious leaders, community leaders, teachers, police) to deliver psychological first aid in response to a mental health crisis is an important step to improving care[198]. The crisis intervention team approach that has been used with law enforcement officers[188] may also be relevant for traditional and religious healers or community leaders, who play an important role in determining community responses to an individual with acutely disturbed behaviour.

The COVID-19 pandemic has had a significant impact on the availability and accessibility of mental health care globally, including in LMICs[199]. Use of hotlines and digital technology creates new opportunities to provide crisis support and to identify and respond to those at risk of suicide, although as elsewhere the most vulnerable may also be at high risk of digital exclusion. Ensuring that crisis care is available in local primary and general health care settings is essential. Competency-based assessments of health workers delivering WHO's mhGAP-IG[200] in non-specialist settings should incorporate de-escalation techniques, and programmes should be informed by the WHO recommendations for crisis care[191] and ensure supported decision-making and provision of alternatives to coercive care.

Formal mental health crisis services also need to be able to move outside of facilities – for example, providing outreach to those in crisis who are homeless or restrained at home and unable to access care. The potential contribution of peer support to many aspects of mental health care, including crisis response, is gaining traction in LMICs[201,202], but starts from a low base of involvement and empowerment of people with lived experience of mental health conditions[203].

Policies and legislation upholding the human rights of individuals experiencing a mental disorder are necessary to the implementation and sustainability of effective and appropriate interventions. The WHO has specified what legislation and regulations need to include, as well as how these might be implemented. For example, current efforts in India to implement these principles through new mental health legislation include strategies to support decision-making for people experiencing a mental health crisis through advanced directives and nominated representatives[204].

Much more robust evaluation needs to accompany programmes to improve crisis response within communities, ensuring that unintended adverse consequences do not result, for example, where law enforcement agencies or traditional healers become involved in crisis response. Before adapting existing or developing new interventions, we need greater understanding of what happens at the point of crisis, to identify ways to move towards more rights-based and person-centred care. Interventions should be co-developed with service users, their families, service providers and other key members of the community to increase their appropriateness, acceptability and sustainability.

For the future, while the transfer of high-intensity, high-resource, specialist models from high-income countries to LMICs is likely to be undesirable and ineffective at meeting need, reverse innovation is possible. Where crisis responses are developed that are embedded in communities and service user involvement, as in the voluntary sector responses discussed earlier, they have the potential to serve as a template for collaborative crisis care in high-income countries.

CONCLUSIONS

Much of the focus in this paper has been on specific acute care models and the potential they hold for improving care and widening the range of options available in a crisis. However, this reflects a clinician rather than a patient perspective. During

a crisis, a service user may seek help from and be supported by a range of local agencies and will be affected not so much by the quality of individual services as by the overall accessibility of appropriate types of help and the extent to which an integrated and flexible crisis response is available from helpful and empathic staff[205].

So far, very little research has focused on the overall patient journey and on crisis care systems[47]. A flexible and accessible local area crisis care system that offers a variety of crisis options to meet service user needs and preferences and that integrates sectors appears optimal. However, a relatively complex service system involving multiple crisis service models may also lead to fragmentation and service gaps. We therefore suggest that how best to design integrated local crisis care systems should be a research and policy priority. Co-production with people who use services and their communities, as well as staff in all relevant sectors, is essential for such redesign to address diverse needs in crisis effectively and acceptably.

