Title Page

A realist evidence synthesis to explain how, for whom and in what circumstances, different community mental health crisis services work.

Short Title: MH-CREST (Mental Health-Crisis Realist Evidence SynThesis)

Dr Nicola Clibbens, School of Healthcare, University of Leeds & Sheffield Health and Social Care NHS Foundation Trust, Leeds and Sheffield, UK.

(Corresponding author contact details: Department of Nursing and Midwifery, Northumbria University & Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, Newcastle-upon-Tyne, UK. Nicola.clibbens@northumbria.ac.uk , 07799333972,).

Professor John Baker, School of Healthcare, University of Leeds & Leeds and York Partnership NHS Foundation Trust, Leeds, UK.

Professor Andrew Booth, , University of Sheffield, Sheffield, UK.

Dr Kathryn Berzins, School of Healthcare, University of Leeds, Leeds, UK.

Mr Michael Ashman, Independent Consultant & School of Healthcare, University of Leeds, Leeds, UK.

Dr Leila Sharda, School of Healthcare, University of Leeds, Leeds, UK.

Dr Jill Thompson, Health Sciences School, University of Sheffield, Sheffield, UK.

Dr Sarah Kendal, School of Healthcare, University of Leeds, Leeds, UK.

Professor Scott Weich, School of Health and Related Research, University of Sheffield & Sheffield Health and Social Care NHS Foundation Trust, Sheffield, UK.

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Authors' competing interests

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Abstract

Background

Mental health crises cause significant disruption to individuals and families and can be life threatening. The number of community crisis services operating in an interagency landscape complicate access to help. It is unclear which underpinning mechanisms of crisis care work, for whom and in which circumstances.

Aim

To identify mechanisms to explain how, for whom and in what circumstances adult community crisis services work.

Objectives

To develop, test and synthesise programme theory via: (1) Stakeholder expertise, current evidence; (2) A Context, Intervention, Mechanisms, Outcome framework; (3) Consultation with experts; (4) Development of pen portraits; (5) Synthesis and refinement of programme theories, including mid-range theory; (6) Identification and dissemination of mechanisms needed to trigger desired context-specific crisis outcomes.

Design

This study is a realist evidence synthesis, comprising (i) identification of initial programme theories; (ii) prioritisation, testing and refinement of programme theory; (iii) focused realist reviews of prioritised initial programme theories; (iv) synthesis to mid-range theory.

Main outcome

To explain context, mechanisms, and outcomes in adult community mental health crisis care.

Data Sources

Data were sourced via academic and grey literature searches; Expert Stakeholder Group consultations and n = 20 individual realist interviews with experts.

Review Methods

A realist evidence synthesis with primary data was conducted to test and refine three initial programme theories: (1) urgent and accessible crisis care; (2) compassionate leadership; (3) interagency working.

Results

Community crisis services operate best within an interagency system. This requires compassionate leadership and shared values that enable staff to be supported, retain their compassion and in turn facilitate compassionate interventions for people in crisis. The complex interface between agencies is best managed through greater clarity at the boundaries of services making referral and transition seamless and timely. This would facilitate ease of access and guaranteed responses that are trusted by the communities they serve.

Strengths and limitations

Strengths include the identification of mechanisms for effective interagency community crisis care and meaningful stakeholder consultation that grounded the theories in real-life experience. Limitations include the evidence being heavily weighted towards England and the review scope excluding full analysis of ethnic and cultural diversity.

Conclusions

Multiple interpretations of crises and diverse population needs present challenges for improving the complex pathways to help in a crisis. Interagency working requires clear policy guidance with local commissioning.. Seamless transitions between services generate trust through guaranteed responses and ease of navigation. This is best achieved where there is interagency affiliation that supports co-production. Compassionate leaders engender staff trust and outcomes for people in crisis improve when staff are supported to retain their compassion.

Future Work

Further work might explore interagency models of crisis delivery particularly rural communities. A focus on evaluating outcomes across agencies with a focus on individual recovery outcomes rather than limiting the focus to service effectiveness. The implementation and effect of mental health triage could be explored further, including via

telehealth. Barriers to access for marginalised populations warrant a specific focus in future research.

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Glossary and List of Abbreviations

Glossary

Approved Mental Health Professional (AMHP)	UK Qualified mental health professionals approved to carry out certain duties under the Mental Health Act. They are responsible for coordinating assessment and admission to hospital in the case that an individual is to be detained under the Mental Health Act.
Crisis resolution team (CRT) / Crisis resolution home treatment (CRHT)	UK National Health Service providing interventions to people seeking urgent support for a mental health problem. Sometimes also referred to as CRHT crisis resolution and home treatment.
JCP	Joint Crisis Plan
Mental Health Act 1983, amended 2007	UK law applying in England and Wales, designed to give health professionals conditional powers to detain, assess and treat people with mental disorders, in the interests of their health or the safety of the public. The Mental Health Act 1983 was amended in 2007.
Mid-range theory	A level of theory that bridges overarching theory and empirical findings.
Programme theory	Explains components and mechanisms of an intervention or programme; programme theory is often used in evaluation studies. Clarifies rationale and assumptions underpinning the programme.
Section 136 (s136) (emergency police power of detention)	UK Police power to remove someone from a public place and take them to a place of safety, if they believe that the individual has a mental illness and requires immediate ‘care or control’

Abbreviations

A&E	Accident and Emergency department (also known as Emergency Medicine department)

AMHP	Approved Mental Health Professional (category of mental health professional)
AMHP	Association of Mental Health Providers (cited paper in this report)
NHS	UK National Health Service
GP	General Practitioner
CRT	NHS Crisis Resolution Team
CRHT	Crisis Resolution and Home Treatment
MHA 1983	Mental Health Act in the UK, amended 2007
S.136	Section 136 of the 1983 Mental Health Act
SPA	Single Point of Access (one-stop-shop for services)

Plain English Summary

The issue

A mental health crisis can be traumatic for individuals and families. There are a lot of different agencies delivering crisis care. This can make getting the right help from services difficult, confusing, and slow. It is not clear which services work best or who they work best for.

What we did

This research explored community mental health crisis services for adults. We focused on what is working, who it is working for, and in what situations. Service users, carers, mental health professionals and service managers formed an 'Expert Stakeholder Group' to guide the project by helping the researchers make sense of what we learned. We gathered information from research reports, other documents, and interviews with experts (service users, carers, professionals, managers). We focused on three questions:

1. How can services make sure that people in crisis can get the right help, quickly?
2. What makes crisis care compassionate?
3. Does it help if different crisis services to work together?

What we learned

Community crisis services are most compassionate and effective when staff from different organisations share information. When leaders of crisis care help staff to work together across services, they find better ways to help people. Close working across teams gives professionals a better understanding of what other services do and makes it easier for them to give people the right help at the right time. When leaders are kind and supportive to staff, they feel better at work and provide better crisis care.

What future work can be done

It would be useful to explore if the most effective crisis services are the same ones that service users like best. We need to know more about mental health triage, interagency working, and telehealth. Our project did not explore diversity, but this is an important topic to investigate.

Plain English Summary Word Count: 300

Scientific Summary

Background

Mental health crises cause significant disruption to the lives of individuals and families and can be life threatening. The drive for community care alongside large reductions in hospital beds has led to a proliferation of community crisis services delivered by a diverse range of provider agencies contributing to difficulties for people in navigating to timely crisis support. There is no single definition of a mental health crisis, people have diverse needs resulting in a large variation in routes into and through mental health crisis care. Service users report unmet need. Services have, and continue to, diversify quickly in response to reported gaps and delayed responses. Diversification has led to geographic differences in available crisis care and created a complex web of agencies with different values, referral processes, interventions, and access thresholds. It is unclear in this complex system which underpinning mechanisms of crisis care are most effective, for whom and in which circumstances.

Aim

To identify mechanisms to explain how, for whom and in what circumstances mental health community crisis services for adults work to resolve crises with a view to informing current and future intervention design and development.

Objectives

1. **Use stakeholder expertise, current practice, and research evidence to develop programme theories to explain how different crisis services work to produce the outcome of resolution of mental health crises.**
2. **Using a Context, Intervention, Mechanisms, Outcome framework (CIMO), to construct a sampling frame to identify subsets of literature within which to test programme theories.**
3. **Iteratively consult via Expert Stakeholder Group and individual interviews with diverse stakeholders to test and refine programme theories.**
4. **Identify and describe pen portraits of UK crisis services that provide exemplars of the programme theories to explain how mental health crisis interventions work in order to explore and explain contextual variation.**
5. **Synthesise, test, and refine the programme theories, and where possible identify mid-range theory, to explain how crisis services work to produce the outcome of resolution of the crisis. Provide a framework for future empirical testing of theories in and for further intervention design and development.**
6. **Produce dissemination materials that communicate the most important mechanisms needed to trigger desired context-specific crisis care outcomes, in order to inform current and future crisis care interventions and service designs.**

Design

A four-phase realist evidence synthesis, reported according to RAMESES reporting guidelines and comprising (i) identification of candidate programme theories from academic and grey literature; (ii) iterative consultation with an Expert Stakeholder Group and individual

interviews to prioritise, test and refine programme theory; (iii) focused realist reviews of prioritised theory components; (iii) synthesis to mid-range theory.

Main Outcome Measures

The principal aim of the review was to generate and test programme theories, and then synthesise these with mid-range theory, to explain what works, for whom, and in what circumstances, in adult mental health community crisis care.

Data Sources

Google scholar searches to identify initial programme theories and logic models; focused searches of academic database searches with backward citation searching; grey literature searches, hand searches via the research team and expert stakeholders to test and refine three theory components. An Expert Stakeholder Group with membership from lived experience, health professional, social care, policy expertise, health management and commissioning were consulted on four occasions across the life of the research to test, refine and connect theories with real world experience. Twenty individual realist interviews with n= 19 participants including service users; health, social care, ambulance, and police professionals; and research and policy experts to further test, refine and sense check theory components where there were gaps in topic expertise or theory.

Analysis

A realist evidence synthesis with stakeholder primary data was used to test and refine three initial programme theories in in adult mental health community crisis care: (1) urgent and accessible crisis care (2); compassionate and therapeutic crisis care; (3) interagency working.

Data analysis involved using realist logic to identify initial programme theories (Objectives 1-3); test and refine the programme theories through focused review of the literature, to extract and configure explanatory causal relationships between context, intervention, mechanism, and outcome (CIMO) (Obj. 3-5). Expert stakeholder consultations supported analysis through linking theories to real world experience enabling exploration and explanation of contextual variation as it related to putative mechanisms (Obj. 3-5). Individual interviews with experts who were purposively selected for their topic expertise related to the programme theory components, were deductively analysed according to the CIMOs. An

inductive process identified any new mechanisms not identified from other data sources (Obj. 3). Pen portraits were developed as illustrative exemplars of the link between context, intervention, mechanism, and outcome and were refined in collaboration with expert stakeholders (Obj. 4). Findings from the focused review of the three theory components were synthesised with mid-range theories to produce a framework for future empirical testing developed (Obj. 5).

Results

The scope of the realist review was refined through an initial consultation and discussion between the Expert Stakeholder Group (ESG) and research team. A Diamond-9 prioritisation process was used to facilitated discussion between ESG members and with the research team and refined the scope of the review. This process resulted in three initial programme theories for testing focused on: (1) urgent and accessible crisis care and (2) compassionate and therapeutic crisis care and (3) interagency working.

The findings from the three focused reviews were synthesised with mid-range theory. Mental health crisis care is provided by a complex array of agencies, each with different definitions of crises, different values about the nature of interventions and different approaches to prioritisation. This is further complicated by multiple overlapping service boundaries. What is apparent is that these differences can only be accommodated within an interagency system where information and decisions are shared from commissioning through to frontline delivery.

Interagency working provides mechanisms that trigger seamless service delivery through improved communication and collaboration. For this system to work, representation from all agencies and stakeholders is needed. National co-ordination at policy level ensures investment is appropriately targeted and that important strategic aspirations are met. National co-ordination should steer, but not dictate, local configurations of the agencies needed. Local crisis services should be configured to meet the crisis care needs of local populations within their geography, taking account of any marginalised individuals or communities they serve.

Commissioning for interagency working needs a focus on managing complex boundaries and transitions across agencies to avoid gaps and disputes. Attention is also needed to how the

interagency crisis system engages with wider systems important to resolution of crises including for example housing, police, local authority, safeguarding and the justice system. Ultimately, the interagency system needs to aim for there being no wrong door for accessing mental health crisis care and once in a service navigation should be facilitated via a single trusted point of liaison. Evaluation is not restricted by organisational boundaries and aims to provide data that takes account of how the whole interagency system is operating. Conceptualisations of crises as single events or as the sole responsibility of statutory secondary mental health systems are unhelpful and generate fragmentation leading to gaps and delays for those seeking crisis care and frustration for leaders and frontline staff.

The *perception* of whether a service and service providers are accessible carry more of an inhibitive effect than *the way that the service is actually organised.* People experiencing a crisis choose to access services they perceive as providing a guaranteed response, that are easy to navigate to, and fit with their definition of the crisis. Whilst the timing of responses remains unclear in relation to outcomes, what is clear is that people feel safer and have a reduced sense of urgency when they trust services. Trust is established through compassionate interactions and proactive management of transitions and waiting. Involvement of the person and their family, or support network in decisions supports a sense of trust and relational safety which may help meet a need for continuity for some.

To sustain compassion, frontline staff need access to support for themselves as well as resources to deliver crisis care that meets their personal and professional ideals. Training in the knowledge, skills and values required for compassion can build confidence in frontline staff in all agencies. System leaders must provide resources and communicate an expectation for compassionate engagement so that it becomes the norm for staff to seek support.

This is achieved in an interagency context where there is interpersonal contact between all levels of worker from commissioning through to frontline delivery that facilitates learning, communication, and appreciation of different roles. Furthermore, co-production of crisis care can be facilitated within the interagency system enabling crisis care to be recognised and valued by the community it serves. Service users perceive a crisis when they feel overwhelmed and anxious and when they perceive that they lack a sense of control. Familiar contacts and a safe environment, coupled with reassurance, can help to shape their perception of the service but, more importantly, can help to reduce distress thereby

mitigating risk and making it more likely that a service user is able to respond to suggested strategies. With an emphasis on rapport and compassion, professionals are encouraged to exhibit positive behaviours that mitigate against the dehumanising and stigma that service users may perceive when they encounter a service and that may precipitate or exacerbate a crisis.

Compassion shown to frontline staff by leaders leads to compassionate care. A tension between exerting control and providing support was evident at all levels. As integrated care systems are introduced, there is an aspiration that strategic partnerships will reduce competing priorities, which appear debilitating to organisations. Alongside these strategic partnerships, there is a need for coherent local strategies for compassionate and psychologically safe crisis care cognisant of the fact that high quality care can coexist alongside the worst examples of care in the same organisation. Strategies should include how compassionate and psychologically safe crisis care is provided. Different values and definitions of crisis are accommodated allowing challenge and debate to become accepted as an opportunity to drive quality improvement.

Strengths and Limitations

Much of the literature was descriptive, and therefore the evidence base was limited. The programme theories identified outline the mechanisms needed to facilitate the best interagency community crisis care. Meaningful consultation with expert stakeholders grounded the theories in the reality of community crisis care, though UK evidence is heavily weighted towards England. Project delivery was impacted by Covid 19 reducing the number of individual interviews and delaying stakeholder consultations. Stakeholder consultation did not reach as wide a group as originally intended.

Conclusion

Community crisis care is likely to continue to be delivered by a complex array of agencies responding to a heterogeneous population that presents with different mental health concerns and perceptions of crisis. Interagency working provides a platform for seamless transitions between services and timely responses. To deliver desired outcomes, interagency working requires continual systems of engagement locally and nationally involving all providers of crisis care through compassionate leadership, sharing of values and shared

understanding of systems. Compassion is central and begins with leaders who can influence the culture of crisis organisations. Compassionate leadership is focused on people over systems enabling frontline staff to retain their compassion and hope, work collaboratively across agencies and provides a platform for shared decision making and co-production. All of this helps people in crisis to recognise the service as designed for them and to have trust in community crisis services.

The study achieved its objectives despite unexpected difficulties resulting from the effects of the Covid19 pandemic, due to an agile and committed research team, flexible and accommodating stakeholders, and support from the funders. Project milestones were adjusted to accommodate the changing context of the study.

Future Work

A framework of programme theories synthesised with mid-range theory developed from this study can inform future research seeking to develop better mental health crisis care systems. Further work might explore how interagency service configurations work, including telehealth are perceived by service users and produce optimal outcomes. Evaluation of crisis care for marginalised groups is needed. The implementation and effect of mental health triage could be explored further. Meaningful engagement with expert stakeholders could be incorporated routinely into research design and delivery.

Mental health triage appears to be a promising approach but has a limited evidence base. Future research could explore and test the implementation and effect of mental health triage systems. This work could focus on different values about prioritisation and how these can be accommodated within an interagency system. A focused realist evaluation is needed to explore in more depth the factors influencing access to and transition through crisis care for these populations. Further exploration of models of crisis care to mitigate barriers to access for those with substance use or alcohol use problems, personality disorders, physical health conditions and autistic spectrum disorders is needed. Interagency models of crisis care are causally linked to optimal crisis outcomes. These outcomes are at times theoretical and have been subjected to limited testing in primary research. UK interagency crisis service models provide an opportunity for mixed method case study approaches to evaluation. A neglected area of focus for this research is the efficacy of models for rural populations. Crisis

interventions involving police and mental health services have a growing body of evidence, there is however a lack of evidence for co-response models involving ambulance paramedic staff or emergency control rooms.

There is a lack of focus on individual recovery outcomes. This review highlights the importance of mechanisms such as psychological and relational safety, compassion and trust in producing optimal crisis outcomes. Research is needed to develop evaluation approaches to measure the presence and impact of these mechanisms in crisis care.

Data from the literature and from engagement with stakeholders (via ESG and individual interviews) combined to refine the realist programme theory/ies to identify mechanisms that might operate across multiple interventions in order to 'trigger' an appropriate treatment response; and contexts related to these key mechanisms that might enhance or detract from intervention success. Meaningful co-production with service users and other expert stakeholders enhances the relevance of research and of should be incorporated routinely into research design and delivery.

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Study Funding

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Study Registration

This study is registered with Prospero reference number CRD42019141680

1 Introduction to the study

1.1 Background and Rationale

Mental health crises cause significant disruption to the lives of individuals and their families and can be life threatening[1, 2]. The need for community crisis care is driven by international de-institutionalisation of mental health care[3] where hospitalisation is a last resort and community services are available to respond to mental health need, including in times of crisis[4]. Crisis resolution services originated in the USA[5, 6] and Australia[7] and were later implemented in the UK[4] and Europe[8, 9].

Since implementation of statutory crisis services from 2000[4], UK crisis services have seen the development of a proliferation of community-based services for people experiencing acute crises embodied in a complex range of service providers, service designs, referral routes and interventions. The voluntary sector has grown significantly in response to gaps in statutory crisis services[10] but this growth has contributed to the confusing array of care pathways, which can be difficult to access and navigate[11, 12]. Evaluation study data suggests that too many people are unable to access timely crisis support and are dissatisfied with the help they receive[12-14] .

Previous research in this field has for the most part focused on: evaluating and developing the fidelity of NHS Crisis Resolution Teams (CRTs)[15-17], scoping the range of crisis services available nationally (including alternatives to hospital admission)[18, 19] and understanding the role of the voluntary sector in crisis care [10, 20]. This collage of evidence leaves substantial gaps in our understanding about how or why these different crisis services work for people in different circumstances.

Mental health crises can be defined in different ways[10] including as a relapse in a psychiatric condition, characterised by increased symptom severity (such as voice hearing, suicidal thoughts, and risky behaviours) and decreases in social functioning (including reduced self-care)[21, 22]. Irrespective of psychiatric diagnoses, crises can also be defined as a reaction to adverse life events, leading to increasing disruption for the person and their family where their usual coping strategies have failed[23]. Being in a state of crisis can also be conceived as an opportunity for change and may enable people to develop new ways of coping[24].

Mental health crises are serious, sometimes life threatening and are often associated with increased risks to the safety and wellbeing of the person or others[11, 25]. The nature of crisis varies between individuals and has a complex aetiology linked to factors including general health, life stresses, treatment adherence, coping skills, and social situation including family, work, income, social support and housing[9, 22]. This can result in a complex array of health problems related to mental, physical and social wellbeing that can, if people are unsupported, lead to catastrophic outcomes, such as suicide[25]. Social stigma and a lack of public awareness about mental health contribute to delays in contacting services due to fear of being coerced into treatment or negatively labelled[26] and may influence how and from whom people seek help in a crisis. The complexity of service structures and referral routes may also present a barrier, resulting in people failing to access the most appropriate or timely crisis care for their needs[12].

The Crisis Care Concordat[27] was a national response in England to urgent improvement in mental health crisis care. A key part of this strategy has been the development of local plans that bring together multiple agencies through local implementation that is coordinated nationally. The Crisis Care Concordat has influenced improvement in crisis services including more people being seen quickly, reporting being taken seriously, and fewer people describing their care as poor or having their first contact with the police[28]. Our review of the crisis care concordat webpages[27] identified that the information sharing component had not been active since 2016 and that much of the data contained there was of poor quality or incomplete. The Five Year Forward View for Mental Health, which followed the Crisis Care Concordat,[11] sets out the broad mental health policy direction and highlights the importance of effective crisis services.

Crisis services across health, social care, local government and the voluntary sector are shaped by health priorities including increasing community based care that is close to home, available urgently across 24/7 [11, 29] and situated in an appropriate safe place[30]. Important too is the involvement of people and their family members in decisions about crisis care[2] and improved access for marginalised communities[11, 29]. Associated policy priorities are to reduce the rate of suicide by 10% by 2020/21[11] and reduce pressure in both hospital bed use and accident and emergency attendances[31].

Mental Health crisis care is delivered through two main commissioned care pathways: the acute mental health care pathway[32] and the urgent care pathway[33]. In theory, Crisis Resolution Teams (CRTs) play a central role in coordinating crisis care, often through a single point of access service[34]. The function of CRTs has been summarised as:

> *1. Assessment of all patients being considered for acute psychiatric hospital admission and act as gatekeeper,*
>
> *2. To initiate home treatment as an alternative to hospital admission until the crisis has been resolved,*
>
> *3. To refer to other services for ongoing support,*
>
> *4. To facilitate and early discharge for those requiring a hospital admission*[9], (p.339).

In practice, implementation of CRTs appears to be highly variable. According to reports published between 2015 and 2018, less than one-half of CRTs in England provide 24/7 services[12], referrals vary between 42 and 430 referrals per 100,000 of the population across England[35] and some core CRT functions are inconsistently implemented[11, 36]. CRTs have however been shown to reduce the cost of crisis care, although estimates vary between 17-30% [37, 38], and they work well for many people[13, 16]. Despite this, areas where CRTs fall short of expectations include the lack of a consistent care worker; the timing, length, and frequency of visits; and the tendency for interventions to focus excessively on risks and medicines management[39, 40]. A fundamental reason for this variability appears to be the lack of evidence for each of the specific interventions delivered by CRTs or indeed consensus about what these, or any other crisis intervention, ought to comprise.

The voluntary sector has a long history of delivering crisis care services alongside statutory care and has gained recognition over the past decade as providing an alternative or an adjunct service as well as occupying the gaps left by statutory services[10]. Voluntary sector crisis care was, initially, largely focused on providing alternatives to acute inpatient care[41] and has increasingly focused on community interventions such as crisis cafes, night-time drop-in services and services to improve access for marginalised communities[42]. Increasingly, community crisis care is jointly funded between local government, NHS and voluntary sector

organisations, as evidenced in the range of investment in crisis care via NHS non-recurrent funding[43].

Currently in England, services for people experiencing a mental health crisis are very diverse, postcode dependent and use an array of different crisis services including:

1. Accident and emergency departments
2. **Ambulance and paramedic services**
3. **Crisis cafes**
4. **Crisis drop-in services**
5. **Crisis houses**
6. **CRTS**
7. **Day treatment services**
8. **Mental health liaison teams**
9. **NHS 111**
10. **NHS 999**
11. **Out of hours teams**
12. **Place of safety suites**
13. **Police**
14. **Specialist home treatment teams**
15. **Street triage teams**
16. **Telehealth.**
17. **GP**

It is unclear what each of these services offer (and how provision may vary in different contexts), or which mechanisms (such as, safety, trust, community involvement) is most effective for whom and in which circumstances.

1.2 Study Justification

1.2.1 Identified Need

There is a drive in the UK to improve experiences of crisis care and to design services and interventions that are effective, timely, and accessible to all those in need[29] as well as addressing the need for parity with physical health[44]. It is therefore vital to develop complex interventions from a theoretical understanding of the mechanisms that produce the desired outcomes and in which contexts these work best. The Crisis Care Concordat[27] identified a need for crisis care to be developed across multiple agencies including statutory and voluntary sectors; to be largely community-based and to improve implementation across the UK to avoid crisis care being postcode-dependent. Attention has been focused on service providers and settings, but there is currently a lack of evidence about the mechanisms that underpin effective mental health crisis care and how these are activated to resolve crises across a range of contexts. A focus on underpinning theoretical development would enable

commissioners to invest in a range of services designed to include the mechanisms that produce the best outcomes across service designs and providers.

Health services are under ongoing financial pressures, and inpatient care is undesirable to many people, expensive[35] and scarce[31]. Community-based crisis care presents an opportunity for cost effectiveness, provided that interventions can successfully be developed, tested and implemented to enable improved prediction of outcomes[45]. The development of effective community crisis care may also help to alleviate pressure in the urgent care pathway, particularly in accident and emergency departments.

1.2.2 Previous Work

Prior to the commencement of the current study, the review group's consultations with people who have accessed community crisis care (PPI) showed that these services resemble a tangled web of overlapping services with complex referral routes and blurred functions. PPI participants endorsed a focus on community crisis services on the grounds that they are generally preferred, they provide the respite, information and support that people ask for, and they avoid the need to be away from home and family. These experiences echoed the published evidence in respect of mixed experiences of CRTs, and lent weight to the need to improve understanding of how services work to resolve crises. This could improve people's ability to access the right care at the right time[12].

1.3 Aim

The aim of this study was to identify mechanisms to explain how, for whom and in what circumstances community crisis services for adults work to resolve crises, with a view to informing current and future intervention design and development.

1.4 Objectives

1. **Use stakeholder expertise, current practice, and research evidence to develop programme theories to explain how different crisis services work to produce the outcome of resolution of mental health crises.**
2. **Use a Context, Intervention, Mechanisms, Outcome framework (CIMO), to construct a sampling frame to identify subsets of literature within which to test programme theories.**
3. **Iteratively consult with stakeholders via a series of Expert Stakeholder Groups and individual interviews with diverse stakeholders to test and refine programme theories.**
4. **Identify and create pen portraits of UK crisis services that provide exemplars of the programme theories to explain how mental health crisis interventions work in order to explore and explain contextual variation.**
5. **Synthesise, test and refine the programme theories, and where possible identify mid-range theory, to explain how crisis services work to produce the outcome of resolution of the crisis; and hence to provide a framework for future empirical testing of theories in the pen portraits and for further intervention design and development.**

6. **Produce dissemination materials that communicate the most important mechanisms needed to trigger desired context-specific crisis care outcomes in order to inform current and future crisis care interventions and service designs.**

2 Review Methodology and methods

2.1 Introduction to methodology and methods

This chapter outlines how the research team used stakeholder expertise, research evidence, and current practice to develop programme theory to explain how, for whom, and in what circumstances different community mental health crisis services for adults work to resolve crises. The chapter was developed as per the publication standards for Realist and Meta-narrative Evidence Syntheses: Evolving standards (RAMESES)[46]. The PRISMA guideline[47] for reporting systematic reviews has been used to structure flowcharts representing the process of identification and selection of included records.