REFERENCES

1. World Health Organization. Mental health atlas 2020. Geneva: World Health Organization, 2021.
2. Howard LM, Leese M, Byford S et al. Methodological challenges in evaluating the effectiveness of women's crisis houses compared with psychiatric wards: findings from a pilot patient preference RCT. J Nerv Ment Dis 2009;197:722-7.
3. Fossey M, Godier-McBard L, Guthrie EA et al. Understanding liaison psychiatry commissioning: an observational study. Ment Health Rev J 2020;25:301-16.
4. Santillanes G, Axeen S, Lam CN et al. National trends in mental health-related emergency department visits by children and adults, 2009-2015. Am J Emerg Med 2020;38:2536-44.
5. Tran QN, Lambeth LG, Sanderson K et al. Trend of emergency department presentations with a mental health diagnosis in Australia by diagnostic group, 2004-05 to 2016-17. Emerg Med Australas 2020;32:190-201.
6. UK National Health Service. The NHS five year forward view. London: National Health Service, 2014.
7. Sampson EL, Wright J, Dove J et al. Psychiatric liaison service referral patterns during the UK COVID-19 pandemic: an observational study. Eur J Psychiatry 2022;36:35-42.
8. Jeffery MM, D'Onofrio G, Paek H et al. Trends in emergency department visits and hospital admissions in health care systems in 5 states in the first months of the COVID-19 pandemic in the US. JAMA Intern Med 2020;180:1328-33.
9. Barratt H, Rojas-García A, Clarke K et al. Epidemiology of mental health attendances at emergency departments: systematic review and meta-analysis. PLoS One 2016;11:e0154449.
10. Cotton M-A, Johnson S, Bindman J et al. An investigation of factors associated with psychiatric hospital admission despite the presence of crisis resolution teams. BMC Psychiatry 2007;7:52.
11. Dombagolla MH, Kant JA, Lai FW et al. Barriers to providing optimal management of psychiatric patients in the emergency department (psychiatric patient management). Australas Emerg Care 2019;22:8-12.
12. Clarke D, Usick R, Sanderson A et al. Emergency department staff attitudes towards mental health consumers: a literature review and thematic content analysis. Int J Ment Health Nurs 2014;23:273-84.
13. Rayner G, Blackburn J, Edward KL et al. Emergency department nurse's attitudes towards patients who self-harm: a meta-analysis. Int J Ment Health Nurs 2019;28:40-53.
14. Fossey M, Parsonage M. Outcomes and performance in liaison psychiatry. London: Centre for Mental Health, 2014.
15. Evans R, Connell J, Ablard S et al. The impact of different liaison psychiatry models on the emergency department: a systematic review of the international evidence. J Psychosom Res 2019;119:53-64.
16. Xanthopoulou P, Ryan M, Lomas M et al. Psychosocial assessment in the emergency department: the experiences of people presenting with self-harm and suicidality. Crisis 2021; doi: 10.1027/0227-5910/a000786.
17. MacDonald S, Sampson C, Turley R et al. Patients' experiences of emergency hospital care following self-harm: systematic review and thematic synthesis of qualitative research. Qual Health Res 2020;30:471-85.
18. Zeller S. Hospital-based psychiatric emergency programs: the missing link for mental health systems. Psychiatr Times 2019;36:1-31.
19. Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 2014;15:1-6.
20. Braitberg G, Gerdtz M, Harding S et al. Behavioural assessment unit improves outcomes for patients with complex psychosocial needs. Emerg Med Australas 2018;30:353-8.
21. Goldsmith LP, Anderson K, Clarke G et al. The psychiatric decision unit as an emerging model in mental health crisis care: a national survey in England. Int J Ment Health Nurs 2021;30:955-62.
22. Hussain D. Mental health patient slept in a CHAIR for a week while waiting for a bed. Birmingham Live, November 18, 2017.
23. Lloyd-Evans B, Slade M, Jagielska D et al. Residential alternatives to acute psychiatric hospital admission: systematic review. Br J Psychiatry 2009;195:109-17.
24. Williams P, Csipke E, Rose D et al. Efficacy of a triage system to reduce length of hospital stay. Br J Psychiatry 2014;204:480-5.
25. Grassi L, Mitchell AJ, Otani M et al. Consultation-liaison psychiatry in the general hospital: the experience of UK, Italy, and Japan. Curr Psychiatry Rep 2015;17:44.
26. Caplan G. Principles of preventive psychiatry. New York: Basic Books, 1964.
27. Mezzina R. Community mental health care in Trieste and beyond: an "Open Door-No Restraint" system of care for recovery and citizenship. J Nerv Ment Dis 2014;202:440-5.
28. Häfner H. Psychiatric crisis intervention – a change in psychiatric organization. Report on developmental trends in the Western European countries and in the USA. Psychiatria Clinica 1977;10:27-63.
29. Katschnig H, Konieczna T, Cooper JE. Emergency psychiatric and crisis intervention services in Europe: a report based on visits to services in seventeen countries. Geneva: World Health Organization, 1993.
30. Stulz N, Nevely A, Hilpert M et al. Referral to inpatient treatment does not necessarily imply a need for inpatient treatment. Adm Policy Ment Health 2015;42:474-83.
31. Parmar N, Bolton J. Alternatives to emergency departments for mental health assessments during the COVID-19 pandemic. London: Faculty of Liaison Psychiatry, Royal College of Psychiatrists, 2020.
32. Di Lorenzo R, Fiore G, Bruno A et al. Urgent psychiatric consultations at mental health center during COVID-19 pandemic: retrospective observational study. Psychiatr Q 2021;92:1341-59.
33. Dalton-Locke C, Johnson S, Harju-Seppanen J et al. Emerging models and trends in mental health crisis care in England: a national investigation of crisis care systems. BMC Health Serv Res 2021;21: 1174.
34. Mind. Listening to experience: an independent inquiry into acute and crisis mental healthcare. London: Mind, 2011.
35. Polak P. Patterns of discord: goals of patients, therapists, and community members. Arch Gen Psychiatry 1970;23:277-83.
36. Jones M, Polak P. Crisis and confrontation. Br J Psychiatry 1968;114:169-74.
37. Querido A. Community mental hygiene in the city of Amsterdam. Mental Hygiene 1935;19:177-95.
38. Querido A. The shaping of community mental health care. Br J Psychiatry 1968;114:293-302.
39. Teague GB, Bond GR, Drake RE. Program fidelity in assertive community treatment: development and use of a measure. Am J Orthopsychiatry 1998;68:216-32.
40. Lambert M, Karow A, Gallinat J et al. Study protocol for a randomised controlled trial evaluating an evidence-based, stepped and coordinated care service model for mental disorders (RECOVER). BMJ Open 2020;10:e036021.
41. Van Veldhuizen JR. FACT: a Dutch version of ACT. Community Ment Health J 2007;43:421-33.
42. Stein LI, Test MA. Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. Arch Gen Psychiatry 1980;37:392-7.
43. Hoult J. Community care of the acutely mentally ill. Br J Psychiatry 1986;149:137-44.
44. Johnson S. Crisis resolution and home treatment teams: an evolving model. Adv Psychiatr Treat 2013;19:115-23.
45. Lloyd-Evans B, Bond GR, Ruud T et al. Development of a measure of model fidelity for mental health Crisis Resolution Teams. BMC Psychiatry 2016;16:427.
46. Hasselberg N, Holgersen K, Uverud G et al. Fidelity to an evidence-based model for crisis resolution teams: a cross-sectional multicentre