2.1.1 Patient and public involvement and engagement (PPI/E)

Prior to commencement of the study, members of the public, people with lived experience of crisis care, their carers, and other stakeholders in statutory and voluntary sector services were consulted to help formulate the general aims and direction of the research. This was achieved through telephone consultations with key voluntary sector service managers, attendance at team meetings in CRT, and a focus group with people who has recently accessed crisis services for themselves or a family member. Visitors from two voluntary sector services involved in pre-protocol PPI consultation continued their involved through membership of the Expert Stakeholder Group (ESG).

2.1.2 Ethical approval

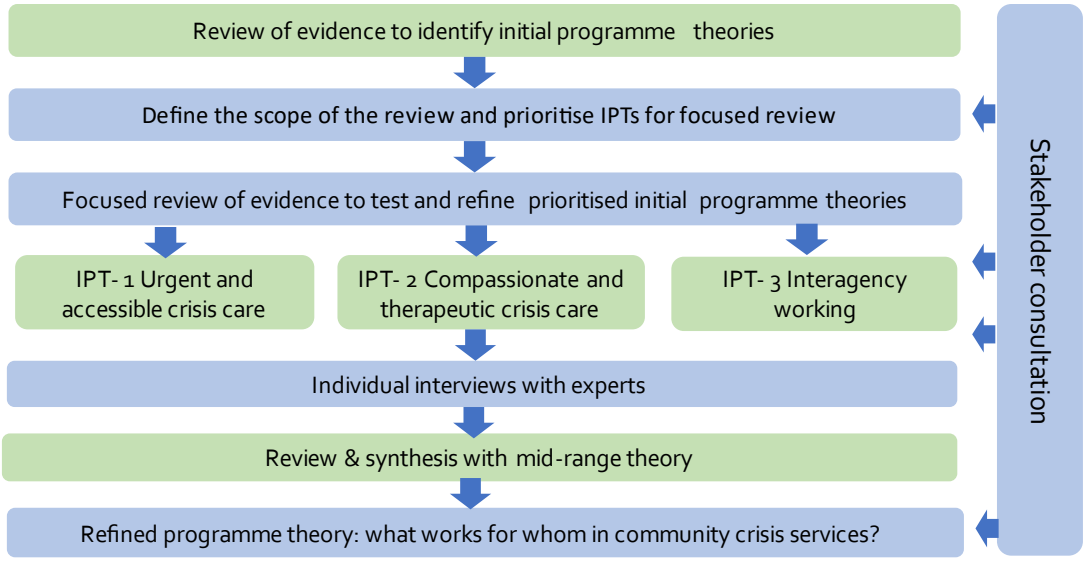
Following favourable review by an NHS Local Ethics Committee, approval was granted on 8th January 2020 (IRAS Reference number: 261486; REC reference: 19/YH/0347). Approvals were obtained for recruitment and consent of members to the expert stakeholder group (ESG) and individual interviews, (See project documentation 1-4).

2.1.3 Study design and rationale

A four-phase realist evidence synthesis design was developed, comprising: (i) identification of initial programme theories; (ii) iterative group and individual interviews to prioritise, test and refine programme theory; (iii) focused reviews of prioritised initial programme theory; (iii) synthesis to mid-range theory. The focus of the realist synthesis was to develop programme theories to explain how different elements of crisis mental health care work to provide

appropriate and effective responses to mental health crises. Figure 1 summarises the study design.

Figure 1: Summary of study design



2.2 Realist synthesis

The synthesis design drew upon realist expertise within the research team. Realist synthesis is a theory-driven approach for understanding existing diverse multiple sources of evidence relating to complex interventions[46, 48]. A realist approach aims to understand the interaction between an intervention and its context, mechanisms, and outcomes[46]. It draws on realist philosophical ideas to answer a generative causal question which, rather than asking *'Does 'A' lead to 'B'?'*, instead asked *'What is it about 'A' that results in 'B' happening, for whom and in what circumstances?'*[49]; in other words, how the context (the situation around a person) affects any mechanism (the resources and human responses), to generate an outcome (intended or not)[46, 50].

How people respond to the resources offered by an intervention is conceptualised in realist syntheses as a 'mechanism'. Realist programme theories are theories about what an intervention is expected to do and how it is expected to work. Realist synthesis uses both iterative and purposive sampling from a wide range of evidence to develop, refine, and test theories about how an intervention works, for whom, and in what circumstances[51].

2.2.1 Application of realist methods to explore complex interventions

The current study conceptualised crisis resolution services as heterogeneous, complex interventions, as defined by the Medical Research Council[45]. Complex interventions activate multiple human responses that interact in non-linear ways to produce highly context dependent outcomes[46]. Realist review offers an optimal approach for exploring how and why complex programmes involving human actions and decisions, such as crisis mental health services, may or may not work, and to inform the theoretical development of intervention(s)[45, 46].

2.2.2 Theory Testing

Outcomes of interventions are causally activated by multiple context-sensitive mechanisms. They happen, not only because of what is done in an intervention, but also because of how people respond[46, 50, 52]. The realist approach offers a participative method of synthesis that allows for, and indeed capitalises on, continual testing and refinement of emergent programme theories against empirical evidence, data from policy documents, as well as primary data e.g. from engagement with stakeholders[48]. The involvement of consumers of healthcare is central to this type of research[53, 54].

A theory-driven approach strengthens the potential to inform commissioning, service design, and delivery that is sensitive to context across diverse service designs and providers[55]. From the perspective of patients and the public, the theory testing provides a platform for future empirical testing of service designs thereby improving access and experience of crisis care. This research aims to inform the ongoing development and evaluation of existing mental health community crisis services and interventions.

2.2.3 Programme and mid-range theory

Realist synthesis offers a lens through which a research team can make sense of what is occurring within a complex intervention, particularly in understanding the circumstances in which it is more or less likely to be effective through the identification and testing of programme theories[46, 48, 56].

'Programme theory' is conceived as a fairly concrete set of ideas and observations that explain how different elements of a specific intervention (or programme) interact to produce the intervention outcomes. In contrast, middle range theories represent intermediaries between

programme theories and 'all-inclusive speculations comprising a master conceptual scheme'[55, 57]. Middle-range theory considers the theoretical and practical issues simultaneously, thus applying theory to practice. Middle-range theories are therefore useful frameworks to guide development of interventions and make generalisations about their application.

In the context of realist synthesis these 'minor working hypotheses' are labelled 'programme theories' or explanations for how the programme or intervention works. Mid-range theories are often useful "*as frameworks for understanding a problem or as guides to develop specific interventions*"[55] (p.229). According to Pawson[48], mid-range theories can be a product of the realist synthesis process. However, the world of health, social and behavioural research is so densely populated with mid-range theories that it is common to find confirmation of programme theory findings in existing mid-range theory. While it has not yet proved possible to harvest these theories in a systematic way realist synthesis harnesses theories identified via the expertise and knowledge of the review team and its experts, through theories referenced in included studies and through a body of theorisation published alongside included studies.

2.3 Study Methods

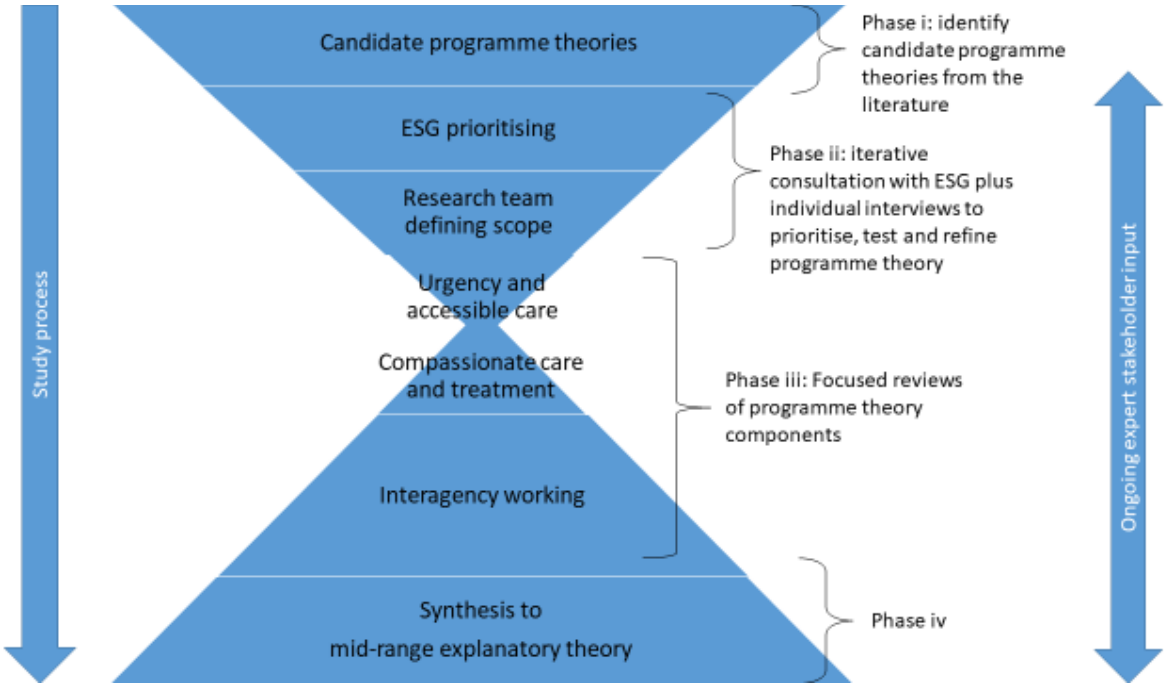
2.3.1 Overview of methods

As realist research is essentially iterative[48], decisions about how to proceed are informed by emerging insights into how best to explore the research question. These methods do not readily fit with a linear narrative and so the following description of methods aims to provide a transparent and clear account of the study components, rather than a strict chronology.

A preliminary search of the literature sought to identify initial programme theories (IPTs) about how UK crisis interventions and crisis services work. Expert stakeholders were consulted to refine the IPTs, agree research priorities and the scope for the review. These processes resulted in three prioritised initial programme theories and were the focus for three focused reviews. Consultation with the Expert Stakeholder Group (ESG) and individual interviews facilitated further sense making, theory testing and refinement. A final search was undertaken to synthesise the programme theory components with mid-range theory. Pen portraits were used to formulate exemplars of service user journeys through the system, to convey generative causal logic, to connect the theory components with real-world

experiences of stakeholders and to explain how mental health community crisis interventions work. Figure 2 illustrates the study process, highlighting how the focus contracted and expanded throughout the review.

Figure 2: The scope & focus across the life of the synthesis



2.3.2 Changes to the study plan including in the context of Covid19 pandemic

This research commenced in September 2019 and was largely conducted during the Covid-19 pandemic. The pandemic precipitated ongoing adjustments to the project milestones and timeline; delaying ethical approval; prolonging uncertainties about the feasibility of face-to-face meetings and interviews; limiting options for recruitment of participants, restricting access to practitioners and service users; challenging continued engagement of stakeholders; and resulting in unexpected absences among the research team. Hence, these challenges were addressed in the context of national restrictions on accessing practice areas and delays in communication due to reduced capacity of many organisations. For example, the expert stakeholder group was established before the start of the government restrictions. They met face-to-face in February 2020. Subsequent delays, postponements or cancellations and a switch to video link may all have affected the ESG contribution.

The original plan to interview up to 50 experts in crisis care from across the UK was modified, after postponement of interview recruitment, planned to include 25 participants and finally

recruited a total on 19 participants to 20 interviews. In addition, issues related to gaining ethical approval during the COVID pandemic restricted recruitment to three NHS health trusts and one NHS ambulance trust in England. The planned six pen portraits were reduced to three linked to each of the three prioritised programme theories. The original plans to support the ESG members to produce a short animation to share the findings with a wide audience has not been achieved due to delays earlier in the project delivery and funding limitations.

2.3.3 Focus of the review

The research team focused the review [58] using the definitions of crisis stated in the Crisis Care Concordat [27] which highlighted the architecture of crisis services summarised as follows:

> *"*Access to support before crisis point…
>
> Urgent and emergency access to crisis care….
>
> Quality of treatment and care when in crisis …
>
> Recovery and staying well…[27] *(p.7)*"

The review focused on 'Urgent and emergency access to crisis care' and 'Quality of treatment and care when in crisis' specifically on initial contact and access via the crisis aspect of services, thereby excluding home treatment and onward referral.

2.3.4 ESG Engagement, recruitment, and membership

Following ethical approval via IRAS/HRA, expert stakeholders (n=15) were recruited through NHS Trusts, the voluntary sector and service user/carer networks. The ESG members included professional and user/carer expertise. Two research team members (JT & NC) maintained contact with two voluntary sector organisations following the pre-protocol PPI which aided engagement and recruitment of those with lived experience to the ESG. Research team member (MA) led and coordinated the recruitment of all stakeholders and co-chaired the group with team member (JT).

The ESG membership comprised: six people with lived experience of using crisis services; a carer; a peer support worker; a consultant psychiatrist; a mental health nurse; an NHS crisis service manager; a mental health social worker with AMHP (Approved Mental Health Professional) experience; a voluntary sector manager; a mental health services commissioner; and a mental health policy specialist.

Membership of the Expert Stakeholder Group (ESG) reflected diverse community crisis care services, recognising that no single individual or group holds all knowledge about crisis care[59]. All were based in England at the time of the consultation. Many participants described dual roles: the peer support worker had (of necessity) crisis service lived experience, but many others had acquired lived experience, either personally or through carer responsibilities. Membership of the ESG remained largely stable throughout the study, with the following exceptions: one service user dropped out; commissioner expertise was covered by two people; and a voluntary sector manager was replaced by their new manager. Table 1 charts the composition of the Expert Stakeholder Group (ESG).

ESG consultations were held in February, September and December 2020 and April 2021. The first ESG meeting was face to face and was recorded through photographs and audio recordings; subsequent meetings were via recorded video link.

Table 1: Composition of the Expert Stakeholder Group (ESG)

ESG role[a]	Number of individuals
Carer	1
Commissioner	2
Consultant psychiatrist	1
Mental health nurse	1
Mental health policy specialist	1
Mental health social worker/AMHP	1
NHS crisis service manager	1
Peer support worker	1
Person with lived experience	Initially 6, reduced to 5 during course of project
Voluntary sector manager	1
Total number of individuals in ESG	15

Some ESG members had lived experience/carer experience and/or another role within the group[a]

2.4 The realist searches

The search followed the six principal procedures for a realist search[60] (see Box 1). Search strategy development was supported by expert guidance from an information specialist.

Box 1:Summary of six principal elements for conducting a realist evidence synthesis

1. Formulate specific questions as lines of enquiry
2. Ascertain previously published research, refining the research question as necessary
3. Identify theories as hypothetical explanatory accounts of how an intervention works in order to identify programme theories.
4. Identify empirical evidence for context-mechanism-outcome configurations to test and refine the programme theories
5. Respond to new information needs as they emerge during testing and refining of the initial programme theory
6. Explicit and transparent documentation of the search process.

Adapted from: Booth (2018, p.7) [60]

2.4.1 Search for initial programme theory

The search for initial programme theory sought to find data to develop initial programme theories related to the architecture of crisis interventions and crisis services in the UK context[60]. During August and September 2019, an information specialist conducted the search using the Google Scholar search engine[46] (see Appendix 3 & Supplementary Materials 1). As programme theories may be located in the title, abstract, and from sections other than the results[61], the search strategy was designed to identify programme theories by screening full texts.

2.4.2 Eligibility criteria

2.4.2.1 Inclusions

Literature related to people aged 16 years or older accessing adult mental health services for a crisis related to mental health, relevant to the UK context. Reports from the EU, US, Canada, and Australasia, with similar structures and a shared history of development, were also considered relevant. Settings included health services, voluntary sector, social care, and police crisis services based in community settings. Published articles, reports, theses, and book chapters were considered eligible and published in English language. No date limits were used for the theory scoping searches but focused reviews included documents published between 2000 and 2021.

2.4.2.2 Exclusions

General hospital inpatient care and acute inpatient mental health care including acute mental health wards, psychiatric intensive care, and short stay acute wards were excluded. Literature related to crises without a mental health focus and crisis services specifically commissioned for children and young people under the age of 16 years was outside the study scope and not eligible. Records that did not contain relevant theory were not eligible.

2.4.3 Search terms- initial programme theory identification

The research team identified twenty-five relevant terms relating to setting (Box 2). Each setting was combined with a filter for identifying logic models together with terms related to mental health and crisis care. Logic models are representations of programme theory that include a focus on steps in the explanatory causal chain including inputs, processes, outputs and outcomes[51].

The first fifty results for each of the 30 systematic searches carried out in Google Scholar were reviewed. When at least one potentially relevant result was found a further 50 records were scanned, summary search terms are shown in Appendix 3 and full search terms in Supplementary Materials 1.

Box 2: Setting search terms

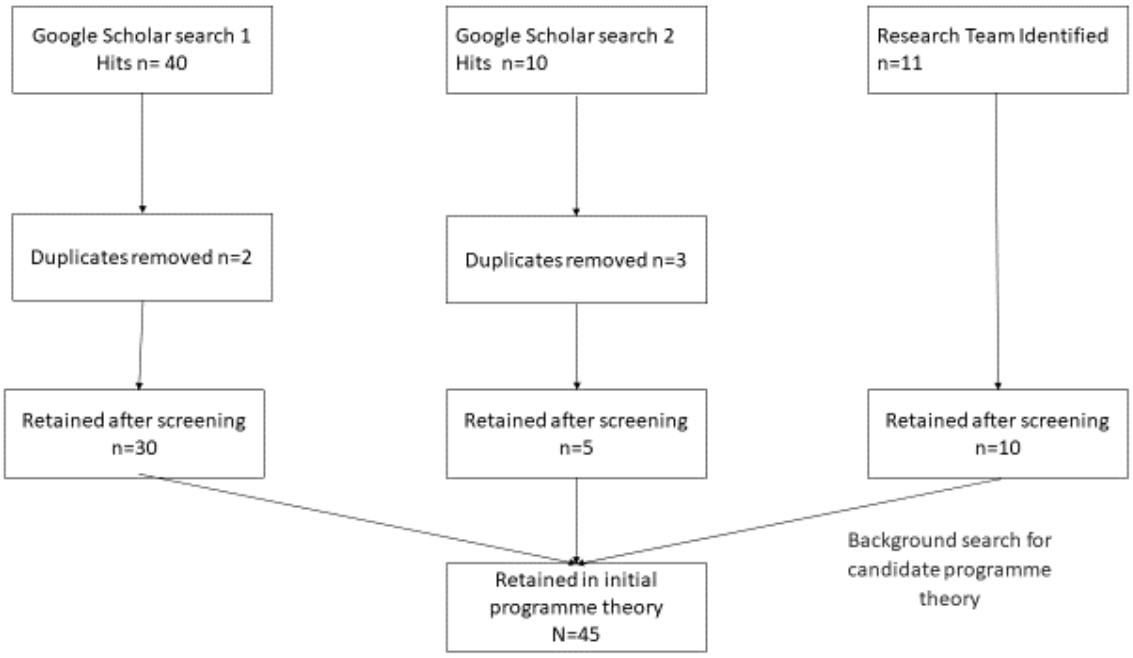
1. NHS 111
2.NHS Direct (Wales)
3.24 hours
4.Helpline
5.Crisis line
6.Accident & emergency (A&E)
7.Hospital
8.999 (telephone number for emergency services in the UK)
9.GP
10.Liaison psychiatry service
11.Local on-call mental health services
12.Social services
13.Community
14.Local community mental health team
15.Crisis houses
16.Crisis teams (CRHT)
17.Café
18.Drop in
19.Day services
20.Day treatment
21.Police

22.Street triage
23.Crisis resolution teams (CRT)
24.Community
25. Decision

2.5 Initial programme theory identification

Selected records were used to construct a long list of initial programme theories[60]. All articles, reports, doctoral theses, and book chapters identified by the information specialist (n=55) were read in full by three researchers independently (KB, LS, NC). Disagreements were resolved through discussion and resulted in ten records being excluded as out of scope (n=5) or containing no relevant theory (n=5). Data on context, mechanisms, interventions, and outcomes were extracted to a MS Excel spreadsheet from 45 records (Appendix 1). The results of the search for initial programme theory is shown in a flowchart in Figure 3[47].

Figure 3: Results of search for initial programme theory



Data extraction from 45 included documents to an MS Excel spreadsheet (Appendix 1) according to Context, Intervention, Mechanism and Outcome (CIMO) resulted in a total of 247 incomplete lines of initial programme theory. At this stage, not all aspects of the CIMO were complete in each line of theory members of the research team (NC, LS & KB) used a sense-making exercise to compare, contrast, and synthesise the initial theories from the extracted data. The extraction and synthesis processes were supported by regular discussions

with all members of the research team. Once the research team reached consensus on eleven embryonic initial programme theory areas (Box 3), these were discussed with the Expert Stakeholder Group (ESG).

Box 3: Embryonic initial programme theory labels for discussion with ESG

A mature multiagency approach and joint commissioning
Urgency of response
Compassionate Care
Involvement
Access to crisis care and treatment
Culturally relevant care and treatment
Ability to meet the needs of vulnerable groups
Service configuration
Therapeutic intervention
Sustaining professionals/staff
Professional/staff skills and knowledge

2.6 Involvement of the expert stakeholder group (ESG)

The ESG worked in partnership with the research team to discuss, refine and test theories and prioritise topics for focused review. Subsequently, the ESG scrutinised the focused review outcomes and contributed to the overall synthesis. Four ESG consultation meetings took place. Engagement with stakeholders at key stages of the research to ensured that important, yet potentially hidden, subtle contextual conditions were not missed [62].

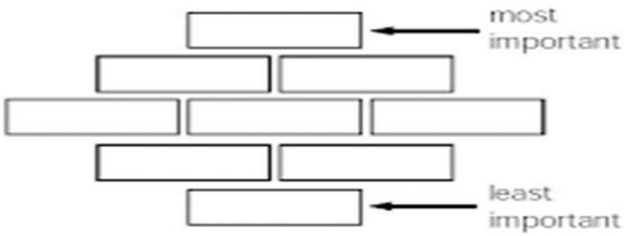
2.6.1 ESG involvement in agreeing on the focus and priorities

In the first meeting, held face to face in December 2019, ESG members were introduced to the project and methods, provided information about taking part and opportunity to ask questions before providing written consent. One lived experience participant declined involvement in the ESG but requested to be invited to take part in an individual interview.

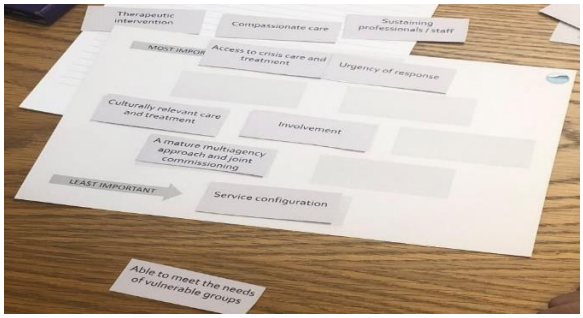
ESG members worked in small groups of mixed expertise to use their expertise to make sense of, debate and rank the importance of the eleven embryonic initial programme theory areas (Box 3). This was achieved using the 'Diamond 9' consensus and prioritisation approach, which encourages participants to work together, developing and exposing thinking[63]. A template used for the exercise is shown in Figure 4 and a photographic image of the ESG group deliberations shown in Box 4. Each of the programme theory areas were printed onto

individual cards along with blank cards to facilitate new ideas from the ESG deliberations. The stakeholders organised themselves into four groups so that they could prioritise, reject, or amalgamate any of the eleven embryonic programme theory areas using a card sort process. Each of the four groups included experts by lived and professional experience. Expert views and rankings were aggregated across the groups to generate overall agreement on refined and prioritised initial programme theories.

Figure 4: Diamond-9 prioritisation template



Box 4:Photograph of ESG members deliberating initial programme theory using Diamond-9



The result of the ESG discussions and Diamond-9 process showed that the most important priority for the ESG members was 'urgency of response'. The pivotal role of urgency and easy access was highlighted by one ESG member, who stated:

> *"…if that's wrong, everything goes out of line because things aren't happening at the right time with the right people."*[64]

The theories ranked in descending order of importance following urgency of response were compassionate care, access to crisis care and treatment, culturally relevant care and treatment, and involvement. Sustaining professionals/staff was identified as the least important.

Initial theories 'service configuration'; and 'mature multiagency approach and joint commissioning' were not prioritised by the expert stakeholder group. However, after discussion between the research team and ESG, the research team retained the 'mature multiagency approach and joint commissioning', considering it integral to the architecture of crisis services and fundamental to the research focus. Through an iterative process of discussion and deliberation between the research team and ESG members, a reduced and refined set of five IPTs were agreed. These IPTs were developed from the data extracted and recorded in an MS Excel spreadsheet (Appendix 1). These are outlined as a narrative summary in Table 2.

Table 2: Summary of five initial programme theories (IPTs)

Context	**Mechanism**	**Outcome**
IPT 1 Crisis services can be accessed urgently		
When community crisis services are adequately resourced, work together across agencies, are known to people and easy to access…	…people are more satisfied with the service and are more motivated to engage. …people believe the service is 'for them'. …staff trust that they have the resources to respond.	…which results in people seeking help earlier in the crisis. People understand what is on offer and make informed choices about where to seek help. Expectations for timely support are met. …staff use resources to provide timely responses according to need.
IPT 2 Care in a crisis is compassionate and therapeutic		
When community crisis services provide compassionate and therapeutic care that is non-judgemental, dignified and safe…by staff who have relevant therapeutic skills and knowledge and support…	…people feel listened to and taken seriously and trust staff. …staff trust the organisation and their peers and believe they have the skills and resources needed for compassionate care.	…which results in reduced distress (and duration of distress) and therapeutic engagement. …staff retain compassion, have confidence
IPT 3 Community crisis agencies work together		
When community crisis services work effectively and seamlessly together across agencies and providers…	….people have a sense of connection that prompts trust. People in crisis and the staff experience a sense of ownership and affiliation. …staff are prompted to have a wider systemic understanding and learn together.	…which results in shared decisions making, improved communication between agencies, improved knowledge of services across the system …reduced likelihood of traumatic repeat assessments …transitions between services are seamless and timely.
IPT 4 Community crisis services are culturally relevant		
When community crisis services are culturally relevant, by employing people that share characteristics of the local population, train staff in knowledge and appreciation of	…people are less stigmatised and stereotyped prompting trust and willingness to engage …staff are confident, aware and sensitive to issues of culture and ethnicity	…which results in people seeking crisis support sooner and being less likely to require hospitalisation or involvement from the criminal justice services.

culture and ethnicity in relation to health and mental health…		Staff have skills and knowledge that enable cultural sensitivity and adapt interventions and refer appropriately across the crisis care system.
IPT 5 Community crisis services are developed and delivered with involvement of service users		
When there is meaningful involvement of people with lived experience of crises and their family and friends, that is recognised by those designing, leading and delivering services and is appropriately resourced…	….people recognise the service as for them, they trust services and believe that the service reflects their expectations. There is ownership and affiliation. Equalising of power is facilitated.	…results in increased engagement and community recognition and acceptance of the service. …people have an increased sense of personal control (agency).

2.6.2 Defining the scope for the focused review

Following the RAMESES guidance on defining and refining the study scope[46, 52], the ESG and research team jointly discussed the scope of the review and the selection of IPTs for focused review. Firstly an overarching focus on the initial stages of a person in crisis seeking help and securing support and the quality of the support provided – key intervention points in the architecture of crisis services as identified in the Crisis Care Concordat[27, 28]was agreed. Although the term multi-agency was initially adopted, it was replaced by 'interagency' in the course of the team discussions because of the perceived synergy between agencies that work together effectively in crisis care. The two terms can be interpreted as broadly synonymous[65].

Figure 5 illustrates the process used to refine the scope of the study and identify the IPTs for focused review from eleven embryonic initial programme theory areas (Box 3) to five initial programme theories (Table 2) and finally resulting in three IPT's retained for focused review. The deliberations between the ESG and the research team resulted in amalgamation of urgency of response and access to crisis care as one was felt to be inherently linked to the other, this is IPT1- Crisis services can be accessed urgently. The ESG and research team combined compassionate and therapeutic care, IPT 2- Care in a crisis is compassionate and therapeutic. The third and final programme theory combined multiagency working and joint commissioning amalgamated to- IPT 3 interagency working.