study in Norway. BMC Psychiatry 2021;21:231.
47. Morant N, Lloyd-Evans B, Lamb D et al. Crisis resolution and home treatment: stakeholders' views on critical ingredients and implementation in England. BMC Psychiatry 2017;17:254.
48. Northumberland Tyne and Wear NHS Foundation Trust. Sunderland and South of Tyne Initial Response Team. https://www.ntw.nhs.uk.
49. Murphy S, Irving CB, Adams CE et al. Crisis intervention for people with severe mental illnesses. Cochrane Database Syst Rev 2015;12: CD001087.
50. Livingston JD. Contact between police and people with mental disorders: a review of rates. Psychiatr Serv 2016;67:850-7.
51. Shore K, Lavoie JAA. Exploring mental health-related calls for police service: a Canadian study of police officers as 'frontline mental health workers.' Policing 2018;13:157-71.
52. Charette Y, Crocker AG, Billette I. Police encounters involving citizens with mental illness: use of resources and outcomes. Psychiatr Serv 2014;65:511-6.
53. Derrick K, Chia J, O'Donovan S et al. Examining Mental Health Act usage in an urban emergency department. Australas Psychiatry 2015;23:517-9.
54. Lamanna D, Shapiro GK, Kirst M et al. Co-responding police-mental health programmes: service user experiences and outcomes in a large urban centre. Int J Ment Health Nurs 2018; 27:891-900.
55. Kirubarajan A, Puntis S, Perfect D et al. Street triage services in England: service models, national provision and the opinions of police. BJPsych Bull 2018;42:253-7.
56. Puntis S, Perfect D, Kirubarajan A et al. A systematic review of co-responder models of police mental health 'street' triage. BMC Psychiatry 2018;18:256.
57. Callender M, Knight LJ, Moloney D et al. Mental health street triage: comparing experiences of delivery across three sites. J Psychiatr Ment Health Nurs 2021;28:16-27.
58. StopSIM. Mental illness is not a crime. https://stopsim.co.uk.
59. Royal College of Nursing. RCN position on the national rollout of Serenity Integrated Mentoring (SIM) and other similar models in England. https://www.rcn.org.uk.
60. Royal College of Psychiatrists. RCPsych calls for urgent and transparent investigation into NHS Innovation Accelerator and AHSN following HIN suspension. https://www.rcpsych.ac.uk.
61. Bowers L, Chaplin R, Quirk A et al. A conceptual model of the aims and functions of acute inpatient psychiatry. J Ment Health 2009;18:316-25.
62. Thornicroft G, Tansella M. Balancing community-based and hospital-based mental health care. World Psychiatry 2002;1:84-90.
63. Almeda N, García-Alonso CR, Salinas-Pérez JA et al. Causal modelling for supporting planning and management of mental health services and systems: a systematic review. Int J Environ Res Public Health 2019;16:332.
64. Gutiérrez-Colosía MR, Salvador-Carulla L, Salinas-Pérez J et al. Standard comparison of local mental health care systems in eight European countries. Epidemiol Psychiatr Sci 2019;28:210-23.
65. Rains LS, Zenina T, Dias MC et al. Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study. Lancet Psychiatry 2019;6:403-17.
66. Keown P, Weich S, Bhui KS et al. Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988-2008: ecological study. BMJ 2011; 343:d3736.
67. Cutting P, Henderson C. Women's experiences of hospital admission. J Psychiatr Ment Health Nurs 2002;9:705-12.
68. Bowers L. Safewards: a new model of conflict and containment on psychiatric wards. J Psychiatr Ment Health Nurs 2014;21:499-508.
69. Nijman H, Palmstierna T, Almvik R et al. Fifteen years of research with the Staff Observation Aggression Scale: a review. Acta Psychiatr Scand 2005;111:12-21.
70. NHS England. Data on patient safety incidents reported to the NRLS by each NHS trust in England October 2019 to March 2020. https://www.england.nhs.uk.
71. Thapa PB, Palmer SL, Owen RR et al. P.R.N. (As-needed) orders and exposure of psychiatric inpatients to unnecessary psychotropic medications. Psychiatr Serv 2003;54:1282-6.
72. Muskett C. Trauma-informed care in inpatient mental health settings: a review of the literature. Int J Ment Health Nurs 2014;23:51-9.
73. Johnson J, Hall LH, Berzins K et al. Mental healthcare staff well-being and burnout: a narrative review of trends, causes, implications, and recommendations for future interventions. Int J Ment Health Nurs 2018;27:20-32.
74. Edwards D, Evans N, Gillen E et al. What do we know about the risks for young people moving into, through and out of inpatient mental health care? Findings from an evidence synthesis. Child Adolesc Psychiatry Ment Health 2015; 9:55.