IPT4, culturally relevant care (although highly relevant) was acknowledged to require consideration beyond the scope of the current study. Our initial searches revealed little published evidence focused on culturally relevant crisis care at a granular enough level in crisis care to provide adequate explanation. It was decided that IPT4 would benefit from a future primary realist evaluation to generate new explanatory evidence. Data pertaining to cultural

relevance, when identified as relevant to causal explanations, has been included IPTs 1-3. IPT 5- Involvement, was felt to be cross cutting and has been reported when causally linked to concepts in focused reviews IPT 1-3.

Figure 5:Figurative illustration of the decision-making process to prioritise and refine the scope of the review

2.6.3 Pen portraits

At the fourth and final ESG meeting, a pen portrait method was used to support theory development. Pen portraits offer an analytic method to focus large volumes of qualitative data while maintaining richness[66]. In ESG meetings brief vignettes (see example in Supplementary Materials 2), were used to structure discussions. These vignettes enabled the ESG members to use their expertise to relate the evidence from the included documents to real world experiences. Discussions took a realist perspective that sought to explain and identify causal links.

Pen portraits were developed once the focused reviews were more fully developed and provided an illustration from a real-world perspective of the causal link between mechanism and outcomes. They were constructed using synthesised data to map components of crisis interventions structured around the TIDieR Template[67] (see Table 9 & Appendix 2), together with context, mechanisms and outcomes, and to inform future empirical testing of the programme theory. The use of vignettes and pen portraits facilitated discussions with ESG members throughout the research, enabling theory to be presented to stakeholders in an

accessible way, to test and refine the understanding of context, interventions, mechanism, and outcomes (CIMO) in crisis services.

Rather than a description of any individual experience, the pen portraits provide examples of people experiencing crises, their circumstances, and the crisis responses. Three pen portraits were developed, i.e., one primarily drawn from each focused review, to illustrate a real-world example of the theories in action and subsequently refined following ESG consultation and through the process of synthesis across focused reviews and mid-range theory. The draft pen portraits were discussed between research team members to ensure the stories effectively linked to the IPT's 1-3 (Table 2) and interventions described in TIDieR Lite (Table 9 & Appendix 2) before presenting them to ESG members. At the fourth and final online meeting between the ESG and research team, ESG members were asked to sense-check three draft pen portraits, by moving between three subgroups. Discussions were recorded and reviewed by members of the research team (NC, KB, LS) and used to refine the pen portraits.

The discussions told us that the pen portraits were recognisable to ESG members, who endorsed them as exemplars of good crisis care. Some found them somewhat idealistic and were not convinced that the system could respond as the pen portraits described. Discussion of the final pen portrait versions is included in the three focused review chapter 3 (Section 3.6.4), chapter 4 (section 4.6.4) and chapter 5 (section 5.5.4).

At this final meeting, ESG members were invited to complete an ESG evaluation, the template for feedback and a summary of the evaluation results are in Supplementary Materials 2 with a blog providing a personal account of participating in the ESG.

2.7 Testing and refining the initial programme theory via focused review

Focused searches were conducted to identify literature to test the initial programme theories[60] between January and July 2020 by an information specialist (RW). Iterative cluster searching was carried out by the researcher in each focused review up to March 2021 (NC, KB, LS). Included documents were published between 2000, when community crisis services were first mandated by the UK government[9], and March 2021.

2.7.1 Sources for empirical testing

Ten academic databases were searched: MEDLINE; Embase, Web of Science Core Collection (Science Citation Index; Social Sciences Citation Index; Conference Proceedings Citation

Indexes – Science and Social Science & Humanities); Cochrane Database of Systematic Reviews; Cochrane Central Register of Controlled Trials; Cumulative Index to Nursing & Allied Health; PsycINFO; Applied Social Science Index; ProQuest Dissertations & Theses A&I; and HMIC.

Search strategies combined mental health keywords with keywords for crisis and keywords for each programme theory, together with a highly sensitive and published geographical UK filter[68], using the AND Boolean operator. The filter was applied to all database searches except ASSIA, ProQuest Dissertations & Thesis A&I and HMIC. All searches were restricted to English Language studies. The search results were managed using Endnote (X9 version 3.3) software[69]. (See Appendix 3 for a summary of search strategy & Supplementary Materials 1 for full search strategy).

2.7.2 Theory orientated searches

Theory-orientated, focused review searches were conducted (February-March 2020) with supplementary searches (July 2020). The intention was to sample, rather than to identify an exhaustive body of literature[70]. A Google Custom Search was created to facilitate supplementary searching of grey literature sources in 32 UK websites (January-April 2020,) with particular attention paid to: NHS England publications; Royal College of Psychiatrists; and the Centre for Mental Health (See Appendix 3 for a summary of grey literature searches).

2.7.3 Cluster searching

The search strategy was developed iteratively and revisited at predetermined milestones, using different permutations and additional concepts [70]. As each focused review progressed the lead author considered how each document contributed to the aims and objectives of the realist synthesis and to theory development. Where relevant lead authors deployed 'cluster searching', an innovative purposive sampling approach, to identify 'clusters' of related publications. This approach added to the conceptual richness and contextual thickness of the studies identified through topic-based searching[70]. Sibling (i.e. outputs directly linked to a single study) and kinship (i.e. papers sharing a common contextual/conceptual legacy) reports were sought to add richness while preserving rigour and relevance[70]. The research team pursued citation networks, using Google Scholar and Web of Science. The iterative approach enabled the research team to search for data beyond the literature particular to community crisis services but also to test veracity in the context of UK community crisis interventions.

The theory was continually tested and refined through expert consultation and individual interviews. The Expert Stakeholder Group also recommended records, based on their expertise. Searching continued until sufficient data were found ('theoretical saturation') to conclude that the programme theory components were coherent and plausible[52, 71].

2.7.4 Screening

Retained records included primary research, reports, policy documents, and expert opinion. Using Endnote (X9), retrieved records were screened for relevance by three members of the research team (LS, KB, NC). Full texts of the selected records were obtained and screened (see Figures 6-8 in chapters 3-5). A list of the retained records from the searches for initial theory is provided in the Appendix 4.

2.7.5 Appraisal of relevance and rigour

A modified realist appraisal tool[72] was used to appraise relevance and rigour across all the retained records[69] (Supplementary Materials 3). Relevance was determined to be less substantial, medium, or high. A document was considered highly relevant when the framing of the research and, the research questions closely matched the review questions. Rigour was assessed by quality appraisal of the study methods using a mixed method appraisal tool (MMAT)[73] (Supplementary Materials 3), in all documents where a methodology was available for assessment[52, 72].

2.7.6 Data extraction

An analytical framework was created by the research team, data extracted included the publication type, origin, type of service or intervention, and influencing factors i.e., theoretical perspective. Where it was possible to make inferences, the data extracted were attributed to context, mechanism, or outcome. Data suggesting explanatory links between context-mechanism, mechanism-outcome or context-outcome was also extracted. Relevant data from the retained records were coded against the analytical framework (i.e., deductive coding) or by identifying new codes (i.e., inductive coding)[46, 48, 52]. Data were extracted into a Microsoft Excel (2016) spreadsheet[74] (Appendix 1) and coded in NVivo Version 12[75].

2.8 Individual Realist interviews

The realist interviews were theory-driven, and used conversation to explore participant views, with the specific aim of investigating 'how, where when and why programmes are and are

not effective'[58]. Ethical approval was obtained for individual interviews as outlined in Section 2.1.3 (See project documentation).

2.8.1 Recruitment

Purposive strategies were used to identify mental health service users, carers, and professionals from diverse organisations including NHS, local authority, university, and the voluntary sectors. Expertise not represented in the research team or the ESG was prioritised. Representation was sought from urban and rural areas, as well as mental health trusts, ambulance trusts and the police force. Study information was distributed to potentially eligible participants, who could contact the research team if they wished to participate.

2.8.2 Sample

Following revision of the size and scope of the sample frame, in view of the 2020 Covid 19 pandemic, study recruitment targeted an updated intended sample size of 25. The final sample comprised 20 interviews, with 19 expert interviewees (one participant took part in two interviews). Table 3 details the sample profile, along with the corresponding interviewee codes.

Table 3: Background of individual interview participants

Interviewee Background 1	**Interviewee Background 2 (Where relevant)**	**Interviewee context**	**Code**	**Number of participants (n=19)**
Academic		Voluntary sector	KB4	1
Ambulance emergency care assistant		Ambulance Trust	LS3, LS4, LS5	3
Carer	Paramedic	Carer accessing crisis care and ambulance trust	NC3	1
Manager		CRT manager	KB6, LS1	2
Mental health nurse		SPA, CRT, A&E liaison	LS2, LS6, NC1, NC2	3
Paramedic		Ambulance trust	KB2, NC4	2
Police		Street triage	KB1	1
Policy expert	Social worker	CMHT, AMHP	KB3	1
Psychiatrist		CRT	KB5, LS7	2
Service user		Crisis services	JT1, JT2, JT3	3

2.8.3 Strategy for realist interviews

A bank of semi structured interview questions formulated according to a realist interviewing approach[76], was agreed within the research team (Supplementary Materials 4). Interview participants were asked to comment on the evidence and how thinking in the research team

was developing. Participants were selected for interview based on their expertise in one or more programme theories. All interviewers had access to all interview questions and could opt for relevant questions as the interview progressed (Supplementary Materials 4).

Participants were invited to take part via Microsoft Teams[77], Zoom[78, 79] or telephone and provided with a participant information sheet and consent form in advance. Their verbal consent was audio recorded before the interview and the interviews lasted up to one hour.

Four research team members conducted the interviews (NC, LS, KB, JT). Interviews were recorded and saved to a secure, password locked server accessible by the research team. The interview recordings were reviewed, and detailed notes transcribed by each interviewer and shared with the research team. Following discussion between the research team members a deductive coding process was used to connect interview data with the IPTs in the focused reviews. Interview data were used to test the veracity of the IPTs, particularly where there were gaps in the published evidence but also to strengthen real world understanding of the architecture of crisis services and causal links between context, mechanism, and outcome. Excerpts from the interviews are reported throughout the focused review chapters in the form of discussion and direct quotations. After the completion of 20 interviews, it was agreed that data were sufficient to inform the programme theories.

2.9 Data synthesis and theory refinement

Data from the focused review chapters, that included contributions from ESG and individual interviews, were synthesised to refine the programme theories. The synthesis enabled the team to identify important mechanisms that need to be 'activated' within a programme or intervention, together with links between the contexts and the key mechanisms. Synthesised CMO configurations are presented in table in Appendix 5. Confidence in the synthesised findings was assessed using GRADE-CERQual[80] shown in Table 8. GRADE-CERQual assesses confidence at the level of findings in four domains; 1) methodological, informed by MMAT appraisal[73], 2) relevance, supported by realist appraisal[72], 3) coherence, the extent to which the finding is grounded in the data and 4) adequacy, the degree of richness and quantity of data[80]. Discussion about relationship between intervention strategies and their underpinning mechanisms is provided in Chapter 6.

2.9.1 Developing a mid-range theory

A final search was undertaken to link the three programme theory components and the study findings, and to mid-range theory[60] (Table 12) . Mid-range theories were identified relating to: interagency collaboration[81, 82];; feeling in control[83]; breaking point[84]; a strengths perspective[85]; compassionate care[86, 87]; protection motivation theory[88].

2.10 Evidence sources

Sources of evidence for the study are summarised in Table 4.

Table 4:Summary of sources of evidence

Source	Utilisation
Literature (academic; grey including websites and reports)	Background search for logic models and candidate programme theory
ESG consultation	Selection of broad theory areas for focused review; theory testing
Literature (academic; grey including websites and reports)	Focused reviews to test programme theory for: Urgency and accessible care; Compassionate and therapeutic care; Interagency working
Individual interviews with experts	Theory testing

2.11 Chapter summary

This chapter provides the rationale for undertaking the realist synthesis, documenting: the search for initial programme theories; procedures for scoping the literature and identifying the initial programme theory; the search for empirical evidence; and the strategy for finalisation and synthesis of the programme theories[60]. It supplies additional detail on how the expert stakeholders contributed through the collection and analysis of primary data and the use of pen portraits to connect the theories to real world stakeholder experience, facilitating the assessment of quality and rigour[60], following RAMESES publication standards[46] (Supplementary Materials 5).

2.11.1 Structure of review chapters

The next three chapters (Chapters 3-5) report the three focused reviews to test and refine IPTs 1-3 (Table 2). IPT 1 Crisis services can be accessed urgently; IPT 2 Care in a crisis is compassionate and therapeutic; and IPT 3 Community crisis agencies work together.

Chapters 3-5 are structured to follow the realist Context, Mechanism, Outcome (CMO) convention. The context is reported first, followed by outcomes and unintended consequences and lastly mechanisms and conclusions. The IPTs are explained from three

circumstances, the person in crisis and their family, frontline staff and the crisis care system. Each chapter concludes with an IF -THEN- LEADING TO statement and pen portrait to illustrate the IPT from a real-world perspective. Synthesis across the findings from IPTs 1-3 and mid-range theory is discussed in Chapter 6.

3 Focused review IPT1: Crisis services can be accessed urgently

3.1 Introduction

This chapter examines the first of the three IPTs: Crisis services can be accessed urgently, identified from the initial searches outlined in chapter 2.

IF crisis services are adequately resourced, work together across providers, are known to people and use shared decision making THEN there is satisfaction with crisis care that meets expectations for urgency, people believe in the service and there is trust LEADING TO people accessing urgent help that is timely and appropriate to their individual needs.

The chapter first describes the characteristics of urgent and accessible services including interventions and intervention components identified in the literature to enhance their development and delivery. The evidence base for urgent and accessible services, the outcomes of urgent and accessible services, and the unintended consequences when key components are not in place or are not effective are described. Next, the chapter describes the mechanisms for urgent and accessible services, demonstrating how they may be facilitated at different points within mental health community crisis care. A narrative drawn from the literature is supported by contributions from the expert stakeholder group discussions and interviews. The chapter concludes with an overview of how urgent and accessible services can enhance mental health crisis care, using the 'IF-THEN-LEADING TO' convention.

3.2 Context: urgent and accessible crisis care

The theory component 'Urgent and accessible care' was prioritised through discussion between the research team and the ESG. Feedback from one breakout group of ESG members emphasised the primary importance of urgent access:

> *"without urgent access to services in a mental health crisis, nothing else will work"*[64].

NICE, The National Collaborating Centre for Mental Health and NHS England[33], (p.9), define 'emergency' and 'urgent' situations as follows:

> *" An emergency is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response. An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening."[33], (p.9)*

Policy and published evidence state that crisis interventions should be 'timely' or 'urgent'[33, 89, 90], yet this has been poorly defined in a mental health context[89, 91]. The focus on waiting times excludes some agencies providing crisis care, contrary to the aspiration for multi-agency collaboration of the Crisis Care Concordat[28, 92]. The risks to safety posed by a failure to respond in a timely way have driven the development of clinical decision tools[92-94]. Clinical approaches including decision tools are not however universally accepted by people using services or by all types of community crisis service[10].

Uncertainty as to what constitutes a mental health crisis, the intervention required[10, 91, 95, 96] and the heterogeneity of the population seeking crisis support[91, 95] means that people access crisis services via a complex range of routes[10, 15, 84, 95, 97-99]. The route into crisis care is different for those known to mental health services compared to people seeking crisis support for the first time[95].

Services have been developed to improve urgent access in a range of settings including in A&E[100]; with the police[98], with ambulance services[101] and in voluntary organisations[10]. The UK government invested in the development of mental health crisis resolution services (CRT) and a body of research has resulted in a service fidelity model[16, 17]. There is a long history of telephone support in crisis services and planned development of telehealth has been fast tracked due to the impact of the Covid-19 pandemic[90]. Shared decision making, information sharing, and skilled frontline staff have been identified in studies of stakeholder perspectives as indicators of good crisis services[89, 102]. Interagency working is important to providing urgent access and has been identified as an IPT explored in detail in Chapter 5. Table 5 lists contextually important intervention strategies that facilitate urgent access to community crisis mental health care.

Table 5:Contextually important intervention strategies facilitating urgent access to community crisis services

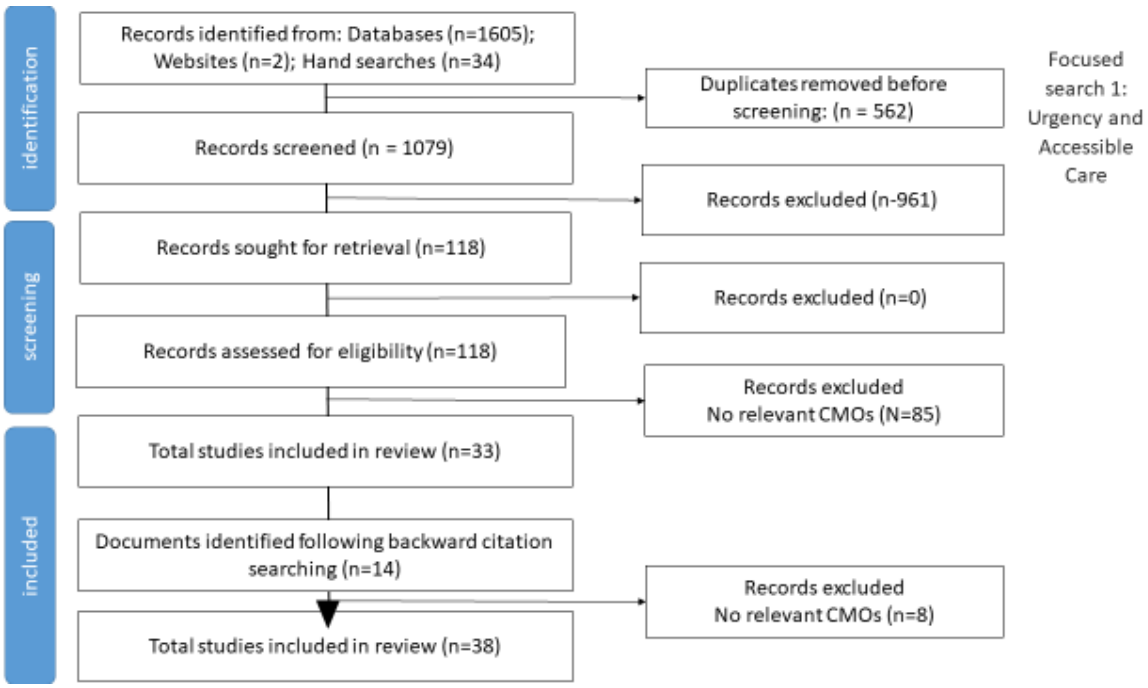
Contextually Important Intervention Strategies
Referral processes[2, 10, 15, 84, 89, 91, 96, 97, 99, 100, 103-106]
Continuity of care[2, 10, 105, 107, 108]
Triage and prioritisation[91, 93, 94, 99, 100, 104, 109, 110]
Waiting time standards[111, 112]
Parallel assessment[84, 95, 98-101, 108-110]
Tele-health[2, 15, 90, 93, 94, 98, 113-115]
Shared decision making[10, 89, 95, 96, 105, 115-123]
Information sharing[89, 102, 118, 121, 123]
Immediate support[89, 93-95, 104, 105, 110]
Staff training, supervision, and support[10, 93, 94, 98, 99, 104, 107, 123]

3.3 The evidence

3.3.1 Approach to identification of studies for review

Three iterative database searches were conducted, the first with search terms related to urgency and access; a second search was conducted using terms related to waiting and delay and a third focused on mental health triage. The results of these searches were combined. After exclusions on the grounds of relevance to IPT1, 'urgent and accessible crisis care', 33 records were retained (n=13 from academic databases; n=5 from grey literature (websites and reports); n= 15 from hand searching). Backward citation searching of 18 records identified in database and grey literature searches a further 14 records were identified of which five were retained. In total, 38 records were included. The flowchart in Figure 6 shows the process of identification of studies for this review[47].

Figure 6: Search results focused review IPT1 urgent and accessible crisis services



3.3.2 Retained records

Details of the 38 retained records for the urgency and accessibility focused review are in Appendix 4.

3.3.3 Settings

The research settings reported included all community mental health services[96, 105, 108, 112, 114-123], community crisis services[2, 10, 15, 89, 91, 102-104, 106], integrated services with the police[84, 95, 98], integrated services with paramedics[101], emergency departments[97, 99, 100, 109-111], and telehealth[90, 93, 94, 107, 113].

3.3.4 Focus

Included documents were focused on joint crisis planning[116-123], crisis response models[84, 89, 91, 100, 108], gatekeeping and referral processes[103, 105, 113], triage and decision making[93, 94, 104, 107, 109], waiting times[109, 111, 112], service user perspectives of crisis services[2, 10, 15, 84, 102, 106, 110, 115], carers' experiences of mental health services[96], co-location models[84, 95, 101], interventions in rural areas[114, 115], telehealth[90, 93, 94, 113-115], experiences of black and minority ethnic groups accessing crisis services[106] and the voluntary sector contribution to crisis services[10].

Companion documents containing findings from the same study focused on joint crisis planning[118-120, 123] and on telephone triage[93, 94].

3.3.5 Appraisal of relevance and rigour

All included documents were appraised for relevance and richness using a modified realist appraisal tool[72] (Supplementary Materials 3). Documents containing primary research data were also appraised for rigour using the mixed methods appraisal tool (MMAT)[73] (Supplementary Materials 3). The combined appraisal of relevance and rigour identified that the evidence supporting IPT 1 urgent and accessible crisis services is based on studies of mixed quality.

One mixed method multi-site study of the voluntary sector contribution to crisis care was highly matched to the theory component providing a rich description of context, mechanism and outcome[10]. This study was methodologically rigorous and highly relevant and included as a key document.

Included documents reporting randomised controlled trials (RCTs) were all focused on joint crisis planning (JCP)[116, 117, 122, 123]. These studies provided context and outcome but provided less substantial theoretical relevance. One study of JCPs reported the economic data drawn from the RCT but the small sample size and lack of quality-of-life measures limited the rigour of these findings[116]. All included RCTs reported methodological problems including small sample sizes[116] due to under-recruitment[117]; a lack of reliability in the measures[122] and inadequate staff training causing intervention implementation problems[123].

Included mixed method evaluations reported small samples, mostly limited to single site, lacked comparators and did not consistently synthesise across methods but provided less substantial[101, 121] to moderate[95, 98, 99, 104, 108] framing of context, mechanism, and outcome.

Included qualitative studies were theoretically rich despite problems of rigour related to small samples that lack variance[84, 94, 110, 118, 119]. Included qualitative studies with less substantial theoretical relevance were rigorous[15, 93, 96, 102, 103, 105, 120]. One qualitative study provided context but lacked rigour[114].

A scoping review[91] and a realist review[97] provided less substantial relevance and one systematic review provided moderate relevance to the theory[100]. A case study design provided less substantial relevance and rigour and was retained due to specific focus of the study on triage decisions[107].

Expert reports were not assessed for rigour. Appraisal of these documents for relevance found that documents moderately framed to the theory provided context and mechanism[2, 109]. Documents with less substantial theoretical relevance provided context[89, 106, 111]. Three documents were retained because they provided specific contextual relevance from policy or services but were less substantially relevant[90, 112, 113].

3.4 Outcomes

This section discusses outcomes relating to service users, staff and systems. Included studies were often focused on service and organisational outcomes over outcomes at an individual level. The documents contained sparse outcomes data often based on studies with methodological limitations.

3.4.1 Service user outcomes

3.4.1.1 Service user outcomes: Urgency and timeliness of response

Service users want to be seen the same day[15]. From a service user perspective, rapid referral to a mental health intervention, a feature of CRT[15], A&E liaison[100], and NHS 111 services[113], is viewed as the most helpful feature of crisis services[15]. Rapid referral[15, 100] and co-response models such as street triage[98] resulted in people reaching a mental health assessment more quickly but may not improve urgent access to a mental health intervention[10, 100].

3.4.1.2 Service user outcomes: Accessibility of crisis services

The timeliness of response of crisis services is linked to accessible service designs. An independent review of acute and crisis services concluded that: *"what happens in the early stages of a crisis response impacts on progress to recovery and their willingness to seek help in the future"*[2] (p.12). Successfully navigating to appropriate crisis support led to people feeling believed and hopeful which in turn enabled them to manage their distress[110].

When people lack information about mental health services [89] or have physical health concerns, they are more likely to contact their GP [84] or attend A&E [97, 99, 108]. Open access (including self-referral) is highly valued by service users and families [15, 104] and is a feature of voluntary sector services[10]. Open access to NHS crisis services is a policy aspiration[89, 92, 104] and often only available to people already engaged in a mental health service[95]. Walk-in services, mostly available via A&E and some voluntary sector services, provide black men with an access route they preferred and were more likely to use[10] thus avoiding delays in seeking help because of stigma related to both racial stereotypes and mental ill health[106].

Service users valued co-response models providing joint assessments by mental health staff and other agencies such as police, ambulance, or A&E staff, especially in situations where risk for violence or suicide were high[84, 98, 101]. Joint responses also helped avoid the stigma, related to being taken into custody[95]. Whilst policy emphasises the need to provide services close to home, for some people, having time away from the context of the crisis, in a community setting, allowed them to "*take stock of the situation*"[10] (p.76) and regain control of the crisis[10, 118].

Accessibility of crisis care was linked to service users and family carers being involved in decisions through gatekeeping[103], the use of video conferencing in rural areas[115] and joint crisis plans (JCPs)[122] JCPs developed with involvement of a patient advocate, when compared to clinical staff alone, were more comprehensively completed and specific about individual needs[122]. Shared decision making facilitated by JCPs with people with personality disorder provided a greater sense of control and improved relationships with their care provider[117]. Despite RCTs findings that JCPs had no significant impact on treatment effects or cost, when compared to a control[116, 123], a difference according to ethnicity was observed. This difference suggested a higher probability of cost effectiveness with black (90%) than white (30%) or Asian (10%) service users[123]. These findings suggest that JCPs may provide a sense of trust for black people who often report experiencing higher levels of fear, stigma, and marginalisation [106, 123].

Where people have personal resources such as family support, they often seek support from them first *(JT2, service user)* but some people are concerned about being a burden to their

family[10]. A less clinical approach, involving peer support seems to act as a proxy for family and friends by providing support in comfortable environments and through an approach that;

> *". . . is not kind of saying 'I'm making you better, it is my job to make you better'. There is something about 'we're in it together, you and I'."*[10] (p. 88).

Access to peer support as part of joint crisis planning generated a sense of being understood[119]. In addition, people from black and minority ethnic communities reported that peer support enabled them to *"learn about themselves and have a new perspective on their situation*"[10](p.76). This was linked to a distal outcome through their recognition of opportunities to volunteer which gave meaning and hope[10, 64].

Services were perceived as more approachable when frontline staff provide immediate interventions including supportive counselling[94] and active listening, this conveyed hope and encouragement thus engendering a sense of relational safet[10]. Relational safety improved therapeutic relationships [116, 123] thereby calming the crisis situation and enabling the person to deal with their crisis[10, 110]. People with lived experience report that this leads to a distal outcome of being more likely to access the service again in the future[2, 64].

3.4.2 Frontline Staff Outcomes

3.4.2.1 Frontline staff outcomes: Urgency and timeliness of response

Outcomes related to the timing of crisis responses were highly theoretical. Frontline staff viewed urgency of response as important and linked this to response times stated in policy of between 1 and 24 hours depending on assessed urgency of need[15, 92]. Staff in CRTs value the role of gatekeepers, originally intended to reduce hospital admissions, but also viewed by staff to control workload by reducing inappropriate referrals[103], although their success in achieving these outcomes is unclear. Fears about being overwhelmed by referrals and about resource pressures made NHS frontline staff reticent about open access service designs[103].

3.4.2.2 Frontline staff outcomes: Accessibility of crisis services

Being able to access a crisis service required frontline staff to have skills to create a sense of trust and safety that facilitates the person being able to communicate their needs[10]. This was achieved when frontline staff had skills in supportive counselling that enabled them to be flexible and responsive to the individual needs of the person seeking help[93]. Compassionate

staff were more collaborative providing a sense of involvement people in crisis value, thereby supporting the immediate stabilisation of the crisis[102, 115], even by telephone[94]. A service user interviewee explained the important link between the interpersonal approach of staff and the development of trust:

> *"Their approach is very person centred [and I have] more trust in that service. They might not be able to solve your problem, but sometimes it is just being able to speak to someone."* (JT3 service user)

Frontline staff deal with trauma, distress and decision making in often pressured situations putting them at risk of the ill effects of stress including compassion fatigue and burnout. Access to clinical leaders and systems of support and supervision were linked to staff being less fearful of blame or competency issues and being more likely to seek out support[104]. and to sustain compassionate engagement[10], When staff were supported decision making improved[104, 107, 115], staff stress reduced, including when support was provided via telephone or video conference[93, 98, 115].

3.4.3 System Outcomes

3.4.3.1 System outcomes: Urgency and timeliness of response

There is a lack of outcome data related to clinically relevant waiting times in mental health crisis care[91]. The rationale for current waiting time standards is not understood by frontline staff;

> *"...some of the standards recommend a time frame, 'see people within 24 hours', [the] new standard is 4 hours. I would like an explanation of where that target comes from, what is the clinical reason and evidence for that."* (LS6- mental health nurse).

The time people wait for a mental health assessment is linked to availability of resources[15, 100] across 24/7[95, 98]. Co-locating mental health practitioners in emergency control rooms improved timeliness of responses by dispatching the most appropriate service or dealing with issues using tele-health[98, 101]. Co-location in emergency control rooms was found to be cost effective and therefore sustainable in the longer term[98] but has not been fully evaluated.

Joint or parallel assessments improved collaboration between staff[100] led to more rapid responses[98, 100, 101, 110], and fewer people failing to reach a mental health intervention[100]. An interviewee stated that as well as saving time, parallel assessments were more accurate and avoided the discomfort of multiple assessments for service users[111] (NC1, mental health nurse).

A mental health triage tool, adapted for use in the UK, has been "*subject to preliminary validity and reliability testing*"[93] (p.334). Following frontline staff training, triage approaches have been linked to more timely and appropriate service responses[94, 104] and improved accuracy in identification of suicidality[104]. The outcomes of service thresholds on timely access to crisis care have not been fully evaluated, ESG members and an interviewee explained that how services manage access thresholds may have more impact on urgent access than assessment and triage processes.

> *"I think once you get through to the triage element and the assessment. You're kind of in. It's …thresholds that I think is quite a barrier to people."*
> (NC1- mental health nurse).

3.4.3.2 System outcomes: Accessible crisis services

There was no published evaluation of Single Point of Access (SPA)[89, 112]. An interview participant suggested that SPA helped to manage staff resources by separating roles between triage calls and crisis intervention follow-up, (LS1- manager). Telephone access has a long history in crisis services and has been used as an alternative to face-to-face contact during the pandemic. The UK government fast tracked implementation of dedicated 24/7 NHS mental health crisis helplines in 2020 to mitigate barriers to access to A&E during the COVID 19 pandemic. Ease of access was prioritised and the new telephone lines received 3 million calls during the pandemic[90] suggesting uptake although individual and service outcomes from these calls have not yet been reported.

The availability of sufficient resources in CRT[15] and in A&E influence the time available to carry out initial assessments[111]. If organisations value involvement of service users and families in their care, providing resources that ensure staff have time for assessment enables greater attention to the person's own interpretation of their crisis and the likelihood of negotiation

and participation in treatment decisions[105]. Time spent in this way may reduce the number of times individuals attend for urgent supports and therefore have the potential for cost effectiveness as well as improved individual experience[99] as one interviewee explained,

> *"It feels like you've had your call now if you call the NHS. So, if I reach that point again in the night, then it is more likely to go down the harm route and I am more likely to then end up in A&E."* (JT3 service user)

Organisations where staff burnout and compassion fatigue are addressed through training and support are more likely to have improved service user experience and may reduce service use for those who access services frequently[94, 99].

Information sharing and shared decisions related to joint crisis planning were limited to those already known to mental health services[118, 120, 123]. Acknowledged problems of engagement of clinical staff with JCPs, suggests that organisational support for sustained change and implementation at organisational level is needed[123]. Information sharing and shared decision making have shown improved service coordination in a crisis for those known to services [121] especially where there is a risk of relapse or frequent need for support such as for people with personality disorder[117]. An interviewee explained,

> *"It does make a difference when they know a little bit about who you are. If they know my diagnosis and what treatment I have had they can then relate stuff that is meaningful*..." (JT2, service user)

3.5 Unintended consequences

3.5.1 Unintended consequences: Service users

3.5.1.1 Unintended consequences service users -Urgency and timeliness of response

Gaps between services mean that the link between access to a rapid assessment and people reaching a rapid mental health intervention is not consistent[98]. Service users and families describe waiting for their crisis to escalate to be accepted into services[64, 105]. Crisis service provision has been historically situated in secondary mental health services, but these services are difficult to access due to high service thresholds. Primary care services designed to meet the needs of those requiring lower intensity interventions[94] have not traditionally accepted crisis care referrals and have long waiting times for interventions[10]. People in crisis

report that waiting for services to respond feels pointless when there is no accurate information about what they are waiting for[110].

3.5.1.2 Unintended consequences service users -Accessibility of crisis services

Complex referral processes such as gatekeeping are viewed by service users as a barrier[105]. Gaps between different agencies and services result in people having multiple assessments, causing unnecessary distress[105], no intervention[10, 15] or circling in the system, with repeat attendances[99, 110]. Not being taken seriously leads to withdrawal from services, isolation, and an increase in negative beliefs about services[2, 105].

Service users described being perplexed when directed to attend A&E by their GP or community-based crisis providers[99, 109] who they believed ought to be able to provide more appropriate crisis support. Referral processes between agencies in crisis care are biased towards statutory services[10]. Often rather than a referral to a voluntary service, people are signposted, leaving the process of accessing the service to the person or their family member to coordinate[10]. As a result, service users and families are often unaware of voluntary sector services and only discover them by word of mouth[10, 64]. An ESG member explained that CRT had not felt right for their needs. They met a friend locally who provided information about a bespoke BAME crisis service in the voluntary sector. They wished they had been referred to the service sooner[64].

Failure to secure appropriate crisis support leaves family members feeling abandoned and they lose trust in mental health services resorting to and calling emergency services or attending A&E[96]. Despite A&E being an uncomfortable environment for many people in crisis, it guarantees that they will be seen[97]. An interviewee explained that this guarantee makes the wait for treatment more tolerable than the frustration of circling the system (NC1, mental health nurse).

Failures in the crisis care system including an inability to provide timely responses, gaps between services that prevent continuity when coupled with individual factors such as perceptions of urgency and the nature of the crisis[10, 99] leads to people circling the system and making repeat attendances. When people attend services frequently[99, 109, 110], service users believed that frontline staff "*regarded them as 'a nuisance' or worse, seeing them as a*

diagnosis or behavioural category rather than a person"[95] (p. 98). An interviewee explained that they had experienced that staff with negative attitudes provided inadequate risk assessment, made assumptions about the person's circumstances (NC3, carer) and people were discharged too hastily which led to further self-harm and escalating behaviour[111]and ultimately more repeat attendances[110].

Whilst access to telephone support was valued as part of crisis services[15], it may not provide the sense of relational safety identified as important[10, 99]. A service user interviewee explained the need for telephone responders to have skills in supporting mental health[93];

> "*Generic answers from NHS lines are not helpful and ... can make things worse...*" (JT3 service user).

3.5.2 Unintended consequences- Frontline staff

3.5.2.1 Unintended consequences frontline staff- Urgency of access to services

Differences in perceptions about urgency[93] and definitions of crisis[10, 96, 109] can lead to disputes about responsibility between frontline staff from different agencies providing crisis services[10]. When staff are not clear about how different agencies work together to respond urgently, it can result in multiple assessments that are distressing for service users and "*exacerbates the crisis*" (JT1, service user) and delays reaching an intervention[110]. Resource pressures can lead to responsibility for crisis care being pushed to the urgent care pathway, the police and to secondary mental health community teams as one interviewee explained,

> *"I personally I found it more challenging to get someone referred.... So, on duty [in a community mental health team] we pick up a lot more of the work that that might have been done by the home treatment team and underlying that is ... how resources have changed and reduced." (LS2, mental health nurse).*

Staff interviews suggest that single point of access (SPA) where frontline staff triage and refer callers, is a challenging role because it can be difficult to secure appropriate and timely support for callers who often expect more than is on offer (NC2, mental health nurse). A service user interviewee (JT1) was sceptical that SPA improved access and believed that people in crisis are still sent *"from pillar to post*". A lack of confidence that services will be

available is stressful for frontline staff and service users and leads to difficulties in developing trust and therapeutic relationships. When staff are stressed about resources, they fear being overwhelmed and act to protect resources as explained by an interviewee.

> *"And this is to do with resources where people just want to protect their own. So, they're like 'We're not taking that referral because XYZ'. There's always a reason why you can say no to accepting referral."* (LS2- mental health nurse).

Whilst telephone interventions have been prioritised, partly in response the pandemic, to ensure timely access to a mental health assessment, an overreliance on telephone consultations in a crisis may lead to frontline staff being complacent, less responsive to risks because their assessment is less detailed[98] or needs being missed[118]. A lack of face-to-face presence of mental health staff may mean that the police are more likely to rely on the use of emergency sections of the Mental Health Act in order to expedite a mental health assessment[98].

3.5.2.2 Unintended consequences frontline staff - Accessibility of crisis services

A mental health nurse interviewee described an experience in SPA where they were unable to secure any follow-up service after several referrals to follow-up services. Despite each service providing services appropriate to the needs of the caller, the referrals were rejected due to "*resource pressures*" or "*not meeting the service threshold*". This resulted in the SPA nurse providing follow-up interventions, outside their role, to keep the person safe (NC2, mental health nurse). When staff are unable to work within their role, they lack belief that the service has the resources to respond in a timely way[15, 108].

The pressure to dispatch callers to an appropriate follow-up service is compounded by imposed maximum waiting times where clinical priorities can become distorted, staff may aim for hasty assessment and discharge[111] and communication may lack empathy and collaboration[105]. Staff become dissatisfied with their role, believing that they are being forced to work outside personal or professional ideals (NC2, mental health nurse). Staff who are exposed repeatedly to situations where there are system gaps, lose motivation and

experience compassion fatigue[64] and "*avoid contact with mental health calls"* (NC4, paramedic).

An unintended consequence of the time spent on mental health calls by ambulance personnel, particularly in rural areas, is a lack of available ambulances causing delays for other emergencies (NC3- paramedic; LS4- emergency care assistant) and increased resentment between agencies providing mental health crisis care,

> *"I've been stuck on these kind of jobs for three or four hours. The crews get incredibly frustrated with these jobs because...they don't feel it's their role, they don't feel they are adequately trained, and they don't feel they get any support or help." (NC4, paramedic)*

Interviewees (NC2, mental health nurse; NC4, paramedic) described frequent attenders in mental health crisis teams as *"the hardest to deal with for staff"* (NC2) and explained that low support for staff when dealing with frequent attenders led to resentment and ultimately unhelpful attitudes towards service users. Staff perceive frequent visits as unnecessary although the person may be objectively as unwell as other non-frequent attenders[109]. Beliefs about crisis being a single episode[10] perpetuates frontline staff attitudes about those who seek support from service more than once, as a service user interviewee explained,

> *"I felt taken seriously the first time but not the second. Feels that professionals expect that you can deal with it the second time, but the first time is seen as more legit."* (JT1, service user).

Negative staff attitudes experienced by service users in A&E led to people being afraid or unwilling to attend again. This can cause delays in transfer by ambulance staff to follow-up crisis care:

> *"Quite a lot of the patients get quite upset with going to A&E, especially if they have been there before."* (LS5, emergency care assistant).

When people stayed away from A&E during the pandemic, negative attitudes of A&E staff towards people attending in a mental health crisis increased,

> *"...during the lock down... pressure was placed on people [experiencing a mental health crisis] not to go to A&E. [I] have experienced attitudinal changes in from the A&E staff who were quite clear that it meant that the people that didn't come had been time wasters before, rather than necessarily appreciating that what we have seen is a huge deterioration [in] people."* (NC1, mental health nurse)

Ambulance paramedic staff in interviews talked about a lack of clarity about their role in transporting people to crisis services. When a service other than A&E was the most suitable for the person, ambulance personnel were conflicted about whether this constituted an emergency and therefore felt it may not be their role to provide transport to these services. In these situations, ambulance staff were also not always aware of the range of community crisis services available or if they were permitted to refer to these services (NC3, carer/paramedic; NC4, paramedic).

Frontline staff are ambivalent about the use of joint crisis plans (JCPs) as a means to shared decision making, believing them to be another layer of bureaucracy[121, 123] and that service users may not choose the most appropriate intervention fearing that this may adversely impact on staff accountability or contradict best practice. Staff also believed that JCPs may give false hope about the interventions available in a crisis[119, 121]. When staff do not engage with JCPs, service users feel disempowered and the crisis plan is not activated[118, 119, 123]. Organisational cultures centred on professional power over therapeutic relationships[121] and a lack of staff resources create barriers to shared decision making[119]. A crisis service manager explained that when staff fail to engage with crisis planning, crisis care becomes paternalistic and people are more likely to be referred to the urgent care pathway, resulting in a "*cautious or paternal response, ringing ambulances ...*". (LS1, manager).

3.5.3 Unintended Consequences- System

3.5.3.1 Unintended consequences system- Urgency of access

The combined pressure of limited resources and waiting time standards may push staff to focus on meeting the waiting time standard, to comply with policy, over focusing on the individual needs of service users. Practice experts believe that waiting time standards could be linked with increased avoidable admissions, inadequate risk assessment, avoidable

restrictive practices due to rushed assessments[111] and reduced involvement in treatment decisions that service users believe leads to increased likelihood of misinterpretation of their crisis[105].

Complex commissioning boundaries for the different agencies involved, for example between ambulance services, A&E, police, and mental health crisis services can result in delays as explained by paramedic interviewees (NC3, paramedic; LS4, emergency care assistant). A lack of multi-agency agreement about responsibility for transport and systems to support transition between agencies [101] caused disputes between staff [10] resulting in delays for service users.

Co-location of mental health staff in emergency control rooms reported potential for positive outcomes for timely access to mental health assessment and dispatch of appropriate resources[98], however, interviewees explained limitations in adoption of the control room model. Sometimes police personnel had already detained the person before seeking support via the control room.

> *"The reality... it's [control room triage] being used after the event, so the service phone the control room triage to just say, well, 'we've put this person under 136'..."* (KB6, manager).

Ambulance staff noted that the control room triage system may not be sensitive to mental health meaning that without an accompanying serious physical health problem the triage assessment would result in a long wait for an ambulance.

> *"Decisions about who attends are made via triage in the control room. Calls will be graded 1-5, Cat 1s are the most serious. A lot of mental health problems, unless it involves harm or loss of consciousness, would be downgraded to 2, 3 or even 4 but quite low-grade calls."* (NC4, paramedic),

and mental health expertise in control rooms may not be available 24/7:

> *"My understanding is that sometimes you can get put onto a mental health nurse, but not very often and invariably, like sods law, not there when you*

want one. Usually, 3 a.m., and... when you really need somebody, you can't get them" (NC4- paramedic).

3.5.3.2 Unintended consequences system- Accessibility of crisis services

The interface between the array of different agencies providing crisis responses is characterised by variation in definitions of crisis [10]. Crisis was described by a service user when interviewed as *"an ill-defined thing"* (JT2). Differences in how crises are defined could be tolerated within a multi-agency system[107]. Where there is a lack of multi-agency collaboration, agreements about different approaches and boundaries are not reached, leading to fragmentation[2, 10, 95]. Fragmented services result in people failing to secure the support they seek, interventions lack continuity and people having to make frequent contact with services, often via the urgent care pathway. One interviewee explained poor communication from services led to a perception that services were unresponsive:

> *"I think we should be more responsive ... some of that's about resources but some of it is about communication. I feel like these different parts of the service are completely not integrated."* (LS2, mental health nurse).

Fragmentation is compounded by a lack of stability in service availability. In the voluntary sector this is often due to time limited funding, particularly for smaller organisations[10]. Instability in statutory services is caused by resource pressures[95] and is managed by having high thresholds for access. Services are then focused on protecting resources rather than being responsive to need[10]. An ESG member talked about their frustration and feelings of abandonment when a crisis service was able to support them on one occasion but when they contacted the service again, with similar mental health issues, they did not meet the threshold for access[64].

An Accident and Emergency department (A&E) is commonly believed to be unsuitable for people seeking crisis support, yet a lack of responsiveness in statutory services pushes people to the urgent care pathway[95, 108, 110]. A paramedic believed that some people, *"... phone 999 because they know they'll get a response"* (KB2, paramedic). A&E also guaranteed a response[97]:

> *"...that is why often people will go to an emergency department... you are guaranteed to be seen..."* (NC1, mental health nurse).

A&E attendances are believed to be appropriate for people in crisis who have physical health concerns, but this assumes that the person is aware they have a physical health issue, or that the systems in place to assess this identify it[118]. An interviewee was concerned that identifying physical needs in a mental health crisis over the phone, such as via NHS 111, may result in potentially unnecessary referral to the urgent care pathway.

> *"The [telephone responder's] first response is to send an ambulance anyway because they are not confident diagnosing over the phone"* (NC4, paramedic).

Equally, a failure to identify physical health issues may put people at increased risk of missed care.

> *"...diversion away from A&E doesn't necessarily work because lots of people have actually got a medical reason. We've seen lots of people that would have got missed if they've been diverted ..."* (NC1, mental health nurse).

Gatekeeping in the crisis care pathway provides an example of unintended barriers to access perceived by service users[2, 103, 108] and staff.

> *"And I know [gatekeeping] also creates complexity and duplication so I might decide [in A&E], that someone needs an admission. The crisis team still insists on doing another assessment. And we've had situations where, as a consultant nurse, and the consultant psychiatrist say yes [to admission]. A band five [crisis team] could say no."* (NC1- mental health nurse).

Conceptualisation of mental health crises as single events, rather than as a series of points in a recovery process[10], makes the continuity that service users seek difficult to provide[2, 105, 107]. As well as failing to meet expectations for continuity, conceptualising crises as single events may perpetuate negative staff attitudes about those who seek crisis support on more than one occasion[10, 99]. A carer (NC3) explained in an interview; *"A crisis is always there, it's just when it bubbles over"* and a nurse theorised in an interview.

> *"…suicide is a chronic, relapsing condition rather than acute crisis every time. I think there's very few people that have that kind of spontaneous combustion moment where it's the last straw. I guess you do get that, but I think it's rare."* (NC1- mental health nurse).

Fast-track implementation of crisis phone lines in England aimed to provide an alternative to A&E[90]. This was prioritised despite evidence that telephone contact does not meet all crisis needs[10, 15] and telephone access was already offered via NHS and voluntary sector services, creating further complexity. There are also reports of individual experiences of people failing to reach services via telephone calls[102] as an interviewee explained;

> *"In an ideal world, an urgent response would be when you call someone up, they would answer the phone. But that is not the reality. SPA never called me back. It is invalidating and it means I will need the help for longer and longer."* (JT2 service user).

One service manager noted that the regional telephone lines may be a barrier to the continuity of supports that service users want.,

> *"... there is now a regional 24-hour helpline number... What we find is that service users who have rung our service for a long time are not always that keen on ringing somewhere different and prefer our response...it takes time to build up people's confidence in different services."* (LS1- manager)

Digital poverty and poor mobile phone coverage (especially in rural areas) requires freephone systems or local systems to overcome barriers to telephone access[114]. An interviewee described people telephoning NHS999 when seeking crisis support because they had no phone credit, the call was free and known to them[97],

> *"How will people know that those crisis lines are in place? ...people will always default to what they know, which ultimately is going to be 999 or 111".* (NC1- mental health nurse)

3.6 Mechanisms

3.6.1 Mechanisms- Service users

Services that people perceive as providing a guaranteed response[97, 110] *(resource)* for example, urgent care services, engender trust[10, 15, 96, 97, 108], a sense of safety[2, 10, 96] and a belief that the service can help[108] *(response)*. Complex referral routes, delays in responses and failure to secure crisis responses reinforce a sense that crisis care is not guaranteed, driving people to contact urgent care services, despite the likelihood of having to wait. People in crisis and their family have a reduced sense of urgency and can tolerate the discomfort of waiting for an intervention or follow-up[97, 110] *(response)* when information is shared with them about the nature of the follow-up and the timing of interventions[110] *(resource)*. People kept waiting without accurate information may become increasingly desperate for support and contact other services or leave without treatment. People are reassured and have a reduced sense of urgency *(response)* when crisis services that require low effort to navigate and are available 24/7 *(resource)*[2, 10, 15, 97, 98]. Access to crisis services with low financial and social burden by having no cost[97, 101] such as freephone[114] not requiring travel or fee paid transport[10, 98] and with minimum disruption to family life through agreed timing and venue of visits[10, 98, 115] *(resource)* people make contact earlier and choose mental health crisis services rather than urgent care services *(response)*.

The person's (or their family's) perception of the urgency of the crisis is acknowledged[2, 64, 96, 102, 118, 119], and frontline staff acknowledge that the person may have already used their personal resources or that their own resources (such as family) are not available (such as during the night)[95, 118], or perceived as unavailable because they do not wish to be a burden to family members[10, 118] *(resource),* there is mutual understanding, open communication[93, 94, 97, 104], a sense of collaboration[110]and respect[118] *(response)*. Support from family and friends in a crisis may also generate continuity not available in some crisis services. Safe and welcoming community spaces with peer support[2, 10] provide a proxy for family and friends generating a sense of safety and belonging[10]. Consistency, continuity, and relational safety are critical factors for people in crisis[10, 108]*(resource)* giving an increased sense of safety, control and a reduced sense of urgency[116, 118-120] and motivate people to make contact with the service again in future crises[2, 10, 110] *(response).*

When a mutual agreement about the support required is agreed alongside negotiation about the timing of any intervention (shared decision making)[118]*(resource),* there is motivation to engage, relational safety[10] and a reduced sense of urgency[2, 10, 64, 94, 121] and people are less likely to feel patronised *(response).* Shared decision making requires frontline staff to have positive attitudes,[2, 10, 106], mental health knowledge and interpersonal and therapeutic skills[93, 102] *(resource)* so that the person in crisis and their family can have a sense of safety, an ability to communicate their need [10] and trust can be developed[2] *(response)*. When there is trust in frontline staff, a therapeutic alliance is developed where immediate supportive interventions to reduce distress can be provided[95], such as active listening and supportive counselling[10, 93] *(resource),* the crisis experience is validated. The person feels believed, that their concerns have been taken seriously[2, 10, 89, 115], that they have been prioritised[110], they feel respected, and able to engage in their care[123]*(response).*

3.6.2 Mechanisms - frontline staff.

Frontline staff have mental health knowledge appropriate to their role and have knowledge about the role of other agencies[89] through access to training appropriate to the context within which they encounter people in crisis[93, 104, 123] provide immediate interventions to reduce distress[110] *(resource)*. Staff invest in shared decision making[10, 98, 118, 119] and are confident in their role[95] *(response)*. Confident staff are open, flexible and able to take account of the views and experiences of the person in crisis[119, 123] and their family[10, 96] empowering services users in the decision process[123]. They understand the importance of providing explanations to the person and their family, including proactively supporting people as they wait for follow-up[64, 93, 104] *(response)*. Referral, liaison and transitions to follow-up care *(resource)* is achieved through mutual understanding and negotiation between frontline staff[91, 98], the person experiencing a crisis[118, 119, 123] and their family/carer[96], enabling a shared commitment to the decisions made[115, 116]*(response).*

Frontline staff have access to support, supervision[10, 104], consultation about decisions and debriefing[10, 93] that is immediately available to them by phone, face-to-face[104] or video call [115] from peers[10] and leaders[10, 104] *(resource). S*taff are less stressed and have improved emotional wellbeing[10, 104] and staff to believe that seeking advice and support is an accepted norm[10] and creates a working environment with a sense of safety, tolerance, and acceptance between

staff[104] *(response)*. When responsibility is shared in high-risk situations *(resource)*, staff are confident with decision-making, less inhibited by fear of blame[104, 123] and less paternalistic in their attitudes to service users[64] *(response).*

3.6.3 Mechanisms- Systems

Service thresholds and staff resources needed to manage workload[15, 114], and systems to deliver care across complex commissioning boundaries have been planned for, *(resource)* allowing frontline staff to confidently liaise and refer people in crisis in a supportive and timely way[114] *(response).* Morale[104] and motivation enable staff to believe in the service and trust that services are available to respond urgently to referrals[10, 95] *(response).*

There is investment in a shared approach to maintaining up to date information across agencies, that is easily accessible to members of the public[64, 89, 97] and includes all types of crisis service[10, 89, 95]*(resource*). People in crisis, their family and frontline staff can make informed decisions about sources of support appropriate to individual circumstances[108] *(response).*

3.7 IPT1 Pen Portrait-urgent and accessible crisis services

The pen portrait shown in Box 5 provides an illustration of the CIMOs identified in the focused review through a narrative characterisation of a person in crisis. The pen portrait was drafted from the chapter findings and through discussion with the research team. A draft version was discussed with ESG members and edited in light of their feedback. The pen portrait of 'Nimra' did not sufficiently convey a sense of proactive follow-up that the ESG members felt was important in providing a sense of safety. One ESG member also commented that men from minority ethnic groups would not receive the same positive response as the woman described in the pen portrait.

Box 5: Pen portrait IPT1, urgent access to crisis services

Nimra's story

It was midnight[2, 10, 89, 94, 97] and Nimra was feeling frightened and that her mental health was getting so bad she couldn't manage any more. Nimra's mum was really worried[10, 95, 96, 102, 109, 114]. Nimra had received treatment from a mental health service before and had information[88] about getting help urgently. Nimra phoned NHS 111 for advice and was automatically given an option to speak with someone from a mental health service[1, 10, 15, 88, 89, 91, 94, 103, 111, 112]. Although Nimra felt anxious as she waited for someone to answer the phone, she felt it was an easy way to reach help[10, 15, 96]. Nimra's mum was relieved that they didn't have to go out of the house at night to get help[10, 89, 96, 97, 100, 107, 113, 144].

Nimra's call was answered by Jobe, a staff member trained in helping people who are distressed over the phone[122, 127, 129, 131, 135, 136]. Jobe introduced himself and explained what would happen during the call. Jobe listened as Nimra talked about what had happened that day. Jobe asked questions about what was happening to Nimra[97, 101, 127, 136] and about family and friends[92, 93, 96, 103, 109, 117] and how quickly Nimra thought she needed someone to help her[2, 95, 101, 104, 117, 118, 135]. He also asked what Nimra thought would be helpful[105, 122]. Nimra felt able to talk to Jobe who seemed to understand what she was saying, and she believed he wanted to help[10, 109, 116, 121.]

Nimra was still feeling distressed and very tired but unable to sleep. Jobe stayed on the phone with her until they had talked about ways to feel calmer and get some sleep[104, 127, 131, 135, 136.] Nimra was worried about still feeling like this the next day. During the call, Jobe arranged an appointment for the morning guaranteeing that Nimra would see someone[96, 109, 142]. He also provided Nimra with a phone number to call back overnight if needed [93, 98] and the address of a walk-in service[1, 10, 15, 88, 89, 91, 94, 103, 111] open during the day for additional support. He offered to call Nimra back later, but Nimra preferred to try to get some sleep. Jobe also spoke with Nimra's mum who wrote down the appointment and contact details[105, 115, 121, 122]. Nimra felt safer and that she was welcome to call back if needed[2, 10, 15, 95, 96, 107.]

Nimra didn't get much sleep but remembered what she had talked about with Jobe, who she trusted[10, 15, 96, 107] and this helped her to feel able to wait for her appointment in the morning. Nimra looked up the walk-in service on her phone and thought it looked like a place she might like because it has a meeting group for women and a café[10, 128, 130, 153.] Nimra wondered if this service might feel welcoming and homely and be able to help in a similar way to her family and friends[10, 118, 153].