75. Akther SF, Molyneaux E, Stuart R et al. Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. BJPsych Open 2019;5:10.
76. Stuart R, Akther SF, Machin K et al. Carers' experiences of involuntary admission under mental health legislation: systematic review and qualitative meta-synthesis. BJPsych Open 2020;6:9.
77. Sheridan Rains L, Weich S, Maddock C et al. Understanding increasing rates of psychiatric hospital detentions in England: development and preliminary testing of an explanatory model. BJPsych Open 2020;6:e88.
78. Walker S, Mackay E, Barnett P et al. Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis. Lancet Psychiatry 2019;6:1039-53.
79. Paton C, Barnes TR, Cavanagh MR et al. High-dose and combination antipsychotic prescribing in acute adult wards in the UK: the challenges posed by P.R.N. prescribing. Br J Psychiatry 2008; 192:435-9.
80. Muralidharan S, Fenton M. Containment strategies for people with serious mental illness. Cochrane Database Syst Rev 2006;3:CD002084.
81. Wood L, Williams C, Billings J et al. A systematic review and meta-analysis of cognitive behavioural informed psychological interventions for psychiatric inpatients with psychosis. Schizophr Res 2020;222:133-44.
82. Goulet M-H, Larue C, Dumais A. Evaluation of seclusion and restraint reduction programs in mental health: a systematic review. Aggress Violent Behav 2017;34:139-46.
83. Bowers L, James K, Quirk A et al. Reducing conflict and containment rates on acute psychiatric wards: the Safewards cluster randomised controlled trial. Int J Nurs Stud 2015;52:1412-22.
84. Putkonen A, Kuivalainen S, Louheranta O et al. Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. Psychiatr Serv 2013;64:850-5.
85. Baker J, Berzins K, Canvin K et al. Non-pharmacological interventions to reduce restrictive practices in adult mental health inpatient settings: the COMPARE systematic mapping review. Health Serv Deliv Res 2021;9:5.
86. McAllister S, Robert G, Tsianakas V et al. Conceptualising nurse-patient therapeutic engagement on acute mental health wards: an integrative review. Int J Nurs Stud 2019;93:106-18.
87. Barbui C, Purgato M, Abdulmalik J et al. Efficacy of interventions to reduce coercive treatment in mental health services: umbrella review of randomised evidence. Br J Psychiatry 2021;218:185-95.
88. Marshall CA, McIntosh E, Sohrabi A et al. Boredom in inpatient mental healthcare settings: a scoping review. Br J Occup Ther 2020;83:41-51.
89. Totman J, Mann F, Johnson S. Is locating acute wards in the general hospital an essential element in psychiatric reform? The UK experience. Epidemiol Psychiatr Sci 2010;19:282-6.
90. Sheehan B, Burton E, Wood S et al. Evaluating the built environment in inpatient psychiatric wards. Psychiatr Serv 2013;64:789-95.
91. Archer M, Lau Y, Sethi F. Women in acute psychiatric units, their characteristics and needs: a review. BJPsych Bull 2016;40:266-72.
92. Evlat G, Wood L, Glover N. A systematic review of the implementation of psychological therapies in acute mental health inpatient settings. Clin Psychol Psychother 2021;28:1574-86.
93. Weich S, Fenton S-J, Staniszewska S et al. Using patient experience data to support improvements in inpatient mental health care: the EURIPIDES multimethod study. Health Serv Deliv Res 2020;8:21.
94. Stapleton A, Wright N. The experiences of people with borderline personality disorder admitted to acute psychiatric inpatient wards: a meta-synthesis. J Ment Health 2019;28:443-57.
95. Johnson S, Needle JJ. Crisis resolution teams: rationale and core model. In: Johnson S, Needle J, Bindman J et al (eds). Crisis resolution and home treatment in mental health. Cambridge: Cambridge University Press, 2008:67-84.
96. Winter DA, Shivakumar H, Brown RJ et al. Explorations of a crisis intervention service. Br J Psychiatry 1987;151:232-9.
97. Glover G, Arts G, Babu KS. Crisis resolution/home treatment teams and psychiatric admission rates in England. Br J Psychiatry 2006;189: 441-5.
98. Bone JK, McCloud T, Scott HR et al. Psychosocial interventions to reduce compulsory psychiatric admissions: a rapid evidence synthesis. EClinicalMedicine 2019;10:58-67.
99. Wheeler C, Lloyd-Evans B, Churchard A et al. Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review. BMC Psychiatry 2015;15:74.
100. Lloyd-Evans B, Christoforou M, Osborn D et al. Crisis resolution teams for people experiencing