3.8 Chapter conclusions

People experiencing a crisis choose to access services they perceive as providing a guaranteed response, that are easy to navigate to, and fit with their definition of the crisis. Whilst the timing of responses remains unclear in relation to outcomes, what is clear is that people feel safer and have a reduced sense of urgency when they trust services. Trust is established through compassionate interactions and proactive management of transitions and waiting. Involvement of the person and their family, or support network in decisions supports a sense of trust and relational safety which may help meet a need for continuity for some.

In order to sustain compassion, frontline staff need access to support for themselves as well as resources to deliver crisis care that meets their personal and professional ideals. Training in the knowledge, skills and values required for compassion can build confidence in frontline staff in all agencies. System leaders must provide resources and communicate an expectation for compassionate engagement so that it becomes the norm for staff to seek support.

Mental health crisis care is provided by a complex array of agencies, each with different definitions of crises, different values about the nature of interventions and different approaches to prioritisation. This is further complicated by multiple overlapping service boundaries. What is apparent is that these differences can only be accommodated within an interagency system where information and decisions are shared from commissioning through to frontline delivery. Conceptualisations of crises as single events or as the sole responsibility of statutory secondary mental health systems are unhelpful and generate fragmentation leading to gaps and delays for those seeking crisis care and frustration for leaders and frontline staff. Access to services for those known and new to services need to be planned for to avoid over emphasis on one over the other.

3.8.1 If-Then Programme theory: urgent and accessible crisis services

IF: Commissioning focuses on maximising access and delivering seamless transition between agencies. Waiting time standards are linked to interventions and desired outcomes. There is information sharing and shared decision making. There are agreements about prioritisation and service thresholds that minimise gaps and delays. Systems to assess urgency (e.g. triage) are agreed between agencies and are evidence-based. The person's (or their family's) perception of urgency is considered. Gatekeeping and referral systems operate to facilitate ease of access. Evidence-based technology and telehealth are used to enhance access and provide support during any waiting. Transition and transportation between agencies are managed proactively and waiting is actively managed. Access to an intervention appropriate to need is guaranteed. Resources enable time for therapeutic engagement, collaboration, support, and learning.

THEN

Frontline staff are confident and trust leaders and agencies in the crisis care system. Staff are confident that there are resources available and, in their ability to provide a response linked

to need. Staff are confident and skilled in using decision aids and technology. Training is appropriate to staff role. There is immediate access to support for decision making from peers and leaders. There is a culture of support rather than blame. Staff are proactive in providing information, supporting people as they wait and facilitating transitions. Staff engage with systems of planning and shared decision making. Compassion is prioritised and fatigue prevented.

Service users and their family or support network believe that a crisis response is guaranteed. People in crisis believe that they have been believed and prioritised. They invest in relationships with agencies and their staff. They feel safe and supported to wait. People reach an intervention. There is low financial, social, and emotional burden when accessing crisis care.

LEADING TO

People attending urgent care services when it is the right service for their needs, such as when they have physical health concerns during a crisis. Ease of access and guaranteed responses in crisis care reduce the need for people to attend A&E. There is a reduction in repeat attendances. People contact crisis services sooner reducing the likelihood of restrictive care. People experience faster access to support that reduces their distress. Staff are supported and have skills appropriate to delivering compassionate crisis care. There is improved experience of crisis services and relationships between communities and services.

4 Focused review IPT2: Care in a crisis is compassionate and therapeutic

4.1 Introduction

This chapter examines the second of the three IPTs: compassionate and therapeutic care identified from the initial scoping searches outlined in Chapter 2 :

> *IF services provide compassionate and therapeutic care that is non-judgemental, dignified, and safe by well supported staff with requisite skills and knowledge THEN there is trust, people feel listened to and taken seriously LEADING TO reduced distress and duration of distress, engagement in services that are delivered by compassionate staff.*

The chapter first describes the characteristics of compassionate and therapeutic care including interventions and intervention components identified in the literature to enhance its development and delivery. The evidence base for compassionate and therapeutic care, the outcomes of compassionate and therapeutic care, and the unintended consequences when key components are not in place or are not effective are described. Next, the chapter describes the mechanisms for compassionate and therapeutic care, demonstrating how it may be facilitated at different points within mental health community crisis care. A narrative drawn from the literature is supported by contributions from the expert stakeholder group discussions and interviews. The chapter concludes with an overview of how compassionate and therapeutic care can enhance mental health crisis care, using the 'if then leading to' convention.

4.2 Context: compassionate and therapeutic care

At the individual level, compassion can be understood as being open to others' suffering, being impacted emotionally and sometimes cognitively, and acting or feeling motivated to help[124]. Compassionate organisations operate person-centred cultures, which prioritise structures and systems, in which high levels of distress can be contained, managed, and alleviated, facilitating compassionate care[125]. Compassionate organisations value employees and allocate ample resources to supporting and developing the workforce, thereby building a compassionate organisational culture[126].

The consensus of the ESG was 'compassionate care comes from the top', organisational leaders being the 'brain' of services, and front-line staff mirroring the organisational values.

"Trusts need to look after their staff, they're the best asset they've got" [64]

Nevertheless, the ESG agreed that although most organisations identified as compassionate and would say they were committed to compassionate leadership and compassionate care, the salient question was whether the care was truly compassionate. 'Organisational commitment and leadership' and 'psychologically safe models of care' were seen as core issues for activating compassionate and therapeutic care and were used as a lens through which to explain compassionate and therapeutic care and the review scope was refined to only include documents focus on these aspects of compassionate care. A list of contextually important intervention strategies of IPT2 were identified from the included documents and confirmed through discussion between the research team and the expert stakeholder group (ESG), listed in Table 6.

Table 6: Contextually important intervention strategies facilitating compassionate leadership of crisis services

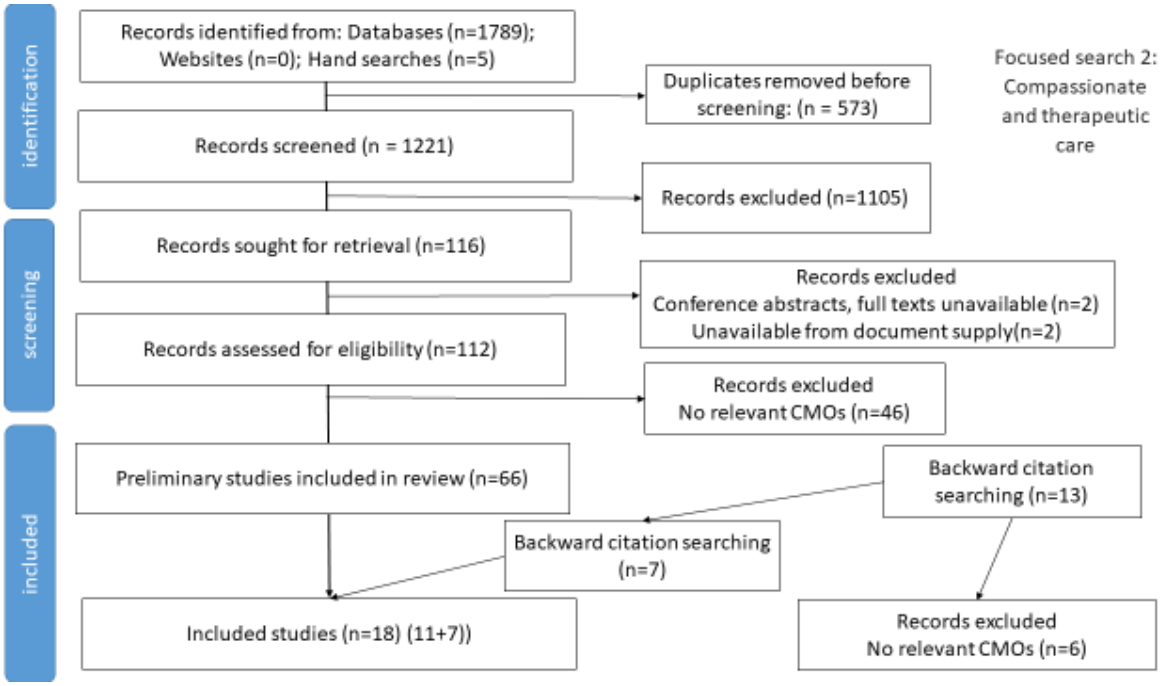
Contextually important intervention strategies
Organisations and leadership [118, 125-129]
Psychologically safe models of care [10, 130-133]
Individualised care [118, 129]
Therapeutic relationships [129, 131]
Safe environments [132]
Safety planning [129]
Support for family and friends [10]
Peer support [132]
Team working [125, 126, 131]
Education and training [128, 129, 131]

4.3 The evidence base

Sixty-six records were identified as part of the preliminary theory component 'compassionate and therapeutic care' (n=54 from academic literature; n=7 grey literature (websites and reports); n=5 from handsearching), and after exclusions on the grounds of irrelevance to theory, 11 were retained. Backward citation searching of these 11 identified a further 13, of

which five were not relevant and seven were included. In total, 18 study records were retained. Figure 7 illustrates the identification of new studies for this review.

Figure 7:Search results focused review IPT2 compassionate leadership



4.3.1 Retained records

Details of the 18 retained records for the compassionate and therapeutic care focused review are detailed in Appendix 4.

4.3.2 Settings

Research settings reported in included documents were: all healthcare[127, 134-136]; adult social care[137]; the NHS in England[138]; hospitals[131, 132]; primary care[139]; community mental health services[118, 125, 126, 129, 133, 140]; the ambulance service[128]; and the voluntary sector[10, 130].

4.3.3 Focus

The included documents investigated lived experiences of crisis[130, 137]; fostering compassionate care through Schwartz rounds[125]; culture of care[127]; crisis planning[118]; care quality[128, 138, 139]; care planning and co-ordination[118, 129]; compassion[126, 134-136], impact of waiting[132], risk management[133], therapeutic relationships[131] and team functioning[140].

4.3.4 Appraisal of relevance and rigour

All included documents were appraised for relevance and richness using a modified realist appraisal tool[72] (Supplementary Materials 3). Documents containing primary research data were also appraised for rigour using the mixed methods appraisal tool (MMAT)[73] (Supplementary Materials 3). The combined appraisal of relevance and rigour identified that the evidence supporting IPT 2 compassionate and therapeutic care is based on studies of mixed quality.

Three records had high relevance, in that they were highly matched to the theory and provided a rich description of mechanisms and context[10, 126, 133]. A high-quality mixed method study of the voluntary sector contribution to crisis services was methodologically rigorous[10]. A qualitative study provided rich accounts of lived experience from a small sample that was limited by a lack of ethnic diversity[133]. The expert report was strongly linked to theory related to practice but reported no method[126].

Most documents were moderately framed to the theory, reporting different but related phenomena, and containing multiple relevant areas of interest[125, 127-129, 134, 136, 138-140]. Of these, four were mixed- or multi-method studies[127, 129, 136, 138] reporting rigorous methods, but limited by; low response to a survey[129]; the narrow focus of the research setting[127, 138]; a stated limitation of the interpretive nature of the study risking biases from the research team[138]; and a lack of detail in the stated method and approach to sampling[136]. A realist evaluation[125] provided rich data related to mechanism but had limitations in linking these and any reported outcomes specifically to Schwartz rounds within a complex clinical setting. Two qualitative studies provided in-depth rich data limited by small samples that lacked variation[139, 140] and data that were over five years old[140].

There were four relevant articles in which the pertinent context, mechanisms and outcomes were less substantial[118, 130-132]; and a further two less substantially framed documents were retained on the basis of their contribution to understanding risk [137] and leadership[135]. Of these, a meta synthesis lacked a focus on community settings[131], two qualitative studies provided in-depth rich data from small samples[118, 130]. The remaining documents were expert reports with no stated methods[132, 135, 137].

4.4 Outcomes

Much of the included documents were highly theoretical in their treatment of effectiveness and the relationships between the contexts, mechanisms and reported outcomes. There appeared to be little in the literature to support the identification of outcomes of compassionate organisations and leadership, linked with psychologically safe crisis care.

4.4.1 Service user, staff, and system outcomes

Where organisations prioritise reducing coercive practices described as "*measures such as compulsory admission, restraint and forced medication"* people in crisis are supported to keep themselves safe, and risk reduces[133] (p94),. Frontline workers feel valued, engaged, respected, less isolated, and less exposed when they are fully supported by their organisation[125, 139]. When frontline workers feel supported, staff groups are more stable and staff turnover is reduced[126]. Hence, compassionate treatment, of both people in crisis and front-line staff, produces better service user and organisational outcomes. Furthermore, in interviews, frontline staff provided insights into how favourable outcomes may depend on how individual staff respond.

> *"Compassionate response is completely dependent on the individual officer. Looking back on my own behaviour I used to be quite by the book. I wouldn't consider and reflect and alter my behaviour at the time; but I don't recognise myself even looking back 5 years. I've changed so much and that's moving from a response officer to a community behaviour, it really brought about a sea change..."* (KB1, Police Officer)

And the wellbeing of the staff has an impact on how able they are to provide compassionate responses.

> *"My personal mental health experience shapes how I deal with people. I notice how much patience I have depends on how tired I am, how hungry I am, whether I've had a break..."* (KB2, Paramedic).

Other times, the behaviour of the person and the escalating nature of some crises make staying compassionate difficult for staff and rely on staff members personal resources and resilience.

> *"Some people will be deliberately antagonistic and aggressive – people shouting screaming and swearing, trying to push me out of the room. They are going to be threatened with police involvement, they are going to get a very different response than those sitting quietly. Even if aggression is a result of distress I don't want to be hit!"* (KB2, Paramedic).

4.5 Unintended consequences

The reality of mental health crisis care was not perceived by many stakeholders to be compassionate and psychologically safe. This reflects literature suggesting that service deficiencies may currently affect help seeking behaviour[10], for example, leaving emergency departments before treatment[132]. Other concerns around services include increased use of the Mental Health Act, particularly among black, Asian, and minority ethnic groups[10]; the use of restrictive interventions[132]; more incidents of self-harm[131] and the potential of negative experiences of crisis care to increase trauma and suicide risk[130, 133].

4.5.1 Unintended consequences, Service users

The crisis care experienced by some people in crisis appears in many ways to lack compassion, being experienced as humiliating, invasive, and traumatising, and in some instances reminiscent of previous abuse[133]. Service users have reported being domineered by frontline workers[118]. They describe feeling dehumanised and losing trust[130]. Loss of trust in services and workers may impact self-confidence, abilities, activities, and thoughts and lead to isolation and anxiety[130]. Inadequate responses and rejection from services has been reported to lead to increasingly desperate people[10].

> *"If they ever offered me any support at all I might have trust in them [crisis services]"* (JT2, Service user).

NHS services such as crisis resolution teams working to the national model may not be able to offer continuity. A service user interviewee (JT1) reported that the lack of continuity was

distressing and prevented them from establishing rapport with workers, and this point was further explained by a mental health nurse (LS6),

> *"A criticism we get is consistency of staff when people come to the CRHT they see different nurses each time. It is really hard for them to connect with people. We try to allocate the same worker to the same service user if we can. But with holidays and breaks in shifts it's really hard to do. They are having to tell the same story. However, much we document things, they feel we ask the same questions, and, in many ways, we are, we ask about risk and medication"* (LS6, Mental health nurse).

A lack of investment in suitable safe spaces for people in a mental health crisis[130] is a challenge for the delivery of compassionate and therapeutic care. Service users may have no choice other than to attend the emergency department, where care and assessment may not routinely be trauma-informed[132].

> *"I have to be in a very bad place to present at A&E. I find it triggers me there. It is not a helpful place to be".* (JT2, Service user)

> *"If someone is stressed, anxious and suffering, to put them in a stressed and anxious environment is not going to help".* (LS6, Mental health nurse).

4.5.2 Unintended consequences, Frontline Staff

Poor leadership at the level of middle management has been identified as detrimental to delivering compassionate care[129]. Compassionate and therapeutic care delivery can be challenged by continuous tension between meeting the day-to-day demands of working in healthcare, developing and supporting teams, and embedding structures and policies[140]. Organisational policies may not support the workforce to make decisions[138]. Lines of accountability can be unclear within multi-disciplinary mental health teams, it may be less apparent who is in charge; or unhelpful power dynamics may undermine operational and clinical decisions[140], with resulting poor communications and disengagement. One interviewee explained,

> *"It is hard to know whose opinion is the top one…so that can cause tensions"* (LS1, Operational manager).

Workload pressures on clinical team leaders may limit their availability to team members[136]. This may be particularly noticeable when things go wrong, as identified by one interviewee,

> *"Everyone's a bit unsure where to go when there have been incidents"* (LS7, psychiatrist).

Inherent conflicts within the leadership role may paralyse the decision making of clinical team leaders. This can lead to a tendency to resist innovation and constructive criticism, label staff who raise concerns as disruptive or complainers, and resort to blaming any service problems either on external circumstances, or on frontline staff, thus absolving themselves of responsibility[135]. In response to these tensions, clinical leaders may also display power and superiority[140] and engage in bullying in order to drive change [134]. Ultimately, these processes may diminish the capacity of a clinical team to deliver compassionate care[134, 140].

4.5.2.1 Staff morale

Clinical leadership approaches may impose solutions that create resentment and resistance at the frontline[140]. In working environments where there is a lack of autonomy, exposure to severe health problems, limited social support, and opportunities for constructive feedback, workplace stress is common[135]. Frontline workers can also feel frustrated and powerless to enact change, resulting in low motivation and morale and consequent disengagement from their teams and from the goals of their organisation[138, 139].

> *"I don't necessarily feel well supported or trusting of more senior [colleagues]. I'd like to feel like I can trust managers a bit more"* (LS2, Mental health nurse)

Disengagement of staff from their employing organisations goals can be linked to high levels of staff turnover[126], resulting in staff shortages, heavy workloads, and unclear priorities[135, 138]. These pressures are compounded by increasing level of need and complexity in UK mental healthcare[129] and the fact that in healthcare when there are workforce gaps, the work still

needs to be done. Interviewees expressed feelings of frustration around the gap between what they felt was needed and what they were able to deliver:

> *"NHS services stretch and stretch to meet impossible demands until the whole system fails"* (NC2, Mental health nurse).

> *"It's leading more towards you know not helping people and not supporting people as much as I'd like to"* (LS2, Mental health nurse).

Frontline staff who attempt to speak up risk being vilified by clinical leaders and might learn not to complain, leading to the failure to escalate concerns[136]. Some frontline workers learn helplessness or focus exclusively on keeping immediate line managers happy for survival and advancement[136]. Some emulate bad role models leading to undesirable behaviours[135].

Quite early in their career, front line workers may become traumatised by the emotional demands of the job, which can limit their personal resources for compassion[134]. They may deal with unresolved emotional burden by distancing themselves from work and colleagues[134]. An interviewee explained:

> *"How we maintain standards is to disconnect [emotionally] so that you can maintain that standard of care"* (LS4, ambulance care assistant).

4.5.2.2 Management of risk

In some areas, systemic failings are driving skills deficits at the frontline[138], especially if there are limited opportunities for professional development[129]. A lack of therapeutic skills and the inability to provide interventions may result in an excessive focus on the mitigation of risk[129] and the prioritisation of medicines and short term, physical safety[133]. If frontline workers fear making the wrong decision and being blamed for the consequences of that decision[137], anxiety may drive behaviours in individuals and teams that are not conducive to providing high quality compassionate care[126]. In the crisis context, a lack of confidence may paralyse decision making[128]. The effect may be that decisions around risk assessments do not involve the people directly affected by the risk[137]:

> *"We have adopted a more litigious approach to society… so for anything neglectful or for omissions there is a high degree of fear in organisations. It*

makes the formal relationship between the organisation and the service user cautious and risk averse." (LS3, Emergency medical technician).

Frontline workers may justify taking coercive actions in challenging situations, on grounds of risk[128, 131]. Concern about paramedics taking people to hospital by force following self-harm, irrespective of motives or severity, has been highlighted in light of the known likelihood that such action can escalate risk, particularly following self-harm[128]. An interviewee reflected on the value of interpersonal skills for risk management:

"Understanding, rapport and de-escalation are soft skills that are important but aren't taught or given the time to be appreciated or reflected on in busy working environments" (LS7, psychiatrist).

Coercive practices undermine the development of trusting relationships[133]. The lack of a trusting relationship may generate fear in staff around risk and decision making[137], increasing levels of coercion. Frontline workers may also respond to risk with complacency e.g., "*He's not going to do it because he's never done it yet*" (NC3, Carer). Alternatively, they may engage in 'positive risk taking'.

"Positive risk taking can be kind of a little bit of a buzzword that we use when we're talking about, you know, justifying why we're not responding to something" (LS2, Mental health nurse).

4.5.3 Unintended consequences, Systems

There is potential for tensions between financial and performance management agendas, and the delivery of compassionate and psychologically safe crisis care[138] , since the systems for regulation, inspection, and commissioning across the healthcare system may directly undermine compassion in organisations[136]. The issue appears to relate to health quality improvement strategies that involve comparative indicators and external audits. It has been observed that evaluation strategies are underpinned by an assumption that public sector organisations cannot be trusted to manage performance, leading to an imposition of standardised quality assurance approaches across organisations[125]. Furthermore, strategies to drive out bad practice based on what can be measured and regulated, may actually restrict the ability of staff to meet service user need[125, 134].

> *"Sometimes you feel like you are governed by performance reporting and the things the commissioners want. You would hope that is about service user outcomes but sometimes it feels like it does restrict you as opposed to free you ...."* (LS1, Operational manager)

The current institutional and regulatory environment requires public sector healthcare organisations to achieve targets, measures, and standards, to seek financial incentives, and to report compliance to multiple overlapping authorities. The obligation to supply metrics in different formats to multiple external organisations is costly and distracting and may lead to fragmented knowledge, competing and ambiguous priorities, diffusion of responsibility, and a lack of innovation[138]. Some service user priorities such as compassion and psychological safety are difficult to measure[125, 136], and may not be reflected in outcomes data that focuses on quantifiable aspects of care. This suggests that there may be better ways to approach service evaluation.

> *"What we are not doing is using the data intelligently to improve outcomes."* (KB4, Researcher)

Voluntary sector systems have been described as relatively compassionate and humane compared with the public sector[10], though similar organisational dynamics appear to be affecting their potential for delivery of compassionate care. Numerous and diverse funding arrangements and relationships between the public and voluntary sectors are contingent on complex factors such as organisational ethos, mission, and strategic objectives[10, 130].

A key informant study in this review[10] investigated the contribution of voluntary sector organisations to mental health crisis care and highlighted the complexity of commissioning decisions concerning voluntary sector mental health crisis care, particularly in the context of austerity and cuts to services. The authors concluded that the quality of services in the voluntary sector can be inhibited, similarly to the public sector, when commissioners operate a business model[10]; however, in other ways, business models can be beneficial to voluntary organisations.

> *"There are large ones [voluntary sector organisations] that are now run like businesses and well off, others that are local and grass roots and struggle" (*KB4, Researcher).

Prioritising finance and performance management over people appears to lead to a lack of investment in peer support services and in physically and psychologically safe and calm alternatives to admission e.g., crisis houses, safe spaces and walk-in services[10], and safe, short-term options for people who are intoxicated or distressed[132, 133].

An NHS England report[136] identified a risk that organisational leaders feed reports and metrics to system leaders without any genuine oversight and interpretation of the data, thereby reducing the potential for outcomes data to inform better service delivery. For example, the interpersonal and relational aspects of care may be less visible (and hence lower priority) to organisational leaders because they are not readily captured, measured, and reported[139].

> *"I don't think there's much connection between sort of ground level staff and the directorate anymore."* (LS2, Mental health nurse).

Therefore, arguably, if primacy is given to achieving financial objectives and to rationalisation, the main unintended consequence of prioritising measurable organisational 'business' outcomes, is that healthcare delivery may become unduly performance and task orientated[125, 127]. Employees may be required to operate as units of production[126] with little regard for the relational or compassionate aspects of care[125]. The Royal College of Psychiatry has argued that hierarchical organisational structures may be unhelpful, especially if the organisation is not clinically led[126]. In an interview, a psychiatrist conveyed the frustrations of having to work with the system:

> *"Your MDT time, your team meetings, governance meetings, those are important. If you don't get the support, it can't happen. They just look at numbers and go you reached that target"* (LS7, psychiatrist).

Managers are equally likely to be frustrated by performance target cultures, as explained by one interviewee:

"There are things you might want to do more work on but…it doesn't fit your current performance target" (LS1, operational manager).

An extensive comparative mixed methods study of mental health teams across six NHS sites in England and Wales[129] found a discernable gap between national policy aspirations for recovery-focused mental health care, and practice. The authors raised concerns about a lack of vision among leadership teams and the impact on front line services as a consequence of budget cuts, under-resourcing and bureaucracy[129]. They highlighted a need to ensure that organisational aims and operations were consistent with supporting staff and service users[129]. The ESG discussions identified that organisational priorities determined *"how well staff are looked after"* and *"how well staff know what is expected of them",* i.e., were focused on staff rather than service users[64].

Although the systems, processes, practices, and disciplines within organisations are reported to determine the boundaries of action; when the organisational structure is fragmented, or a product of isolated decisions and workarounds, there is potential for toxic cultures and unhelpful norms to emerge[136]. Increasing demands create conditions for defensive and reactive responses from organisational leaders, leading to quality improvement efforts that may not use robust methods, or findings that are not subject to scrutiny. There may be 'magical thinking'[138] and indiscriminate use of particular approaches. One interviewee described investing time in a quality improvement project only for ideas to be *"rubbished"* (LS2, mental health nurse) by organisational leaders, providing an example of how a perceived lack of support risks discouraging frontline workers from engagement in quality improvement initiatives.

4.6 Mechanisms

4.6.1 Mechanisms- Service users

Service users have the opportunity to form supportive trusting relationships[130], to retain control[118], and for safety to be balanced with independence in a collaborative way[133, 137]. A consistent and stable staff group enables early signs of deterioration to be noticed and service users trust the opinion of frontline workers who raise concerns[133] *(resource)*. Trust in frontline workers provides a sense of belonging to service users in crisis[130]; frontline workers provide consistency and service users feel that frontline staff are interested in the psychosocial

context of their distress and prioritise emotional safety, healing, and relationships[133]; service users are not turned away if they identify that they need help[137]; treatments are individually tailored[118]; there is freedom, control, and privacy and service users can engage in meaningful social and occupational activities and maintain social roles and relationships that are important to their well-being during a mental health crisis *(response).*

4.6.2 Mechanisms- Staff

4.6.2.1 Frontline workers

Frontline workers emulate and practice prosocial behaviours and skills role modelled by clinical leaders [134]. Teams interact, take lunch breaks and there is an opportunity to be social[135] *(resource).* Employees are connected to their humanity, the goals of the organisation, and their core purpose[136]. There are shared values, openness[126] and mutual trust[140]. Professional and personal values are aligned, and the staff feel more satisfied at work[139]. There are good relationships at all levels and there is active engagement with organisational and clinical leaders[138] *(response).*

> *"It's really important part of my professional practice to work alongside people in their own care*" (LS2, Mental health nurse)

There is communication and teamwork[131]. Speaking to colleagues about difficult encounters prompts feedback and discussion[135]. Good relationships with peers are important to be able to be able to reflect in real time and after events. There are valued support structures such as supervision, debriefing, reflective practice[131], and communities of practice[139] *(resource)*.

The provision of formal clinical supervision with "*someone senior who has more experience than you*" safeguards against the "*echo chamber you get with peers*" (LS7, psychiatrist). In these circumstances, frontline staff feel empowered to act[140], they engage in ongoing problem solving[126], they challenge bullying and blaming [126] and frontline workers speak up if the behaviour of leaders falls below expectations[136](*response*). Frontline workers are compassionate, able to tolerate distress, and are empathetic and non-judgemental[125, 126].

> *"We are a very reflective station, some of the stations there is no reflective practice, they are quite burnt out. They just take people to hospital. There is no reflection or thought."* (LS5, Ambulance care assistant).