mental health crises: the CORE mixed-methods research programme including two RCTs. Programme Grants for Applied Research 2019;7:1-102.
101. Lamb D, Lloyd-Evans B, Fullarton K et al. Crisis resolution and home treatment in the UK: a survey of model fidelity using a novel review methodology. Int J Ment Health Nurs 2020;29:187-201.
102. Hopkins C, Niemiec S. Mental health crisis at home: service user perspectives on what helps and what hinders. J Psychiatr Ment Health Nurs 2007;14:310-8.
103. Lyons C, Hopley P, Burton CR et al. Mental health crisis and respite services: service user and carer aspirations. J Psychiatr Ment Health Nurs 2009;16:424-33.
104. Lloyd-Evans B, Osborn D, Marston L et al. The CORE service improvement programme for mental health crisis resolution teams: results from a cluster-randomised trial. Br J Psychiatry 2020;216:314-22.
105. Stulz N, Wyder L, Maeck L et al. Home treatment for acute mental healthcare: randomised controlled trial. Br J Psychiatry 2020;216:323-30.
106. Dirik A, Sandhu S, Giacco D et al. Why involve families in acute mental healthcare? A collaborative conceptual review. BMJ Open 2017;7:e017680.
107. Seikkula J, Alakare B, Aaltonen J. The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. Psychosis 2011;3:192-204.
108. Pilling S, Ziedonis D, De Oliveira Gomes M et al. Open Dialogue: development and evaluation of a social network intervention for severe mental illness (ODDESSI). https://www.ucl.ac.uk.
109. Mezzina R, Johnson S. Home treatment and 'hospitality' within a comprehensive community mental health centre. In: Johnson S, Needle JJ, Bindman J et al (eds). Crisis resolution and home treatment in mental health. Cambridge: Cambridge University Press, 2008:251-65.
110. Rosen A. Integration of the crisis resolution function within community mental health teams. In: Johnson S, Needle JJ, Bindman J et al (eds). Crisis resolution and home treatment in mental health. Cambridge: Cambridge University Press, 2008:235-50.
111. Taube-Schiff M, Ruhig M, Mehak A et al. Staff perspectives: what is the function of adult mental health day hospital programs? J Psychiatr Ment Health Nurs 2017;24:580-8.
112. Schene A. Day hospital and partial hospitalization programmes. In: Thornicroft G, Szmukler G, Mueser KT et al (eds). Oxford textbook of community mental health. Oxford: Oxford University Press, 2011:283-93.
113. Marshall M, Crowther R, Sledge WH et al. Day hospital versus admission for acute psychiatric disorders. Cochrane Database Syst Rev 2011;12:CD004026.
114. Priebe S, Jones G, McCabe R et al. Effectiveness and costs of acute day hospital treatment compared with conventional in-patient care: randomised controlled trial. Br J Psychiatry 2006;188:243-9.
115. Lamb D, Steare T, Marston L et al. A comparison of clinical outcomes, service satisfaction and well-being in people using acute day units and crisis resolution teams: cohort study in England. BJPsych Open 2021;7:e68.
116. Lamb D, Davidson M, Lloyd-Evans B et al. Adult mental health provision in England: a national survey of acute day units. BMC Health Serv Res 2019;19:866.
117. Morant N, Davidson M, Wackett J et al. Acute day units for mental health crises: a qualitative study of service user and staff views and experiences. BMC Psychiatry 2021;21:146.
118. Johnson S, Gilburt H, Lloyd-Evans B et al. Inpatient and residential alternatives to standard acute psychiatric wards in England. Br J Psychiatry 2009;194:456-63.
119. Bola JR, Mosher LR. At issue: predicting drug-free treatment response in acute psychosis from the Soteria project. Schizophr Bull 2002;28:559-75.
120. Thomas KA, Rickwood D. Clinical and cost-effectiveness of acute and subacute residential mental health services: a systematic review. Psychiatr Serv 2013;64:1140-9.
121. Prytherch H, Cooke A, Marsh I. Coercion or collaboration: service-user experiences of risk management in hospital and a trauma-informed crisis house. Psychosis 2020; doi: 10.1080/17522439.2020.1830155.
122. Sweeney A, Fahmy S, Nolan F et al. The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: a cross-sectional study. PLoS One 2014;9:7.
123. Gilburt H, Slade M, Rose D et al. Service users' experiences of residential alternatives to standard acute wards: qualitative study of similarities and differences. Br J Psychiatry 2010;197(Suppl. 53):s26-31.