Frontline workers are motivated to care rather than coerce or be rule bound[126] *(response).* There is recognition of the key role played by relationships and the potential for coercive measures to be re-traumatising[133]. There is trust and recognition of the central role of power, choice and control in the development of and recovery from mental distress[133, 137]. Decisions about risk are made with the people directly affected by the risk and the tension between ensuring safety and enabling rights is managed by understanding and negotiating[137]. Frontline workers understand accountability, implement clear and predictable boundaries, which maintain safety[131], and deploy *"the least restrictive intervention*" (LS7, psychiatrist). Anxieties about risk are managed through clear organisational structures and procedures and working collaboratively[131] *(resource).* There is greater tolerance of risk, and respect for individual freedoms [137], particularly following self-harm[131]. Frontline workers are recognised, rewarded, and thanked for remaining compassionate in difficult and pressurised times[135] *(response).*

> *"We take risks in collaboration with service users and carers. We try to work out risks they are comfortable with and support them with that."* (LS6, Mental health nurse).

4.6.2.2 Clinical Leaders/middle managers

A culture of care in which staff and service users are regarded compassionately is achieved when there are shared values and objectives between leaders at all levels and the frontline[138]. Clinical leaders promote 'healing environments'[135] in which there is affiliation within teams and between teams [126, 127], and frontline workers are supported, treated humanely [125], and respected[140]. The Royal College of Psychiatrists in their report on the importance of compassionate care[126] stress the benefits of flat workforce structures in which clinical leaders are visible, accessible, and compassionate. There is a culture of being *'at service'*[135]. The role of the operational manager is to buffer external demands and to make the work of frontline workers easier[126] to enable them to care:

> *"Leadership is massively important and visible…That's for me integral. The quality of a good leader is someone people go to when things get hard. You would like to go to a leader to debrief and have that trusting relationship"* (LS7, psychiatrist).

Education may include listening, legal frameworks, mentalising, reflection, humanities, ethics, awareness of unconscious processes, and how to address the barriers to compassion[126]. Education *"should involve everyone from support workers to consultants"* (LS7, psychiatrist). *(Resource)*

> *"First and foremost, education, increases confidence"'* (LS3, Emergency medical technician).

Compassionate leaders implement balanced governance, which carefully facilitates support and accountability[138]. Leaders ensure that roles and expectations are clear[131] and they hold front line workers to account for values and performance[136]. Practicing senior clinicians provide the clinical direction[126]. Clinical leaders may role model prosocial behaviours and skills to frontline workers[134]. Clinical leaders foster growth and make time for staff development[129, 131, 139]*(response).*

4.6.3 Mechanisms- Systems

4.6.3.1 Organisational leaders

Organisational leaders create the conditions for compassionate care and set the tone[138]. There is a strong focus in compassionate organisations on supporting a culture that benefits service users and in addressing system problems[138]. Compassionate organisations have a clearly articulated vision, which maps on to a realistic number of goals for quality and safety and an achievable strategy[138]. They are transparent about their philosophy e.g. of recovery and personalisation[129] and they communicate *"what's going on"* (LS2, Mental health nurse) *(resource).* A culture of reflective practice is embedded in the organisation and reflective practice is considered fundamental, not only for clinicians but also for those in leadership roles[139] *(response).*

For example, compassion is central to recruitment and selection processes [126]. Values, standards, and behaviours are incorporated into job adverts, job descriptions, job plans, appraisals, complaints, and compliment forms *(resource)*. Governance is carefully balanced for delivering accountability and support[138]. There are clear structures, procedures, and standards to support employees to respond to risk[133, 137] *(response).*

Performance management aims to motivate and align values with the values of the organisation and strategies include creating opportunities for professional networking, sharing knowledge, reflection, team development, and developing peer negotiated standards[139]. Clear evidence based guidelines offer decision-making support and ensure that employees can be held accountable[126]. However, governance arrangements are sufficiently flexible to avoid institutional responses to risk, *(resource)* ensuring decisions can be made on an individual basis by frontline workers in collaboration with service users[137] *(response).*

There is status and recognition for those who provide compassionate care, especially in pressured circumstances[126, 135]. Compassionate organisations openly acknowledge human resource limitations[126] *(resource).* Compassionate organisational leaders do their utmost to ensure there are resources to meet unpredictable demands e.g. the staffing levels and skill mix are adequate[138]. Compassionate organisational leaders reduce the burden of administrative tasks as much as possible to enable front line workers to care[126]. They promote affiliation across institutional boundaries and a culture of care in which staff and service users are regarded compassionately[126, 127] *(response).*

Intelligence is generated using a range of methods and organisations are not reliant on mandated measures[138]. Quality improvement uses robust methods, the findings are monitored and critically evaluated, avoiding the potential for indiscriminate use of particular approaches, and magical thinking[138]. An executive and a non-executive director may be elected to take a special interest in compassion, with 'critical friends' e.g., nonexecutive directors, governors, or PALS staff invited to undertake formal observations of the care and staff support, reporting directly back to the board[135]. Other recommendations in the literature include using mystery shoppers, shadowing peers, and swapping roles for a short period[138] *(resource).* These approaches may enable problems to be identified early and for staff who are compassionate to be identified and recognised[135]. Service user and staff feedback is heard, even when the content is uncomfortable or challenging[126, 136, 138] *(response).*

4.6.3.2 System leaders

Compassionate leadership is required across arm's length bodies, assurance, and oversight bodies[136]. Compassionate commissioning, regulation, and inspection can reinforce

compassion in organisations. System leaders have a duty of care and must not collude with distorted objectives[136]. There is a need to recognise the tension between efficiency and mass production and the importance of the interpersonal and relational aspects of care[139] *(resource).* Compassionate system leaders offer governance that balances control and support, which is demonstrable in policy and across regulatory systems, and ultimately improves the experiences of service users[138] *(response)*. A member of the ESG said: *"Quality needs to be more than a tick box" [64].*

Compassionate system leaders drive investment in services, which are valued by service users, such as those that provide physically and psychologically safe and calm alternatives to admission to hospital *(response)*. Examples in the literature include crisis houses, peer support, safe spaces, walk-in services[10, 133] and women-only environments[133] *(resource).*NHS clinicians who interact with non-clinical services generally view them favourably. However, there may be stringent access criteria compared to the NHS. An interviewee (JT3, service user) described experiencing a crisis house as being very person centred, inspiring trust. However, were other interviewees who believed that that staff from voluntary organisations may be "*over involved"* and sometimes have unrealistic expectations about what can be done (NC2, Mental health nurse).

> *"My impression is that you go there [voluntary sector services] and they haven't got a checklist of things they need to do for somebody. They don't ask much of people"* (LS6, Mental health nurse).

Co-production *(resource)* ensures the aspirations of service users are encapsulated in the delivery, monitoring, and evaluation of services across the system[137] *(response)*. Co-creating services with the benefit of systemic, relational and experiential knowledge is reported to drive quality[139]. However, an interviewee cautioned that there could be a tension if the service users involved in co-producing services do not have contemporary experiences of using services (LS1, Manager). There may be a need for active recruitment of service users to this role and enhanced remuneration. There also seems to be a need for more service user consultation at this level. An interviewee perceived that people might be *"unwilling to talk to services"* but would be *"more likely to feedback to outside organisations"*, (JT3, service user).

"If the community services are commissioned and work like they should the numbers [attending the emergency department] should be reduced" (LS7, psychiatrist).

4.7 IPT 2 Pen Portrait- Compassionate and therapeutic crisis services

Whilst ESG members endorsed the central importance of compassion, some stakeholders found it challenging to engage with pen portrait IPT2, compassionate and therapeutic care, especially in relation to how compassionate organisations and leaders might forge compassionate and psychologically safe crisis care at an individual level.

Box 6:Pen portrait IPT2 compassionate leadership

Maxine's story

Maxine's GP and alcohol worker wanted her to go into hospital. A community mental health nurse arrived at Maxine's house to do an initial assessment. The nurse talked to Maxine about why people were concerned and asked what she thought[122, 127, 129, 131, 135, 136]. Maxine did not want to go into hospital. The nurse recognised that going to the hospital might be traumatic for Maxine because of her history but was worried about Maxine's safety[10, 122, 129, 131]. Maxine and the nurse considered the options together[115, 121, 122]. Maxine's partner did not think the hospital was right for Maxine either. Maxine, her partner who lives at the address, and the nurse negotiated an individual plan[115, 117, 118] so that Maxine could remain at home safely[10, 89, 96, 97, 100, 107, 113, 144]. Maxine and the nurse knew each other well and there was mutual trust[10, 97, 100, 118]. Maxine knew that the nurse would be open and honest with her and that if her mental health deteriorated, she could pick up the phone and would not be turned away[93, 98, 109, 116, 120, 142.]

The nurse went back to the office and communicated the assessment to the team. The nurse felt anxious about the decision to support Maxine at home because the GP had been so concerned, that they had initially wanted to call the police. The GP was insistent that Maxine was unable to keep herself safe[15, 92, 93, 97, 103]. The nurse trusted their colleagues and felt able to voice their concerns in the office[10, 97, 100, 103, 122]. Although the nurse's colleagues said they would have reached the same conclusion based on the assessment, they all agreed it would be valuable to take the discussion to the team reflective practice session as there were some specific issues, which they thought would be helpful to reflect on as a wider team[134, 136, 138].

The next day the alcohol worker called the office to complain about the decision to support Maxine at home. The team manager listened to the concerns flagged by the alcohol worker and wondered how they might work more collaboratively[127, 134, 136, 138.] The team manager spoke to the nurse to see if they could offer any support. The nurse knew the team manager respected him and felt comfortable in voicing their distress. In the past, the nurse had been well supported at work by the team manager[133, 123, 138].

The nurse asked the team manager if they could do a joint visit and as a practicing senior clinician, the team manager was pleased to accompany the nurse to see Maxine later that day. The nurse called Maxine to let her know that he would be visiting with the team manager in the afternoon. The nurse asked Maxine if she would like him to do a joint visit with her alcohol worker later in the week[127, 132, 133, 136, 138].

4.8 Conclusions

Some of the evidence included in this chapter presents a dichotomous view of a system, which either prioritises finance and performance management or compassionate and psychologically safe crisis care. The reality appears to be more of a mixed picture.

It is apparent from this part of the evidence synthesis that the conditions for compassionate and psychologically safe crisis care must be created by compassionate leaders. Compassion shown to frontline staff by leaders, leads to compassionate care. A tension between exerting control and providing support was evident at all levels. As integrated care systems are introduced, there is an aspiration that strategic partnerships will reduce competing priorities, which appear debilitating to organisations. Alongside these strategic partnerships, there is a need for coherent local strategies for compassionate and psychologically safe crisis care, cognisant of the fact that high quality care can co-exist alongside the worst examples of care in the same organisation[127]. Strategies should include how compassionate and psychologically safe crisis care is provided to people who may be currently excluded from a range of crisis services, such as people who use alcohol or drugs and people who self-harm.

4.8.1 If-then Programme theory

IF

System leaders streamline expectations and operate governance, which balances oversight and assurance with support. They engage in coproduction, which is actively resourced. System leaders recognise the value in services in which performance data is less readily captured e.g., crisis houses and peer support. They use diverse data to monitor services, and inform decision- making, and trust organisational leaders to deliver high quality services. There is investment in compassionate and psychologically safe services that service users value.

THEN

Organisational leaders have a clear vision, philosophy, and values that map onto a realistic organisational strategy. There is transparency. There is affiliation across institutional boundaries and a culture of care in which staff and service users are regarded compassionately. There is status given to compassionate people. There is a culture of addressing system problems. Intelligence is generated using a range of methods and organisations are not reliant on mandated measures. Quality improvement uses robust methods. Compassion is central to recruitment. There is a compassionate workforce strategy and contingency to meet unpredictable needs. There is governance, which balances

accountability and support, and facilitates decision making at the front line. There is evidence-based decision support. Reflection is embedded throughout the organisation. There is staff and service user engagement, and willingness to hear uncomfortable feedback. Performance management is focused on motivating and aligning values.

Clinical leaders/middle managers share values and objectives with organisational leaders and seek to align the values of frontline workers. There are flat workforce structures and practicing clinical leaders who role model prosocial behaviours, and skills. There is a culture of being at service and of making the work of frontline clinicians easier. Clinical leaders foster growth and make time for reflective practice and staff development. There is affiliation across institutional boundaries and a culture of care in which staff and service users are regarded compassionately. Clinical leaders/middle managers implement balanced governance, which carefully facilitates support and accountability. Clinical leaders aim to motivate rather than control, but they ensure that roles and expectations are clear. They hold front line workers to account for values and performance. There is open and honest communication and clinical leaders support decision making at the frontline.

Frontline workers are connected to the goals of their organisation and their core purpose. There are shared values and there is valued reflective practice and opportunities for development. Staff groups are more stable, turnover may be reduced and there is more time. There is open communication, relationships, and trust, and frontline workers confidently engage with the leadership team, each other, and service users. Frontline workers practice prosocial behaviours and are motivated to care rather than rule bound. Frontline workers are empowered to speak up and to act. There is the capacity to tolerate personal discomfort. Frontline workers prioritise relationships seek to understand, negotiate, and offer choice. Frontline workers trust service users and are compassionate.

LEADING TO

Trust that facilitates belonging. Emotional safety and healing are prioritised, and decisions are made collaboratively. Social roles and relationships are prioritised, and safety is balanced against independence. Freedom, control, and privacy are maintained. Treatment and support are personalised. People in crisis are not turned away.

5 Focused review IPT3: Community crisis agencies work together

5.1 Introduction

This chapter examines the third of the three IPTs: Community crisis agencies working together identified from the initial scoping searches outlined in chapter 2:

> *IF there is effective seamless interagency working, THEN there is trust, a sense of connectedness, ownership and affiliation prompting systemic understanding of the crisis care system LEADING TO improved shared decision making and communication without repeated assessment or delay.*

Interagency working occurs when multiple agencies contrive to work jointly to deliver crisis care. The term 'multi-agency' occurs frequently in the literature, and is often used synonymously[65], but for this study it was decided that the term 'interagency' was preferable as it conveys a stronger sense of agencies working closely together, rather than in parallel and will be used from this point forward.

The interagency programme theory differs from the others as it was considered of low priority by the ESG members. Following discussion between the ESG and the research team on the basis of their prior knowledge of the interagency nature of crisis responses, the IPT focused on interagency working was retained. Indeed, the review findings highlight the extent to which sharing knowledge and practices between agencies supports all aspects of adult community crisis care.

The chapter first describes the characteristics of interagency working including interventions and intervention components identified in the literature to enhance interagency crisis care. The evidence base for interagency working in crisis care, the outcomes of interagency care, and the unintended consequences when key components are not in place, or are not effective, are described. Next, the chapter describes the mechanisms for interagency crisis care, demonstrating how it may be facilitated at different points within mental health community crisis care. A narrative drawn from the literature is supported by contributions from the expert stakeholder group discussions and interviews. The chapter concludes with

an overview of how interagency working can enhance mental health crisis care, using the 'if then leading to' convention.

5.2 Context: interagency working

The context of interagency working in mental health crisis care is a complex one[65, 81]. The nature of mental health crisis means that agencies from statutory sectors within and outside the health sector are involved, including commonly the police[141] but also Emergency departments[142], the NHS 111 telephone or online advice service[143] or paramedic[142]. Non-statutory services such as voluntary organisations are also frequently involved[10].

> *"…you want this independence from the stat[utory] sector because you want to be able to pick up the people who aren't going to turn up or whose behaviour might be a risk, so in an ecosystem you want all of this range- and some of these were people in an urgent state"* (KB4, Academic).

Agencies responding to people experiencing mental health crises require links across the whole system. These links are subject to temporal changes as services are commissioned and decommissioned and relationships between staff develop or diminish[10]. Interagency working operates at a range of levels from joint decision making with limited shared resources through to more complex and fully integrated systems[81]. There is no single model of integrated care; what matters is that the integration is primarily designed and coordinated around the needs of individuals rather than to serve the needs of organisations[144].

Interagency working is seen as a way to coordinate complex systems of care and was initiated across England in the context of mental health crises by the Crisis Care Concordat[27, 28]. It is currently implemented at area commissioning level, enabling community crisis services to be designed to meet local population need[30, 92]. More recently, interagency crisis care has been described in four categories: i) Community based crisis services; ii) Blue light services; iii) Liaison mental health services; and iv) Age-specific services[89]. Organisations employ many strategies to deal with the inherent complexities of crisis care systems, ultimately commissioning of interagency crisis care must support the principles of intervention being "*everyone's job*" and there being "*no wrong door*"[145] (p. 10). Contextually important

intervention strategies of interagency working that support community crisis services delivery were identified and are shown in see Table 7.

Table 7:Contextually important intervention strategies for interagency crisis services

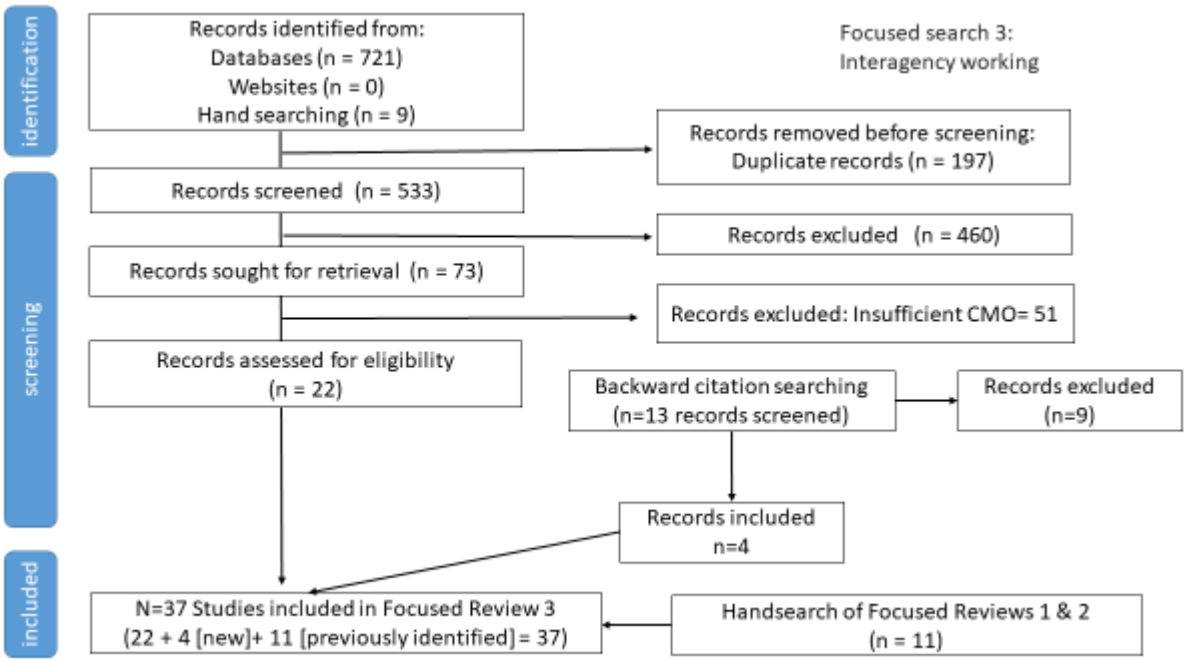
Contextually important intervention strategies
Co-location, co-response and parallel assessment[10, 28, 30, 81, 98, 101, 141, 142, 145-152]
Interagency meetings[10, 27, 28, 89, 98, 144, 153]
Joint training, job shadowing and networking[10, 15, 27, 30, 98, 147, 149, 150, 153, 154]
Role clarity and role allocation[98, 118, 131, 132, 134, 138, 140, 149, 153]
Care co-ordination, system navigators[138, 144, 147, 153]

5.3 The evidence base

For the theory component 'interagency working', 721 new records were identified from electronic database searches and 9 from iterative handsearching. Of these, 22 were retained. A further 4 were retained from a backward citation search of the 22 new included documents.

In view of the emerging insight into the core relevance of interagency working, the results of focused review searches 1 (Urgent access) and 2 (Compassionate and therapeutic) were iteratively hand searched, generating an additional 11 included records for this review (Interagency working). Six of these 11 records are appraised in Chapter 3: Urgent and accessible crisis services (Section 3.3)[2, 15, 94, 101, 106, 118]. The remaining five are appraised in Chapter 4: Compassionate and therapeutic crisis services, (Section 4.3)[55, 131, 132, 134, 140]. In total, n=26 new records and n=11 previously identified records were retained. Figure 8 illustrates the identification of studies for this review.

Figure 8: Search results focused review IPT3 interagency crisis services



5.3.1 Retained new records: Interagency working

Details of the 26 new retained records for the interagency working focused review are in Appendix 4.

5.3.2 Settings

Research settings reported in the retained new records (n=26) were: interagency crisis services[27, 28, 30, 89, 155]; specific interagency collaborations including between police and mental health services[81, 98, 141, 146, 148, 150-152] and with paramedics[142], voluntary sector services[10, 156], integrated mental health services[147, 157], integrated health services[144, 149, 153, 154], commissioning health services[145, 158], crisis mental health services[143].

5.3.3 Focus

The retained records reported on models of integrated service design[81, 98, 144, 151-153, 156, 157]; policy guidance[27, 28, 30, 145] , good practice guidelines[89, 147, 154, 155]; service user experiences[146] voluntary sector contribution[10], staff experiences[149, 150], decision making[148], commissioning[158], interagency self-harm interventions[142], and NHS access to urgent crisis help[143].

5.3.4 Appraisal of relevance and rigour

All included documents were appraised for relevance and richness using a modified realist appraisal tool[72] (Supplementary Materials 3). For this review, records were scrutinised for relevance to interagency working in mental health crisis services. Documents containing primary research data were also appraised for rigour using the mixed methods appraisal tool (MMAT)[73] (Supplementary Materials 3). The combined appraisal of relevance and rigour identified that the evidence supporting IPT 3 interagency working is based on studies of mixed quality.

Two documents were highly matched to the theory component by providing rich description of context, mechanism and outcome and were key documents focusing on voluntary sector crisis services[10] and interagency crisis care between police and health services[98]. Both studies reported rigorous mixed method studies limited only by being at the level of description[10] and reporting inconsistencies in analysis related to limitations in clinical data recording[98].

One mixed method study evaluated the impact of implementation of the crisis care concordat and was rich in context and outcome, providing moderate relevance to the theory component, though limited by evaluating data from 12 months of implementation[28]. Two further mixed method studies were less substantially relevant to the theory component, providing mostly context[148, 153]. An included survey provided less substantial relevance and was limited by a small sample size[149].

Included qualitative studies provided rich description of context integrated of police and health services with some reference to outcomes but very little mechanism and were moderately framed to the theory[150, 152]. Both studies were limited by a lack of lived experience perspective[150, 152] and in one study by describing a model of interagency crisis care not available in the UK[152]. A further qualitative study was less substantially relevant to the theory, providing mostly context with limited mechanism or outcome. This study reported a very small sample with resulting lack of variation[146]. Two literature reviews; a scoping review[81] and meta-synthesis[142] were less substantially relevant, providing only context.

Expert reports containing rich description of context and mechanism were moderately framed to the theory[89, 144, 147]. Expert reports less substantially relevant were limited to

providing interagency context[141, 151, 154, 156-158]. Included policy documents were moderately framed when they contained specific context related to interagency crisis services[27, 30] and were less substantially relevant when they were limited to local context[155] or had a wider context than mental health[145]. Expert reports and policy documents were not appraised for rigour as they reported limited or no information on method.

5.4 Outcomes

5.4.1 Interagency working- Service user outcomes

As there are numerous agencies that can become involved in trying to provide support for a person experiencing mental health crisis, it is inevitable that they will not all have staff with expert mental health knowledge and experience. One of the benefits of interagency working is providing a range of expert input to meet different health needs[147]. What is important to those accessing services is co-ordination, people are often less aware of how services integrate unless a failure to integrate results in discontinuity[154]. People seek a "*single trusted point of liaison*"[154] (no pagination). An interviewee explained that continuity depends on the availability of a *"key contact"* responsible for planning and relaying information (JT1, service user).

A focus on joining up statutory health services with non-health services (such as housing) and non-statutory organisations such as the voluntary sector are a stated priority although a lack of outcomes data makes assessing the extent to which current interagency working achieves this difficult[10, 145]. From a practice services delivery perspective, improvements in street triage models have prioritised development of systems to foster interagency links as explained by an interviewee:

> *"…so, they've got a vulnerable person's hub…with links to safeguarding and to local authority and our emergency duty team…"* (KB6, manager).

Interagency systems that include providing more user focused interventions, show promise in improving outcomes related to the experience of people in crisis by providing interventions including shared decision making peer support, befriending and advocacy[10, 89, 155]. Good practice documents suggest that co-produced crisis care is an aspiration that requires interagency working[89].

In-depth qualitative analysis of service user narratives identified that interagency working between police and mental health staff in a street triage model provided more immediate access to specialist support in a setting suited to the person's circumstances but also minimised unnecessary and potentially traumatic retelling[146] and care was experienced as more dignified, less restrictive and less disruptive to the lives of the person and their family when staff were working within defined roles and across integrated agencies[152].

Service users want frontline staff to have two key areas of knowledge[154]. Firstly, they want staff to know about them as individuals and secondly, they want staff to know how to help and from where help can be reached[154]. To achieve this, staff require knowledge about different parts of the interagency system, there needs to be information sharing, and meaningful communication between staff in different agencies.

An interviewee explained how having meaningful communication is helpful,

> *". Sometimes it does help as you can mainline the supervisor and we are [usually] very strict on chain of command…. but having that relationship, you can bypass that and go straight to the person you know"* (KB1, Police Officer).

Activities that facilitate interpersonal contact between staff in different agencies, such as through job shadowing, joint training and cross agency meetings[145] have been linked to improvements in knowledge about different agencies, information sharing and interagency communication[10, 145, 148]. This can improve immediate referral of people in crisis to the most appropriate service through a more streamlined process with fewer 'closed doors' and ultimately greater satisfaction with crisis support for service user[147]. Improved communication and information sharing between police and mental health services facilitated improved care planning that helped to reduce re-presentations in services and had reduced the use of police time[148, 150].

People in crisis view co-location and co-response models favourably although this was not necessarily related to the agencies being based at the same location[98] An interviewee stated that being co-located in "*neutral spaces*" produced better outcomes (KB6, manager). Service users focused more on joined up and seamless receipt of care that met their individual's

needs[145]. Interagency working can provide a stability in the delivery of crisis care that can lead to better outcomes, this has been emphasised in policy as especially important for people presenting with multi-morbidities or complex needs such as substance use and mental ill health[145]. The findings from a national evaluation of integrated care found that after service integration, service users had received their care plans more frequently and that their care was better co-ordinated[153].

5.4.2 Interagency working-Staff outcomes

In a national evaluation of integrated care, staff reported taking on greater responsibility within their role that made their job more interesting. They did however identify a need for additional training to support integrated working[153]. Importantly, frontline staff rated service integration to have improved patient care for 53% of respondents and only 1.1% believed that care had got worse[153].

Joint training can, most obviously, lead to a better knowledge of the services that make up the complex network of crisis services in a locality and how that network operates[10, 150]. Frontline staff who have knowledge of available services are better able to help service users to navigate more smoothly to the most appropriate services[147]. Joint training can improve relationships between staff in different agencies leading to improved information sharing[98] through a mutual understanding of different roles and by providing an avenue for exploring different values within an interagency system[10]. Successfully integrated care relies on the attitudes of the staff within the system and the relationships between them[150]. These relationships alongside interagency leadership are more important to successful interagency working than the structural aspects of the system[147].

Joint training programmes enhanced knowledge of options available to police officers resulting in deceases in detentions using Section 136 of the UK Mental Health Act[98]. The design and content of joint training is less clear but established interagency fora at managerial and frontline service delivery levels provide a platform for co-design of training[27, 30].

Job shadowing, where staff from one agency shadow staff from another, that they will be frequently in contact with, is promoted by some multi agency system[98]. Interpersonal contact between staff in different agencies can lead to a more streamlined processes and ultimately

greater user satisfaction with crisis support. When services are more streamlined, there is the potential for reduced service costs as inappropriate referrals cost resources and cause distress [153].

Police having immediate access to expert mental health advice by telephone was shown in a local service evaluation to be highly valued by police in helping them respond in challenging situations such as where the person has self-harmed or suicidal[148]. Evaluation findings concluded that access to telephone advice in this way improved decisions and co-ordination of multiagency responses especially during the night, and reduced police time spent attending the call[148].

5.4.3 Interagency working- System outcomes

The Crisis Care Concordat (CCC)[27, 30] identified continuity of care as important factor in producing desired outcomes in crisis care, yet this has been identified as difficult to provide in a system that conceptualises crises as single events[10]. The CCC[27] also set targets to reduce costly and distressing out-of-area placements. This has been achieved through interagency collaboration and when successful, enabled diversion of funding from reduced costs to improvements in community crisis interventions[157]. A reduction in the use of Section 136 of the Mental Health Act[27, 150] has been observed through implementation of street triage (an interagency response between police and mental health) by up to 32%[146].Other beneficial outcomes included reduced transportation to places of safety by ambulance and police services[101] and reduced attendances at Emergency Departments[98, 146].

Health and social care services form a complex system, as the commissioning and contracting out of health services that has been the dominant model, this has led to a range of providers delivering services[158] each with different organisational boundaries. A police force area might cover several NHS Trust areas, whereas a small voluntary organisation service might only serve one town within this area. Thus, in any given region of the UK, there will be a network of specialist and non-specialist agencies that respond to people experiencing mental health crisis across different sectors[10]. Sometimes only one agency can respond to the crisis (a first response) but it is more likely that an immediate referral will be made to another agency (a second response)[152].

Specified first and second responder roles were highlighted in an Australian interagency model as important to improve the outcomes related to transition between services within an interagency system[152]. The terms 'first' and 'second' responder are not usually associated with crisis mental health service design in UK settings as explained by an interviewee.

> *"This is where it gets quite complicated if you use the term first responders, it's actually a program [of volunteers] in the ambulance sector. The ambulance and police would normally say first on scene. I think this is where language is really important, because yeah, they do mean different things. I guess they just need to be clear because if they're calling themselves first responders, they could be mistaken for volunteers."* (NC1, Mental health nurse).

Despite the potential for confusion, the term 'first response' is beginning to appear in more recent UK descriptions of good practice in interagency crisis care models[151, 157] , e.g., *"Receives a first response in the community"*[89].

The voluntary sector can have a unique role as main provider in supporting communities especially for those who report longstanding poor relationships or low expectations of statutory services[10, 64, 106], for example, the Health and Wellbeing Alliance is a voluntary organisation that supports communities that experience health inequalities[156].

> *"This is key – there's a normative assumption that integration with public services is helpful but some people have had contact with public services e.g., afro Caribbean men and they don't have a lot of truck with them so organisations supporting them might want to keep their independence, people who've been multiply sectioned."* (KB4, Academic).

A typology of voluntary sector services providing mental health crisis care shows that co-location or jointly commissioned service models between voluntary sector and statutory services have provided a platform for interagency working[10]. Co-location models have been linked with more efficient use of resources in police and ambulance/paramedic contexts by enabling faster transfer of care to an appropriate service, following an immediately accessible, expert, mental health assessment. 'Downtime' for police or 'time taken for call'

for ambulance paramedics is reduced and cost efficiency improved[98, 101]. Joint response services between police and mental health have been found to be most effective when covering a smaller area with a dense population compared, with the greater reach of mental health support via the emergency control room[98, 150].

Mental health staff located with police resulted in reduced the need to transport people to A&E, places of safety or use Section 136 MHA[98]. A UK local service evaluation of a pilot mental health ambulance car reported that the proportion of people transported to A&E had reduced by one third with associated cost savings suggested[101].

Multi-agency forums were highlighted by the Crisis Care Concordat as beneficial to mental health crisis services[30], and the importance of multi-agency leadership and co-ordination has been endorsed as key to positive outcomes in crisis care[10, 15, 64, 108, 154].As recommended by the Crisis Care Concordat[27, 30] a single point of access service (SPA) can enhance effective interagency working. SPA is an arrangement whereby all services provided by multiple agencies are channelled through one referral process, and may be accessed simply, for example by phoning a single telephone number. The effectiveness of a SPA relies on people with knowledge of the whole system, who can connect or reconnect people to the best service to meet their needs. Although there is a paucity of published evidence on the efficacy of SPA interventions, there is some tentative evidence that staff acting as navigators for a person experiencing a crisis improved the knowledge of providers and helped staff feel more confident when co-ordinating crisis responses[157].

Staff's systemic understanding of the remit of different services was improved through well maintained 'warm networks' facilitated by job shadowing, focused induction programmes for staff that include different agencies and inter-team meetings[98] An ESG member described the link between these warm networks and what they termed '*warm handovers'*, where good interpersonal relationships encourage frontline staff to invest in information sharing between agencies[64].

For interagency working to succeed, there is a need to focus on improving team working both "*within and between organisations*"[153] (p. 5). The degree of engagement between staff across agencies is a predictor of organisational performance[147]. Co-ordination of interagency

working is considered most important where there is complexity and/ or urgent need and can improve outcomes in healthcare generally[144] and has been shown to have positive impacts in crisis services[28]. Co-ordination is also identified as important to how service users experience services[154].

In terms of distal outcomes and future policy aspirations, interagency collaboration is a pre-requisite for co-produced crisis services as it provides a platform for all voices to be heard[89, 154]. Interagency approaches facilitate quality improvement approaches that are instigated from commissioning through to delivery and evaluation have the best chance of enabling co-production[89].

Whilst there is no single model of integrated care, leaders should focus on removing barriers and adopting change models that are not overly prescriptive about how integration is achieve[144]. The greatest impact on individual outcomes is likely to be achieved when integration is focused on meeting the needs of people where co-ordination is at its weakest [144] such as in crisis services. Whilst integration can improve the process of care, it is not guaranteed to reduce costs[153]. Success of interagency systems rely on having goals that form part of a shared vision led through engagement that empowers all partners[157].

5.5 Unintended consequences

5.5.1 Interagency working - Unintended consequences Service user

In response to the many ways in which mental health crises manifest, there are a range of different agencies that can be called upon to respond[89]. The responder depends partly on the location and circumstance of the person in crisis, whether they or their family actively seek help, and from whom. Staff working within this network of different agencies might not have a 'systemic understanding' of the network they are part of, particularly where there is high staff turnover and frequent service reconfiguration[10].

For many people and their families, this system complexity might mean not knowing how and where to seek help and impact on the chances of them being directed to the most appropriate place for their situation. It might also result in people having continually to repeat traumatic details to different people, adding to their already acute distress[146]. System navigators are needed to pull together integrated care[147] and in the context of crisis care, this function may

not be best provided by existing systems of care coordination, particularly for those new to services.

An interviewee explained that a crisis care system that is provided by multiple agencies should improve outcomes, but the benefits are not realised unless the system operates in an integrated way:

> *"…you would think that the model that is in place at this moment in time is much better and it's actually not. It's too detached and I think that's always been the problem…when I interviewed all of the service users [interagency working] …was the one thing that they all said was useful"* (KB6 manager)

Added to this complexity are differences in the route into crisis care linked to ethnicity and cultural beliefs[106]. A failure to accommodate this variation in routes to crisis care can result in people being delayed in reaching services and more distressed at first contact. This delay contributes to increased likelihood of hospitalisation, detention and restrictive interventions[106]. Interagency collaboration is needed to ensure that the aspiration for 'no wrong door' is a reality for minority groups who are more likely to be marginalised by mainstream services [10]. Interviewees explained that some cultural groups access services via different routes and have different beliefs about seeking help that can act as a barrier,

> *"In the south Asian community, people are less likely to contact the police or mental health. Some cultures naturally don't involve the authorities and the same with mental health."* (KB1, Police officer).

> *"A good example is the Imams and community leaders take the place of social workers and decision makers, they resolve domestic and criminal matters…the number of things that are brushed under the carpet…not just in Asian but in non-indigenous white communities."* (KB1, Police Officer).

> *"BAME groups are less likely to come to A&E or any service really and that's to do with different systemic factors, structural inequalities, racism, suspicion of services seen as for the white majority, not seen as culturally sensitive, different beliefs about health and health care and a more close-*

knit family environment which tends to manage crises at home rather than access outside help" (KB5, Psychiatrist).

A lack of integration results in fragmented services that may result in 'responsibility cordons' with gaps in support resulting in service users being ill informed, distressed, and potentially at risk[10, 138]. Services users place high importance on continuity, if this is lacking during a mental health crisis, the stress people experience is increased[118]. An interviewee (JT1, service user) reported that when they ask for things, they are commonly told it is somebody else's job. This is a phenomenon described by a participant in a mixed method study of the voluntary sector contribution to crisis care as services playing "*responsibility tennis*"[10] (p.85).

Integration does not always produce positive outcomes, service users reported that after integration, they found it harder to see a nurse of their choice, were listened to less frequently and felt less involved in their care[153]. Furthermore, these disadvantages were most evident for people who were considered at highest risk[153] such as people experiencing a mental health crisis.

5.5.2 Interagency working- Unintended consequences Staff

5.5.2.1 Staff identity and role clarity

Barriers to interagency working relate to the beliefs of staff in different agencies about their role in mental health crisis care, for example, a review of street triage reported that some police officers are critical of mental health systems believing that dealing with mental health crises is outside the police service remit and they are called upon to fill gaps in services[151]. In a study of paramedic responses to people who self-harm, one respondent described being criticised by other paramedics when they took time to talk with the person; they believed that this was the job of a social worker[142]. Police reported a lack of clarity about roles for themselves and staff from other crisis response agencies. The impact of this was a reduced ability to make decisions about risk and delays for the person[149]. The organisational culture in these examples appears to suggest that mental health care is on the periphery, rather than central to their role[142] although blue light services routinely come into contact with people in crisis[89]. This can result in these staff being conflicted in their role when attending mental health calls. The culture of their organisation and their profession appears to drive this conflict and as a result can act as a barrier to optimal mental health crisis care.

> *"The service users I talked to said that the police …are really lovely, really caring really kind when they were with them in A& E, or when they were talking to them on a bridge, [and] in the car having a chat. But they weren't nice when they were in the police cells."* (KB6, Manager).

Although co-location models have provided a platform for collaborative working between blue light services[98], the voluntary sector[10] and statutory mental health services, this approach may not universally supported by the staff within these agencies. The ESG members[64] and some staff are reported, in a study of the voluntary sector, to believe that the unique value and independence of the different agencies risks being lost if organisations become too closely aligned with statutory services[10]. Joint training may provide a forum for articulating differences between values and perceptions by:

> *"…offering a radical critique of public sector services, which may not be well received by the public sector and may challenge the development of collaborative relationships, inadvertently fuelling unhelpful stereotypes."*[10](p.90).

However, training framed as 'joint', but which lacks a sense of collaboration can cause frustration; an interviewee explained that they had volunteered for a workshop with the police but found it:

> *"…so disappointing, it was joint ambulance-police and was dealing with absconded patients, which is now an ambulance service job. [But] instead of being a workshop, a police officer that said, 'we're not doing this [dealing with absconded patients] anymore' and that was that. No practical useful work. We get no info and have to go [back to the ambulance team] with no other information. Incredibly difficult."* (KB2, Paramedic).

Furthermore, if the training has no mechanism for sharing the learning with others across agencies, then the knowledge is embodied in one individual who is not always available:

> *"…they don't always cascade the knowledge down, so you end up with silos of knowledge and experience and then they are off sick or leave…"* (KB1, Police Officer).

5.5.2.2 *Co-ordination across agencies*

A lack of interagency working leads to mistrust and suspicion, resulting in reduced collaboration or cooperation between staff groups[151] and an overly dismissive approach to referrals from some agencies[64]. Differences in the approach to onward referral between NHS and voluntary organisations have been described as the subtle but important differences between signposting, where the person and their family have to coordinate and navigate to the service, and referral, where access is facilitated by services[10]. A limitation of co-response models from the perspective of police was an inability to coordinate attendance between agencies, often due to poor systems of communication[149].

When resources are not co-ordinated or properly resourced, partner agencies have difficulty knowing how to respond[149]. Slow responses, or high thresholds for access from crisis teams, often due to resource pressures, are perceived by police as system failings and can breed resentment, a barrier to interagency collaboration[149]. Difficulties sharing information were attributed to IT systems not being integrated, as one interviewee explained:

> *"The inoperability of the IT systems was a complete nightmare, data sharing and all that…"* (KB6, manager).

5.5.2.3 *The effect of staff burnout*

Frontline workers may not trust service users[134], each other[140] or clinical and organisational leaders, and may also resist interagency working. A lack of interagency working can leave individual frontline staff feeling that they are powerless and unable to help, and they commonly become frustrated[132], demonstrating negative attitudes, anxiety and avoidance[131]. High staff caseloads in crisis care can have a profound impact on staff morale and their ability to work collaboratively within an interagency system[147]. If there is an absence of support, there is a strong risk staff will become cynical[136, 159] and they may engage in conflict[138]. A lack of support generates defensiveness, weak communication, and poor teamwork[140] within agencies, making interagency working less likely.

5.5.3 Unintended consequences: System

5.5.3.1 Commissioning and evaluating interagency systems

A search of the Crisis Care Concordat webpages, originally used as a repository of good practice in crisis care across England, revealed that data were last updated in 2016 and the quality of the data held there was inconsistent[30]. As this website has also been a communication hub for national coordination of crisis care in England, there is currently little evidence of ongoing national coordination, and it remains unclear how interagency crisis care has been coordinated in the other nations of the UK. Whilst policy has stipulated interagency systems are required in crisis care, and some have been established, there is a sense that implementation has been inconsistent[144].

Regionally devolved responsibility for interagency crisis care has contributed to large variations in the system of agencies involved in delivering crisis services and how these agencies operate together[157]. These differences may be accounted for, at least in part, by commissioning responses to local population need or geographic differences but meaningful evaluation of what is working is as a result very complex. A failure to design and commission services to meet the needs of local populations taking account of the geography can create barriers to collaboration between staff[150], as one interviewee explained:

> *"…it's so big the geographical area is … nobody's bought into it 'cause nobody benefits from it, you know? I absolutely understand why they think …strategically; 'put the investment into one big centre'… so it works for them [police] because they only have one control room triage, that's fine. Don't work for us [working across] three mental health providers that go over [the whole geography]"* (KB6, manager).

NHS regulation focuses on individual organisational performance rather than across the system [144], making evaluation of interagency working lower priority and potentially producing fragmented data. An absence of joint commissioning that reaches beyond crisis care services risks gaps and delays for people needing more than one agency to respond[147]. Poor co-ordination of interagency services results in people becoming lost in the system where their care is delayed or duplicated, the quality-of-care declines and the service is less cost effective[144].

Devolved commissioning and contracting out of health services can lead to the dual and often competing aims of cutting costs and responding to local need[158]. These commissioning processes often mean that the configuration of service availability frequently changes and, as a result of contract changes, the (often related) appearance and disappearance of providers[10].

5.5.3.2 Impact of interagency systems on service delivery

A failure to include all relevant agencies in the interagency system can contribute to delays and disputes about responsibility[10]. This can be especially difficult when the excluded agency has a statutory responsibility, such as for transporting people in crisis. If ambulance teams are excluded from interagency agreements about transportation[101, 160] and this is coupled with a failure to acknowledge the important contribution that ambulance staff make beyond transportation, ambulance staff believe they are treated like a taxi service[142] breeding resentment and resulting in responsibility disputes[10, 149].

The specialisation of teams can lead to staff becoming protective of their service creating barriers to interagency collaboration. This can result in polarisation of agencies in the system generating systemic inflexibility that prevents access and transition through the system[161]. Polarised services within the system can create service silos that are unable to meet all the needs of people in crisis because they are not able to operate beyond the boundary of their own service something that has been noted is a particular challenge for people with more complex needs[161].

Having guarantees about crisis care was identified as a mechanism in IPT 1 important in how people make decisions about where and from whom to access help in a crisis[97]. Inconsistencies in these guarantees such as for an agreed care plan, a named care coordinator and telehealth have been identified as an artefact of policy variations rather than an issue about spending[144] and may therefore have the greatest negative impact on those with complex needs requiring responses from multiple agencies. A further organisational issue is that amongst these multiple agencies there are not always coterminous operational boundaries and this can lead to one agency having to network with several others performing the same role, depending on the precise location and needs of the person requiring support[150].

Co-location models highlight tensions between providing services that are adequately resourced across 24/7 and having periods of wasteful inactivity that can lead to staff being re-deployed to other parts of the service, rendering them unavailable for crises that occur after re-deployment[98]. Findings show that co-response models result in efficiencies for the non-mental health service (police, A&E, ambulance) although there are significant methodological limitations in these health economic calculations[98, 101]. There is, however, a lack of data related to the impact on cost and resources in mental health services as part of co-response models and doubts have been expressed whether simply placing professionals together in the same location is enough to ensure collaborative service delivery[147]. An interviewee described these problems:

> *"I'm not a fan of nurses in police cars. The only reason being is you're always in the wrong place. So …you can only have one nurse ever on at a time. the problem[is] if you say you've got a nurse in a car that will respond to every mental health incident, you haven't! Because you've only got one nurse here… you just can't deliver that as a consistent service. And that's the problem. You will always have police officers and that go, 'well I rang and [the nurse] weren't there'. And then [they] just stopped believing in it and stop, engaging in it 'cause it didn't work for them*" (KB6, manager).

5.6 Mechanisms

5.6.1 Mechanisms- Service-users

When people recognise crisis services as being relevant for them *(response)* by having been developed with involvement from their community[106] *(resource)*, people have a sense of connectedness to the service[2, 10] *(response).* Interagency working that is planned and delivered with involvement with those who access services *(resource)* generates mutual trust and shared ownership [89, 147]*(response)*. Interagency services that demonstrate culturally sensitive values[106] by being staffed by people that represent the diversity within the community they serve; having had training to improve cultural awareness; and using language and communication that avoids stigma and racial stereotyping[89, 106]*(resource);* promote a sense of belonging and shared values which in turn lead to reduced fear or shame about accessing the service [118]*(response).* When people are less afraid (or stigmatised), they take an

active role in their own recovery[2, 10], engendering a sense of ownership and pride that enables them to take an active role in their community, for example through volunteering or providing peer support, and challenging negative attitudes [10, 64]*(response)*.

When an interagency system of crisis services provides user focused interventions including peer support, befriending, advocacy and less clinical services such as those delivered in the voluntary sector*(resource),* then people in crisis recognise service as being 'for them' providing a sense of safety that fosters engagement [10, 89, 145, 155]*(response*). Within a complex interagency system when individuals are provided with a "single trusted point of liaison"[154] (no pagination) *(resource)*, they feel confident to navigate the system and are able to build trust that provides the sense of continuity and relational safety that people seek[10, 147] *(response).*

5.6.2 Mechanisms- staff

When staff have attended training suited to their specific role in providing support in a mental health crisis, staff have increased knowledge, improved skills, increased confidence in providing crisis care and there is more interpersonal contact between the person and staff member *(resource).* This can lead to practice that is less risk-averse and restrictive[98, 147].The person in crisis is more likely to feel supported and trust the service to keep them safe by providing care that people value, staff are happier and have more confidence in their crisis response *(response)*.

Clarity about how the pieces of the system fit together help to reduce concerns about, for example, a perceived shift from a more psychosocial focus to a bio-medical and risk focused approach[15] *(resource).* Role clarity, coupled with system knowledge, within interagency services *(resource)* supports staff to hold a more balanced perspective between legitimate concerns about the nature and timing of responses and an informed acceptance that the spectrum of care is available across the system. This enables frontline staff to understand where their role fits allowing each part of the system to "*play to its strengths*" *(response)*[10] (p. 79). Clarity about how their role fits within the wider service enhances frontline staff confidence that they are working within an accepted role and their belief that their contribution is valued, reducing suspicion and cynicism about other frontline staff roles[10] and enabling improved communication[161] *(response).*

Interagency working needs stable internal team working, facilitated by leaders who drive integration [147] *(resource)* to enable different agencies to operate collaboratively *(response).* When team working is stable within and across agencies *(resource),* frontline staff are able to create a positive team culture that is open to 'being challenged' [10] (p.79) *(response)*. Openness and challenge within and across teams provides opportunities for professional and user debate that facilitates scrutiny and advocacy, *(response)* especially where this involves voluntary sector teams [10]*(resource)*.

Increasing interpersonal contact and rapport between staff in different agencies by facilitating gatherings in which people share experiences and perspectives[28, 150], including through joint training[10, 94, 98, 149] and job shadowing[27] *(resource)* mutual understanding and respect for differences in values and approaches to crisis care is fostered [10, 15, 153]*(response)*. Mutual understanding achieved through interpersonal contact *(resource)* can help to facilitate the development of shared goals and understanding of each agency's role, and the overall "*landscape of demand*"[28](p.22) on all parties[149, 150] *(response).*

Learning together *(resource)* creates new lines of communication and a sense of collaboration and a shared language that can overcome communication difficulties caused by jargon [98, 104, 149]*(response)*. This means that in future contact they might know the person they are liaising with and this goodwill on both sides make the process go more smoothly with agreements being able to be made and negotiation over who will provide what *(response).* Leaders and staff within each agency have new perspectives *(resource)* through which they developed improved understanding of how demands on their services differed *(response)* and through sharing, *(resource)* new ways of responding could be fostered [28] *(response)* and warm handovers provide opportunities for improved information sharing between agencies [64, 161]*(resource)*.

The presence of colleagues with different expertise in the same office or car, or by rapid remote access over video calls or telephone (co-location & co-response) provide instant access to specialist advice *(resource)* can help spread of good practice [30, 98]*(response)*. Co-location and co-response models *(resource)* promote collaborative decision-making between staff in different agencies *(response)* by drawing on a range of expertise including being able to draw on each other's established links to services and knowledge supporting decision

making regarding it is appropriate to refer a person onwards to them *(resource).* The social contact of sharing a car, or office, responding to calls together and getting to know each other promotes professional trust and respect for the other's expertise *(response).*

5.6.3 Mechanisms- systems

Agreements about shared procedures between agencies, including assessment, prioritisation processes and information sharing that is supported by integrated information technology (IT) systems[147, 150] *(resource)* enable staff to 'buy into' the system [10, 94, 147]*(response)*. Shared agreements such as these provide clear boundaries for staff *(resource)* allowing them to overcome anxieties regarding rules about data protection and confidentiality, improving confidence when communicating between agencies and motivation to do so from all involved [96]*(response).* Shared assessment processes *(resource)* streamlined communication and improve decision making[98] between agencies ensures that the assessment gathers all the information needed by each agency, so that each agency can quickly access the information it requires and reduce the number of times people in crisis have to repeat themselves [64]*(response).*

When commissioners and leaders across agencies work to co-produce and co-design crisis care informed by local population and geographic data[64, 158] in collaboration with representation from all stakeholders [89]*(resource)*, different values and definitions of crises are accommodated, problem solving is conducted across the system *(response).* When evaluation is carried out using methods that incorporate interagency data *(resource),* commissioning is informed by a whole systems approach [153, 161]*(response)*. By taking a whole system approach to commissioning organisations, particularly smaller voluntary sector organisations, can have a stable presence[10] and there is system wide understanding of the resources required. A system wide understanding helps to avoid the detrimental impact of agencies operating in silos and being focused on protecting resources thereby improving the ability of the whole system to maintain the flow of people through the complex pathway[147]. There are links between national policy expectations and coordination of interagency crisis services commissioning and local delivery [27, 30, 89, 152]*(resource)*. There is legitimacy for interagency quality improvement, evaluation, and research direction for system leaders [10, 28]*(response).*

5.7 IPT3- Pen Portrait-Community crisis agencies work together

Box 7: Pen portrait IPT3 interagency crisis services

Karl's story

At 9pm Karl was in a very distressed state in the town centre near where he lives, he was shouting and gesticulating at passers-by. A staff member at a corner shop called 999, worried that Karl is a risk to others, she thought he might be drunk or on drug[2, 10, 15, 89, 94, 97.]

A police officer arrived at the corner shop and is shown which direction Karl had headed. The police officer finds Karl leaning over the edge of a bridge over the railway. He tries to approach Karl but he threatens to climb over the side of the bridge if he comes any nearer. From what he is saying the police officer suspects Karl might be experiencing a mental health crisis. The police have a street triage service, so the officer is able to immediately phone for support from a mental health nurse[97]. The nurse is located in the emergency control room but is also able to attend in person[97, 141, 147].

The nurse went to the bridge where she recognised Karl from when she worked in a previous role in mental health services. She also knew the police officer from being based in the same building and attending training together[124, 125, 129, 137]. They were quickly able to work collaboratively to decide on a plan for Karl[97, 115, 121, 122, 151]. They decided it was best if the police officer kept his distance, while the nurse approached Karl, addressing him by name[122, 129]. She can see how upset he is and reassured him that he won't be in trouble with the police. After taking time to talk with Karl, he eventually sat on the ground, making it safer for the nurse to approach him[127, 128, 131, 135, 136, 138.]

Karl tells her that someone has broken into his flat and stolen his money, he feels overwhelmingly upset and angry. The nurse asks Karl who supports him these days, and does he have any support at home?[95, 96] Karl says that he sees his community nurse once a month, he goes to a service user run café every few days and has regular contact with his brother. The nurse knows the café, it's run by a voluntary organisation who also have a crisis drop-in until midnight which she has taken people to before[10, 128, 130, 153]. She asks what would help Karl best now? They decide he needs help getting his door secured and tidying up his flat, he's also worried about who has broken in[10, 95, 108]. They agree that the priority is for Karl to feel calmer, so the nurse suggests they go to the crisis drop-in service[122].

Karl agrees for the nurse to explain the situation to the police officer. Karl passes on the name of the housing association so the police can contact them to arrange a locksmith[118, 120]. The police officer leaves the scene to follow-up on the break-in. The nurse accompanies Karl to the crisis drop-in and, with permission from Karl, explains what has happened[10]. The nurse agrees with Karl that she will also update his community nurse who is also his care co-ordinator about what's happened and ask him to contact Karl to check he's ok[136, 142, 145, 151, 152].

Once he feels calmer, a peer worker[10, 153] at the crisis drop-in helps Karl contact his brother who goes to meet the police at the flat and then comes to collect Karl and take him to his house for the night[10, 95, 96, 102, 109, 114]. The voluntary organisation made an appointment with Karl for the next afternoon with a support worker and also give him a number to ring if he needs help before then[10, 89, 96, 97, 100, 107, 113, 144]. Karl is glad he hasn't had to keep repeating himself[110, 117, 131] and he's really glad he wasn't arrested as he had bad experiences with the police in the past[10, 97, 100, 129, 130, 131].

Discussions with ESG members identified that pen portrait IPT3, Karl's story was limited to providing one example of interagency crisis care amidst a vast array of possible interagency

responses. Whilst ESG members recognised Karl's experience as representing one experience of interagency crisis care, a limitation of using pen portraits in this programme theory was the limitless possibilities for interagency configurations that cannot realistically be represented in this way.

5.8 Chapter conclusions

Interagency working provides mechanisms that trigger seamless service delivery through improved communication and collaboration. For this system to work, representation from all agencies and stakeholders is needed. National co-ordination at policy level ensures investment is appropriately targeted and that important strategic aspirations are met. National co-ordination should steer, but not dictate, local configurations of the agencies needed. Local crisis services should be configured to meet the crisis care needs of local populations within their geography, taking account of any marginalised individuals or communities they serve.

Commissioning for interagency working needs a focus on managing complex boundaries and transitions across agencies to avoid gaps and disputes. Attention is also needed to how the interagency crisis system engages with wider systems important to resolution of crises including for example housing, police, local authority, safeguarding and the justice system. Ultimately, the interagency system needs to aim for there being no wrong door for accessing mental health crisis care and once in a service, navigation should be facilitated via a single trusted point of liaison.