124. Osborn DP, Lloyd-Evans B, Johnson S et al. Residential alternatives to acute in-patient care in England: satisfaction, ward atmosphere and service user experiences. Br J Psychiatry 2010;197(Suppl. 53):s41-5.
125. Drake R, Bond G. Psychiatric crisis care and the more is less paradox. Community Ment Health J 2021;57:1230-6.
126. Paton F, Wright K, Ayre N et al. Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. Health Technol Assess 2016;20:1-162.
127. Lean M, Fornells-Ambrojo M, Milton A et al. Self-management interventions for people with severe mental illness: systematic review and meta-analysis. Br J Psychiatry 2019;214:260-8.
128. Johnson S, Lamb D, Marston L et al. Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial. Lancet 2018;392:409-18.
129. Department of Health and Social Care. Independent review of the Mental Health Act. London: Department of Health and Social Care, 2018. https://www.gov.uk.
130. Newbigging K, Rees J, Ince R et al. The contribution of the voluntary sector to mental health crisis care: a mixed-methods study. Health Serv Deliv Res 2020;8:29.
131. Care Quality Commission. Right here, right now. People's experiences of help, care and support during a mental health crisis. Newcastle: Care Quality Commission, 2015. https://www.cqc.org.uk.
132. Crisp N, Smith G, Nicholson K. Old problems, new solutions - Improving acute psychiatric care for adults in England. The Commission on Acute Adult Psychiatric Care, 2016. https://www.rcpsych.ac.uk.
133. Care Quality Commission. Monitoring the Mental Health Act in 2016/17. Newcastle: Care Quality Commission, 2019. https://www.cqc.org.uk.
134. Dayson C, Wells P. Voluntary and community sector policy under the coalition government. People, Place and Policy 2013;7:91-9.
135. Macmillan R. 'Distinction' in the third sector. Volunt Sect Rev 2013;4:39-54.
136. Froggett L. Public innovation, civic partnership and the third sector – A psychosocial perspective. In: Agger A, Damgaard B, Hagedorn Krogh A et al (eds). Collaborative governance and public innovation in Northern Europe. Soest: Bentham, 2015:231-48.
137. Boscarato K, Lee S, Kroschel J et al. Consumer experience of formal crisis-response services and preferred methods of crisis intervention. Int J Mental Health Nurs 2014;23:287-95.
138. Hutchinson G, Gilvarry C, Fahy TA. Profile of service users attending a voluntary mental health sector service. Psychiatr Bull 2000;24:251-4.
139. Morant N, Lloyd-Evans B, Gilburt H et al. Implementing successful residential alternatives to acute in-patient psychiatric services: what can we learn from professional stakeholders' perspectives? Psychiatr Prax 2011;38.
140. Edquist K. EU mental health governance and citizen participation: a global governmentality perspective. Health Econ Policy Law 2021;16:38-50.
141. Faulkner A, Basset T. A long and honourable history. J Ment Health Train Educ Pract 2012;7:53-9.
142. Wallcraft J, Bryant M. The mental health service user movement in England. London: Sainsbury Centre for Mental Health, 2003.
143. Faulkner A, Kalathil J. The freedom to be, the chance to dream: preserving user-led peer support in mental health. London: Together for Mental Wellbeing, 2012. https://www.together-uk.org.
144. Gillard S, Foster R, Gibson S et al. Describing a principles-based approach to developing and evaluating peer worker roles as peer support moves into mainstream mental health services. Ment Health Soc Incl 2017;21:133-43.
145. Mead S. Defining peer support. http://chrysm-associates.co.uk.
146. Stone N, Warren F, Napier C. Peer support workers' experience of an intentional peer support scheme on an acute psychiatric ward. Mental Health and Learning Disabilities Research and Practice 2010;7:93-102.
147. Rooney JM, Miles N, Barker T. Patients' views: peer support worker on inpatient wards. Ment Health Soc Incl 2016;20:160-6.
148. Moran GS, Kalha J, Mueller-Stierlin AS et al. Peer support for people with severe mental illness versus usual care in high-, middle- and low-income countries: study protocol for a pragmatic, multicentre, randomised controlled trial (UPSIDES-RCT). Trials 2020;21:371.
149. Lloyd-Evans B, Mayo-Wilson E, Harrison B et al. A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. BMC Psychiatry 2014;14:39.
150. Lyons N, Cooper C, Lloyd-Evans B. A systematic review and meta-analysis of group peer support interventions for people experiencing mental health conditions. BMC Psychiatry 2021;21:315.
151. Vandewalle J, Debyser B, Beeckman D et al. Peer

workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: a literature review. Int J Nurs Stud 2016;60:234-50.
152. National Survivor User Network. Peer support charter. London: National Survivor User Network, 2019. https://www.nsun.org.uk.
153. Gillard S. Peer support in mental health services: where is the research taking us, and do we want to go there? J Ment Health 2019;28:341-4.
154. Faulkner A. Peer support: working with the voluntary, community and social enterprise sector. London: National Survivor User Network, 2020. https://www.nsun.org.uk.
155. Stratford AC, Halpin M, Phillips K et al. The growth of peer support: an international charter. J Ment Health 2019;28:627-32.
156. Wusinich C, Lindy DC, Russell D et al. Experiences of Parachute NYC: an integration of open dialogue and intentional peer support. Community Ment Health J 2020;56:1033-43.
157. Venner F. Leeds Survivor Led Crisis Service – survivor-led philosophy in action. A Life in the Day 2009;13:28-31.
158. Bagley A. Leeds Survivor Led Crisis Service. https://www.lslcs.org.uk.
159. Faulkner A. Remote and online peer support: a resource for peer support groups and organisations. London: National Survivor User Network, 2020. https://www.nsun.org.uk.
160. Mishara BL, Daigle M, Bardon C et al. Comparison of the effects of telephone suicide prevention help by volunteers and professional paid staff: results from studies in the USA and Quebec, Canada. Suicide Life Threat Behav 2016; 46:577-87.
161. Sheridan Rains L, Johnson S, Barnett P et al. Early impacts of the COVID-19 pandemic on mental health care and on people with mental health conditions: framework synthesis of international experiences and responses. Soc Psychiatry Psychiatr Epidemiol 2021;56:13-24.
162. NHS England. NHS mental health crisis helplines receive three million calls. London: NHS England, 2021. https://www.england.nhs.uk.
163. Chakrabarti S. Usefulness of telepsychiatry: a critical evaluation of videoconferencing-based approaches. World J Psychiatry 2015;5:286-304.
164. Hubley S, Lynch SB, Schneck C et al. Review of key telepsychiatry outcomes. World J Psychiatry 2016;6:269-82.
165. Serhal E, Crawford A, Cheng J et al. Implementation and utilisation of telepsychiatry in Ontario: a population-based study. Can J Psychiatry 2017;62:716-25.
166. Salmoiraghi A, Hussain S. A systematic review of the use of telepsychiatry in acute settings. J Psychiatr Pract 2015;21:389-93.
167. Saurman E, Johnston J, Hindman J et al. A transferable telepsychiatry model for improving access to emergency mental health care. J Telemed Telecare 2014;20:391-9.
168. Saurman E, Kirby SE, Lyle D. No longer 'flying blind': how access has changed emergency mental health care in rural and remote emergency departments, a qualitative study. BMC Health Serv Res 2015;15:156.
169. Donley E, McClaren A, Jones R et al. Evaluation and implementation of a telepsychiatry trial in the emergency department of a metropolitan public hospital. J Technol Hum Serv 2017;35:292-313.
170. Hensel J, Graham R, Isaak C et al. A Novel emergency telepsychiatry program in a Canadian urban setting: identifying and addressing perceived barriers for successful implementation. Can J Psychiatry 2020;65:559-67.
171. Narasimhan M, Druss BG, Hockenberry JM et al. Impact of a telepsychiatry program at emergency departments statewide on the quality, utilization, and costs of mental health services. Psychiatr Serv 2015;66:1167-72.
172. Seidel RW, Kilgus MD. Agreement between telepsychiatry assessment and face-to-face assessment for Emergency Department psychiatry patients. J Telemed Telecare 2014;20:59-62.
173. Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. Gen Hosp Psychiatry 2007;29:199-206.
174. Melia R, Francis K, Hickey E et al. Mobile health technology interventions for suicide prevention: systematic review. JMIR Mhealth Uhealth 2020; 8:e12516.
175. Hensel JM, Bolton JM, Svenne DC et al. Innovation through virtualization: crisis mental health care during COVID-19. Can J Community Ment Health 2020;39:2.
176. Woolliscroft JO. Innovation in response to the COVID-19 pandemic crisis. Acad Med 2020; 95:1140-2.
177. San Juan NV, Shah P, Schlief M et al. Service user experiences and views regarding telemental health during the COVID-19 pandemic: a co-produced framework analysis. MedRxiv 2021; 21251978.
178. Torous J, Bucci S, Bell IH et al. The growing field of digital psychiatry: current evidence and the future of apps, social media, chatbots, and virtual reality. World Psychiatry 2021;20:318-35.
179. Shore JH, Schneck CD, Mishkind MC. Telepsychiatry and the coronavirus disease 2019 pandemic – current and future outcomes of the rapid virtualization of psychiatric care. JAMA Psychiatry 2020;77:1211-2.
180. Unützer J, Kimmel RJ, Snowden M. Psychiatry in the age of COVID-19. World Psychiatry 2020;19:130-1.
181. Evans-Lacko S, Aguilar-Gaxiola S, Al-Hamzawi A et al. Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: results from the WHO World Mental Health (WMH) surveys. Psychol Med 2018;48:1560-71.
182. Drew N, Funk M, Tang S et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. Lancet 2011;378:1664-75.
183. Clement S, Schauman O, Graham T et al. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med 2015;45:11-27.
184. Nadkarni A, Hanlon C, Bhatia U et al. The management of adult psychiatric emergencies in low-income and middle-income countries: a systematic review. Lancet Psychiatry 2015;2:540-7.
185. Gureje O, Nortje G, Makanjuola V. The role of global traditional and complementary systems of medicine in the treatment of mental health disorders. Lancet Psychiatry 2015;2:168-77.
186. Smartt C, Prince M, Frissa S et al. Homelessness and severe mental illness in low-and middle-income countries: scoping review. BJPsych Open 2019;5:e57.
187. Minas H, Diatri H. Pasung: physical restraint and confinement of the mentally ill in the community. Int J Ment Health Sys 2008;2:1-5.
188. Kohrt BA, Blasingame E, Compton MT et al. Adapting the crisis intervention team (CIT) model of police-mental health collaboration in a low-income, post-conflict country: curriculum development in Liberia, West Africa. Am J Public Health 2015;105:e73-80.
189. Asher L, Fekadu A, Teferra S et al. "I cry every day and night, I have my son tied in chains": physical restraint of people with schizophrenia in community settings in Ethiopia. Glob Health 2017;13:1-14.
190. Tanaka C, Tuliao MTR, Tanaka E et al. A qualitative study on the stigma experienced by people with mental health problems and epilepsy in the Philippines. BMC Psychiatry 2018;18:325.
191. World Health Organization. Mental health crisis services: promoting person-centred and rights-based approaches. Geneva: World Health Organization, 2021.
192. World Health Organization. Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) for mental, neurological and substance use disorders in non-specialized health settings, version 2.0. Geneva: World Health Organization, 2019.
193. Keynejad R, Spagnolo J, Thornicroft G. WHO mental health gap action programme (mhGAP) intervention guide: updated systematic review on evidence and impact. Evid Based Ment Health 2021;24:124-30.
194. Odenwald M, Lingenfelder B, Peschel W et al. A pilot study on community-based outpatient treatment for patients with chronic psychotic disorders in Somalia: change in symptoms, functioning and co-morbid khat use. Int J Ment Health Systems 2012;6:8.
195. Nelson D, Walcott G, Walters C et al. Community engagement mental health model for home treatment of psychosis in Jamaica. Psychiatr Serv 2020;71:522-4.
196. Bertolote J, Fleischmann A, De Leo D et al. Repetition of suicide attempts: data from five culturally different low-and middle-income country emergency care settings participating in the WHO SUPRE-MISS study. Crisis 2010;31:194-201.
197. Amadéo S, Rereao M, Malogne A et al. Testing brief intervention and phone contact among subjects with suicidal behavior: a randomized controlled trial in French Polynesia in the frames of the World Health Organization/Suicide Trends in At-Risk Territories study. Ment Illn 2015;7:5818.
198. Wang L, Norman I, Xiao T et al. Psychological first aid training: a scoping review of its application, outcomes and implementation. Int J Environ Res Public Health 2021;18:4594.
199. Kola L, Kohrt BA, Hanlon C et al. COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health. Lancet Psychiatry 2021;8:535-50.
200. Kohrt BA, Schafer A, Willhoite A et al. Ensuring Quality in Psychological Support (WHO EQUIP): developing a competent global workforce. World Psychiatry 2020;19:115-6.
201. Puschner B, Repper J, Mahlke C et al. Using peer support in developing empowering mental health services (UPSIDES): background, rationale and methodology. Ann Glob Health 2019;85:53.

202. Ryan GK, Kamuhiirwa M, Mugisha J et al. Peer support for frequent users of inpatient mental health care in Uganda: protocol of a quasi-experimental study. BMC Psychiatry 2019;19:374.
203. Ryan GK, Semrau M, Nkurunungi E et al. Service user involvement in global mental health: what have we learned from recent research in low and middle-income countries? Curr Opin Psychiatry 2019;32:355-60.
204. Pathare S, Kapoor A. Implementation update on Mental Healthcare Act, 2017. In: Duffy R, Brendan K (eds). India's Mental Healthcare Act, 2017. Singapore: Springer, 2020:251-65.
205. Groot B, Vink M, Schout G et al. Pathways for improvement of care in psychiatric crisis: a plea for the co-creation with service users and ethics of care. Arch Psychol 2019;3.

DOI:10.1002/wps.20962