Leaders need to drive team working within and across agencies. Different values and definitions of crisis are accommodated allowing challenge and debate to become accepted as an opportunity to drive quality improvement. Evaluation is not restricted by organisational boundaries and aims to provide data that take account of how the whole interagency system is operating. This is achieved where there is interpersonal contact between all levels of worker from commissioning through to frontline delivery that facilitates learning, communication, and appreciation of different roles. Furthermore, co-production and co-design of crisis care can be facilitated within the interagency system enabling crisis care to be recognised and valued by the community it serves.

5.8.1 If/then/leading to

IF

Crisis services operate within an interagency system that supports information sharing, communication and interpersonal contact between agencies and staff. Technology operates across agencies. There is shared decision making across agencies and with people in crisis and their support network. Leaders drive interagency collaboration and support team working within and across agencies. Staff relationships and leadership have equal emphasis to the structure of the interagency system. Specialisation of services and staff is balanced with flexibility that allows interagency co-operation. Staff understand how their role fits within an interagency system. Training is co-designed and shared between agencies and with involvement from communities and individuals. Services are designed with the communities they serve and reflect their diversity. There is cultural awareness. There are system navigators and co-ordinators with knowledge of the whole system and resources to support people to make seamless transitions into and through crisis care. Crisis care operates to national guidance with local configuration. There is stability in services and funding.

THEN

The interagency system is co-ordinated and operates to meet national, local, and individual expectations and aspirations for good crisis care. Differences in definition of crises and values about interventions are accommodated. There is co-operation between agencies. There is a platform for co-production and co-design of services. System problems are tackled collectively. Commissioning takes account of gaps, transitions, and operates to resource the whole system. Boundaries between different agencies are proactively managed at commissioning and supported by system leaders. Services are stable and wasteful duplication is reduced. There is investment in joint training and interpersonal contact between staff across agencies. There are open channels of communication between agencies. Staff retention is improved.

Frontline staff have clarity about how their role fits within the whole crisis care system. Staff trust leaders. They have access to information about roles of agencies other than their own and the staff working within them. Trust between staff and different agencies facilitates a culture of learning. It is safe to challenge and debate. Staff understand their role within the

wider system. Staff are open to new roles and ways of working. Joint training is meaningful. Staff are culturally aware. Staff rely less on restrictive approaches and seek support from across the interagency system. Staff invest in information sharing, providing warm handovers. They are less stressed, better informed and can sustain compassion. Decision making is safer.

Service users, family and support network find it easy to access crisis care that is trusted and guarantees a response appropriate to perceived needs. Crisis care is provided with minimum disruption and burden to the person and their family or support network. There is an identified trusted person to support navigation and communication. Involvement in decisions is the norm. Service users can and have contributed to the design and delivery of the crisis interagency system. The crisis care system reflects the characteristics and needs of the community it serves. There are services that are recognisable and trusted as "for me" within the interagency system.

LEADING TO

Nationally led and locally designed crisis care that has been commissioned across agencies. There is stability for agencies, staff, and people in crisis. Relationships and leadership are prioritised. Information is shared, decisions are collaborative and people from communities are involved and invested in their crisis services. Wasteful duplication is minimised, and cost effectiveness improved. Staff believe in the service, trust system leaders and staff retention is improved. Service users and their support network are not turned away. There is a single trusted point of liaison. Multiple and complex needs can be accommodated. People reach an intervention suited to their needs, values, and expectations.

6 Discussion

In this synthesis chapter, findings from the urgent and accessible compassionate care and the interagency focused reviews are synthesised. These cumulative explanations are used to refine the realist programme theory and to identify mechanisms that might operate across multiple interventions to 'activate' an appropriate treatment response.

6.1 Summary of key findings

Our aim in this review was to improve understanding of how, why and in what contexts crisis mental health crisis services for adults can be designed in order to optimise mental health outcomes and service user satisfaction. A synthesis across the three focused reviews identified 40 causally linked context, mechanism, and outcome configurations (Appendix 5). The confidence in each of these 40 review findings has been assessed using GRADE-CERQual[80] summarised in Table 8 (full assessment of confidence see Appendix 6). These findings were synthesised with mid-range theory and linked to interventions using TiDieR (lite)[67] summarised in Table 9 and reported in full in Appendix 5.

Table 8:Summary of confidence in review findings, GRADE-CERQual

Summary Review Finding (C=context; M=mechanism; O=outcome)	**Studies contributing to the review finding**	**CERQual [80] assessment of confidence**	**Explanation of CERQual assessment**
Routes into crisis services 1. (C_1) People in crisis who have physical health concerns or (C_2) lack information about crisis services (M) seek help from services they know, trust and are easy to access (O) making it more likely that they will attend A&E, call 999 or 111 or see GP.	10, 83, 88, 96, 98, 107, 117, 141	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy, and relevance.
Guaranteed service response 2. (C) If people in crisis believe a service provides a guaranteed response, (M) they have a reduced sense of urgency, feel safer and trust that the service can help. The guarantee of a response makes them more likely to choose the service and tolerate waiting. (O) If crisis services guarantee a response, then people are less likely to attend A&E.	2, 10, 15, 83, 88, 95, 96, 98, 107, 109, 142	Moderate confidence	Moderate methodological limitations, no concerns about adequacy and minor concerns about coherence and relevance.
Safe spaces 3. (C) When people in crisis access safe spaces away from home, (M) they are less fearful and can take stock of their situation thereby regaining control over their situation, managing their distress and (O) have improved experiences of services.	10,117, 128, 131, 136, 153	Low confidence	Moderate methodological limitations, moderate concerns about coherence and adequacy and minor concerns about relevance.
Non-clinical safe spaces, open access and peer support 4. (C_1) Non-clinical safe spaces in communities (C_2) have open access and (C_3) include peer support, (M) the service seems to act as a proxy for family support by providing a sense of safety, belonging, and being understood. People in crisis seek this support sooner (O_1) improving engagement, reducing distress and (O_2) attendance at A&E.	10, 105, 109, 118, 128, 130, 153	Moderate confidence	Moderate methodological limitations, minor concerns about adequacy and no concerns about coherence or relevance.
Early navigation to help 5. (C) People in crisis successfully navigate to help in the early stages of a crisis (M) they feel believed and hopeful, they regain control over their situation and manage their distress. (O) People in crisis have Increased willingness to seek help in the future.	2, 10, 15, 96, 97, 109, 111, 145	Moderate confidence	Moderate methodological limitations, minor concerns about coherence, adequacy, and relevance.
Services fit around personal circumstances 6. (C) People in crisis receive a response that fits around their personal circumstances with minimal disruption to usual life with no social or financial burden. (M) They perceive the service to be easy to access, designed for them prompting help seeking sooner in the crisis. (O_1) People have personal control and are (O_2) less likely to access crisis support via the urgent care pathway.	1, 10, 89, 94, 96, 97, 100, 105, 107, 109, 113, 114, 144	Moderate confidence	Moderate methodological limitations, minor concerns about coherence, adequacy, and relevance.
Ease of access and referral 7. (C^1) Crisis services can be accessed without complex referral routes (C^2) this was particularly important for black men who prefer open access services. (M) People in crisis, especially black men, perceive open access services to be easy to access and designed for them. More generally, people in crisis who find access easy, experience reduced fear and services are accessed sooner. (O^1) People are less distressed at first contact and (O^2) particularly black men are less likely to experience coercive responses.	1, 10, 15,88, 89, 91, 94, 96, 103, 111, 128, 129, 130, 131	Low confidence	Serious concerns regarding methodological limitations, moderate concerns about adequacy of data and minor concerns about coherence and relevance.
Gatekeeping 8. (C) Frontline crisis staff (particularly in statutory services) value gatekeeping. (M) Gatekeeping seems to provide reassurance to staff who are less fearful of being overwhelmed, they feel able to control their workload (O^1) minimising the impact of inappropriate referrals and (O^2) reducing the number of hospital admissions. (O^3) Resource pressures are managed.	2, 15, 94, 102, 104, 107, 111	High confidence	Minor methodological limitations and minor or no concerns about coherence and adequacy and relevance.

Shared decision making 9. (C) Decisions are reached through negotiation between staff across agencies and involve the person in crisis, especially important for black people. (M) People in crisis trust the service, have personal control, the person and family perception of the crisis is acknowledged and there is a shared commitment to decisions (O) improving relationships between services and people in crisis.	2, 95, 101, 102, 105, 114, 115, 116, 117, 118, 121, 122	High confidence	Minor methodological limitations and minor or no concerns about coherence and adequacy and relevance.
Organisational culture and therapeutic relationships 10. (C) The organisational culture is centred on therapeutic relationships. (M^1) Frontline staff trust shared decision making, take a collaborative approach and prioritise shared decisions. (M^2) People in crisis feel respected, and engage, (O) improving people's experience of crisis services.	114, 115, 116, 117, 118, 120, 121, 122, 129, 131.	Low confidence	Moderate methodological limitations and concerns about coherence. Minor concerns about adequacy and relevance.
Therapeutic skills, risk and relational safety 11. (C) Frontline staff have therapeutic skills and provide compassionate crisis interventions. (M) Frontline staff deliver care that is balanced between mitigating risk and providing care that promotes relational safety. (O^1) People in crisis are more likely to be involved in decisions and (O^2) have improved experience of and satisfaction with crisis care.	10, 127, 131, 135, 136, 145.	Moderate confidence	Minor methodological limitations and minor or no concerns about coherence and adequacy and relevance.
Peer support 12. (C^1) Peer support is available, (C^2) particularly important to black and minority ethnic people, who (M^1) believe that they have learned about themselves and gained a new perspective giving a sense of being understood and a (M^2) recognised opportunities to contribute that (O) gave hope and meaning.	10	Very low confidence	Minor methodological limitations, serious concerns about coherence and adequacy and no concerns about relevance.
A proxy for family 13. (C) When the support of family and friends is not available, or perceived to be unavailable, people can access a proxy for family via peer support provided in non-clinical safe spaces. (M) People in crisis have a sense of connectedness and trust. (O) The person in crisis feels safe and has reduced guilt about being a burden to family and friends.	10, 95, 117, 118, 131, 153.	Moderate confidence	Minor methodological limitations and minor concerns about coherence, adequacy, and relevance.
Family and friends first 14. (C) When people have access to support from family and friends, (M) they have a sense of connectedness, trust and safety that enables collaboration in decisions and mutual respect. The person seeks help from family and friends first and (O) secure help quickly.	10, 92, 93, 95, 96, 102, 103, 109, 114, 117	Moderate confidence	Moderate methodological limitations and minor or no concerns about coherence, adequacy, or relevance.
Immediate supportive responses 15. (C) Frontline staff have skills that enable them to provide immediate supportive responses including active listening and counselling. (M^1) Staff are more flexible and responsive. (M^2) People in crisis experience relational safety, hope and encouragement and can communicate their needs, regain control, manage their distress, and believe that the service can help. (O) The person is more likely to contact the service again in the future.	2, 10, 92, 101, 109, 116, 117, 121, 127, 131, 136	Moderate confidence	Moderate methodological limitations. Minor or no concerns about coherence, adequacy, or relevance.
Compassionate crisis responses 16. (C) Frontline staff are compassionate in their responses (in person or via telehealth) to people in crisis and their family & friends. (M) People in crisis are valued, believed, respected, and involved in their care. (O^1) People in crisis experience relational safety, (O^2) stabilisation of the immediate crisis, (O^3) improved service user experience and (O^4) there is improved job satisfaction for staff.	10, 101, 112, 114, 117, 121, 123, 125, 127, 128, 130, 131, 132, 137, 138	Moderate confidence	Minor methodological limitations. Minor concerns about coherence, adequacy, or relevance.
24/7 access and same day responses 17. (C) Crisis services are available 24/7 and provide same day responses. (M) The expectation of people in crisis (and their family) for an urgent response are met, they trust the service and have a reduced sense of urgency. (O) People in crisis access a mental health assessment quickly.	2, 10, 15, 89, 94, 96, 97, 99, 109, 115, 117, 118, 119	Moderate confidence	Minor methodological limitations. Minor concerns about coherence, adequacy, or relevance.
Trauma informed parallel assessment 18. (C) Crisis services provide co-response models that include parallel assessment. (M) People in crisis experience less fear (of traumatic re-telling) and a greater sense of personal control. (O^1) People in crisis experience a reduced	97, 99, 100, 110, 117, 131, 141, 147,	Low confidence	Moderate methodological limitations. Moderate concerns about coherence and adequacy, minor concerns about relevance.

number of assessments and related traumatic re-telling and (O^2) have faster access to a mental health assessment that is holistic and more accurate.			
Interagency co-location 19. (C) Co-location of mental health staff in emergency control rooms where non-mental health specialist staff (e.g police, ambulance) and specialist mental health staff share workspaces. (M) Non-mental health specialist staff are more confident in responding and feel supported in decisions. (O^1) Services are more cost effective and sustainable. (O^2) People in crisis experience faster responses to mental health calls because of improved decision making and appropriate onward referral. (O^3) There is a reduced likelihood of people in crisis being taken to (or choosing to attend) A&E or coercive responses being implemented (e.g., Mental Health Act) by clinical staff or police.	97, 99, 100, 109	Low confidence	Minor methodological limitations. Serious concerns about adequacy, minor concerns about coherence and relevance
Supportive clinical leaders 20. (C) Frontline staff have access to clinical leaders and systems of support (e.g., clinical supervision). (M) Frontline staff are less fearful of blame and seeking support is an accepted norm that facilitates acceptance and tolerance between staff. (O^1) Frontline staff sustain compassion, are more confident in decision making and staff stress is reduced. (O^2) Staff job satisfaction is increased, and staff turnover is reduced.	10, 92, 103, 106, 114, 123, 125, 137	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy and relevance.
Decision making 21. (C) Decision making is supported by evidence-based decision aides that are understood across the interagency crisis care system (e.g., triage tools) and decisions are linked to available services. (M^1) Frontline staff have confidence in decisions and there is mutual trust across agencies. (M^2) Staff have less fear in referring to other agencies and a sense of role clarity. (O^1) Accuracy in identification of urgency and need (e.g., suicidality) is improved. (O^2) Improved decisions enable improved interagency service co-ordination and more accurate resource allocation. (O^3) There are reduced disputes about responsibility between staff and agencies.	10, 15, 92, 93, 97, 100, 103, 122	Low confidence	Moderate methodological limitations and moderate concerns about coherence. Minor or no concern about adequacy and relevance.
Leaders buffer external demands 22. (C^1) Frontline staff in 'first response' roles have immediate access to clinical leaders to support and manage resource pressures and disputes about responsibility across the interagency system. (C^2) Leaders focus on buffering external demands and pressures. (M) Frontline staff are confident in decisions, have role clarity and can focus on the person in crisis. (O^1) Disputes about responsibility are reduced. (O^2) Frontline staff are focused on the person in crisis rather than resource pressures and disputes enabling them to retain their compassion and make decisions that are collaborative and safe.	10, 92, 101,103, 106, 114, 125, 127, 133, 134, 137, 150	Moderate confidence	Moderate methodological limitations and moderate concerns about coherence. Minor or no concern about adequacy and relevance.
Definitions, values and interagency affiliation 23. (C) Multiple definitions of crises are understood across agencies. (M^1) Frontline staff accept, have a sense of ownership of, and work with different values across the crisis care system. (M^2) Commissioners and leaders design services that accommodate different approaches to crises allowing healthy challenge and debate (that challenges e.g., unhelpful stereotyping and operational or professional silos). (M^3) Interagency affiliation facilitates improved communication, information sharing and engagement. (O) Staff work flexibly across agencies reducing gaps and delays.	10, 95, 105, 108, 124, 125, 136, 137, 138, 145, 154	Low confidence	Serious methodological limitations. Moderate concerns about coherence and adequacy and minor concerns about relevance.
Crises as part of recovery 24. (C) Mental health crises are conceptualised as part of a recovery journey rather than as single events. (M^1) Frontline staff are accepting of people who may require multiple crisis interventions and confident to refer and liaise across the crisis system. (M^2) People in crisis feel confident when contacting crisis services more than once without fear of rejection. (O^1) Frontline staff retain compassion. (O^2) People in crisis requiring multiple crisis responses are more likely to engage and less likely to escalate risky behaviour. (O^3) There is a reduction in repeat attendances and people leaving the service without treatment.	2, 10, 88, 93, 94, 98, 105, 108, 109, 110, 114, 122, 130	Low confidence	Serious methodological limitations. Moderate concerns about coherence and adequacy and minor concerns about relevance.
Time for assessment	2, 10, 93, 94, 95, 98, 101, 104, 108,	Moderate confidence	Minor methodological limitations and no or minor concerns about coherence, adequacy and relevance.

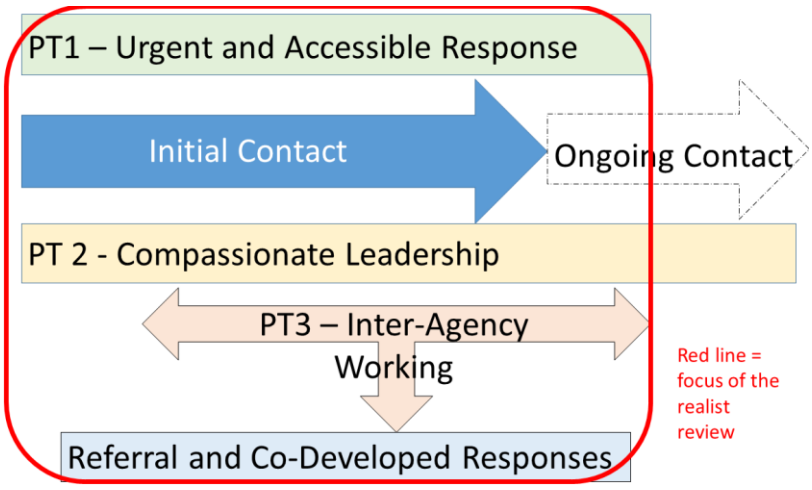
25. (C) Frontline staff have time to assess people in crisis. (M) Staff are less pressured for time and enabled to focus on the person's interpretation of the crisis and involve them in decisions. (O^1) Comprehensive assessment is more likely to be accurate with appropriate onward referral, reducing the need for repeat attendances. (O^2) People in crisis are more likely to reach an appropriate intervention and experience a reduced likelihood of escalation of distress and harm. (O^3) There is improved cost effectiveness and service user experience.	109, 110, 117, 118,		
Implementation and change 26. (C^1) Organisational strategy and operational leadership drive sustained engagement with information sharing and shared decision making. (C^2) Crisis planning and information sharing are particularly important for people known to services or who attend services frequently. (M^1) Frontline staff are engaged and adopt changes into practice. (M^2) People in crisis perceive that the service knows something about them, and they are more engaged in their care. (O) There is improved service co-ordination, faster responses, and sustained change.	116, 118, 120, 122	Very low confidence	Moderate methodological limitations. Serious concerns about coherence, moderate concerns about adequacy and minor concerns about relevance.
Managed waiting 27. (C) A focus on compassionate and psychologically safe crisis care drives proactive management of waiting at strategic, operational, and clinical levels. (M^1) Frontline staff provide information about waiting times to people in crisis, what the wait is for and what the person can do to stay safe during the wait. (M^2) There is a shared understanding of waiting time policy and staff act to meet the standard. (M^3) People in crisis and their family can tolerate waiting and the sense of urgency is reduced. (O^1) People in crisis are less likely to disengage from services without treatment or circle the system. (O^2) People in crisis experience reduced distress and harmful behaviour is less likely to escalate.	2, 10, 15, 90, 92, 93, 96, 104, 109, 110, 125, 128 130, 131	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy and relevance.
Boundary management 28. (C) When commissioning takes account of how complex boundaries between agencies (including thresholds for access) impact on service delivery and service user and family experience. (M^1) Commissioners and leaders drive interagency agreement about geographic and service remit boundaries. (M^2) Staff believe in the service and act to collaborate across organisational and geographic boundaries. (O^1) Gaps, delays and disputes about responsibility are reduced. (O^2) Staff morale is improved. (O^3) There is improved service delivery and cost effectiveness. (O^4) People in crisis are less likely to experience coercive crisis responses.	10, 15, 27, 94, 103, 113, 139, 140, 144, 145, 147, 148, 149, 155	Low confidence	Serious methodological limitations, moderate concerns about coherence and minor concerns about adequacy and relevance.
Continuity and stability 29. (C) Crisis services are commissioned to provide continuity and have a stable presence in communities. (M) People in crisis and crisis staff know their local crisis services and can navigate to them. (O^1) Frontline staff are responsive to the needs of people in crisis (rather than focused on protecting scarce resources). (O^2) Resources are available to provide continuity at service and individual levels.	2, 10, 94, 104, 115, 117, 118, 119, 126, 145, 147, 156	Moderate confidence	Minor methodological limitations. Moderate concern about adequacy, minor or no concern about coherence or relevance.
Co-production and stigma reduction 30. (C) Co-production (including co-design of training) is actively resourced. (M^1) The aspirations of service users (communities) are incorporated into design, delivery, and evaluation of services across the interagency system. (M^2) People in crisis recognise the service as designed for them and have a sense of ownership and affiliation and talk positively about crisis care. (O^1) People in communities become aware of local crisis services. (O^2) There is reduced fear and shame about accessing crisis services (stigma). (O^3) The quality of crisis care is improved.	2, 10, 88, 105, 117, 135, 137, 145, 156,	Very low confidence	Serious methodological concerns. Serious concerns about coherence, moderate concerns about relevance and minor concern about adequacy.
Diversity and inclusion 31. (C) Crisis services are designed and delivered with involvement from the communities they serve, and the staff reflect local diversity. (M^1) Staff use language and communication that avoids racial and other stereotypes. (M^2) People from black and minority ethnic populations recognise the crisis service as being for them. (O^1) There is reduced fear and shame about accessing services (stigma). (O^2) The quality of crisis care is improved.	2, 10, 88, 105, 117, 137,	Low confidence	Moderate methodological limitations, minor concerns about coherence, moderate concerns about relevance and serious concerns about adequacy.
Evaluating interagency crisis services 32. (C) When diverse data are used to monitor services and inform decision making, including data from across agencies and aspects of service delivery that are harder to measure (e.g., relational safety and compassion). (M)	10, 135, 136, 137, 143,	Low confidence	Moderate methodological limitations, concerns about coherence and relevance. Serious concerns about adequacy.

End users of services are involved in evaluating services from multiple perspectives and commissioners and leaders are focused on shared priorities (rather than competing priorities). (O) Quality of care is understood from multiple perspectives including priorities of service users and communities served.			
Technology and information sharing 33. (C) Technology operates across crisis agencies to support information sharing. (M) Frontline staff are confident to communicate across different agencies, they 'buy into' the system and trust is established. (O^1) Improved information sharing reduces the number of assessments and related risk of trauma. (O^2) Improved communication systems help to reduce barriers to information sharing caused by rules about confidentiality and boundary disputes. (O^3) People in crisis experience faster access and transition through different agencies.	10, 93, 95, 97, 141, 145, 148,	Low confidence	Moderate methodological limitations and concerns about coherence, adequacy and relevance.
Interagency staff support 34. (C^1) There is equal emphasis on interagency leadership and staff relationships as there is to the operational structure of the interagency system. (C^2) Clinical leaders and middle managers are focused on support that balances the day-to-day demands of service delivery with attention to the needs of staff. (C^3) Workloads allow leaders to be available to staff. (M) Staff are clear about lines of accountability and seek support with clinical decisions. (O^1) Improved morale in leaders and staff, staff retention is improved. (O^2) Frontline staff retain compassion. (O^3) Resources are managed effectively sustaining clinical priorities. (O^4) Staff are empowered (rather than helpless).	125, 127, 132, 133, 134, 136, 137, 138,	Low confidence	Serious methodological limitations. Minor or no concerns about coherence, adequacy or relevance.
Compassionate leadership 35. (C) There are shared values and objectives between leaders, who model compassion. (M^1) There is affiliation within and between teams, there is a flat structure and leaders make themselves accessible and visible, expectations are clear. (M^2) Staff are regarded compassionately, humanely, and respected, there is staff development and (joint) training that fosters growth. (O^1) Compassionate leaders set the tone for compassionate care and people in crisis experience reduced distress and increased satisfaction with crisis services. (O^2) There is greater likelihood that services are cost effective.	97, 123, 124, 125, 127, 129, 133, 136, 137, 138, 151.	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy and relevance.
System navigators 36. (C) There are system navigators and co-ordinators with knowledge of the whole crisis system. (M) People in crisis experience continuity through trusted points of liaison. (O^1) Reduced time for police dealing with crises. (O^2) People in crisis are more likely to transition through agencies seamlessly.	136, 142, 145, 146, 151, 152	Very low confidence	Serious methodological limitations, moderate concerns about adequacy and minor concerns about coherence and relevance.
Interagency commissioning 38. (C) There is a system-wide approach to commissioning crisis services. (M) There is a system wide understanding of the resources required and agencies operate to manage complexity across the system (rather than operating in silos to protect resources). (O^1) There is greater likelihood of cost effectiveness through more streamlined processes across the system and a reduced focus on resolving disputes. (O^2) Interagency systems that provide seamless crisis services are more likely to reduced distress and increase satisfaction with crisis services.	4, 10, 80, 97, 145, 151, 159	Moderate confidence.	Minor methodological limitations, minor concerns about coherence, adequacy and relevance.
National standards and local implementation 39. (C) Crisis care operates to national standards with local implementation. (M^1) Leaders engage with quality improvement, they set standards (nationally and locally) and lead the delivery of crisis services that meet these standards and expected outcomes. (M^2) Commissioners and leaders pay attention to local populations making service design responsive to local need. (O) Crisis services have potential for cost improvements through reduced use of the urgent care pathway.	27, 28, 30, 88, 91, 97, 144, 150, 155.	Low confidence	Serious methodological limitations. Moderate concern about adequacy and minor concerns about coherence and relevance.
Interagency role clarity 40. (C) Staff understand how their role fits within an interagency system. (M) Staff across agencies have confidence (rather than concern) that the spectrum of care is available across the interagency system. (O) Suspicion and mistrust between different agencies are reduced and there is improved communication between staff and between agencies.	10, 15, 140, 147, 149, 159.	High confidence	Minor methodological limitations and minor concern about coherence, adequacy and relevance.

The findings from this realist review reveal that community mental health crisis services share a requirement to provide an urgent response that is perceived as accessible by people in crisis and their family or friends. The immediate response, needs to be delivered within a culture of compassionate concern which can be largely, but not exclusively, shaped by the service leadership. However, accessible, and responsive services delivered compassionately according to this leadership imprint are necessary but not sufficient.

Extending beyond the remit and capacity of each individual organisation is a requirement for interagency interaction and joint working facilitated by such interventions as improved communication, information sharing, joint training, sharing of values and shared understanding of systems and service thresholds. Evidence suggests that joint working may witness an eroding of traditional stereotypes whereby it is only health professionals, who have a capacity for compassion[162]. While compassion for service users is critical, this cultural attribute relates strongly to having an empathic attitude towards staff from other agencies [163]. Interagency working does not relate simply to allowing staff from different agencies to access a common knowledge base, it also includes learning about how to communicate effectively across organisations, understanding the respective roles of different agencies and developing new relationships while learning side-by-side[163]. The diagram in Figure 10 illustrates the overarching programme theory for this synthesis.

Figure 9:Conceptual diagram illustrating overarching programme theory



However, this apparently linear relationship for crisis management is potentially misleading given that compassionate leadership may shape the quality of inter-agency interactions.

Similarly, the perceived accessibility of the response depends upon the configuration of the collective inter-agency response. Where collaboration works well it can lead to an improved understanding of roles and responsibilities in the 'other' agency and lead to the development of local agreements for information sharing[150]. Furthermore, referral to existing services is a key function[150] that may require a response that bypasses repeated contact, and reinforcement of relationships within the same single agency, requiring instead targeted, co-developed responses from multi-agencies. This complexity extends to interventions such that joint training may include mutual understanding that facilitates appropriate referral and may also help in extending a compassionate and caring environment beyond an organisation's peripheries to its points of contact and interactions with other agencies. Nevertheless, tensions may arise as agencies working towards a common goal find themselves competing for available resources[150].

6.1.1 Summary of Interventions

Table 9 provides a summary of the interventions identified through our research using the TIDieR (lite) framework[67]. A table showing the full detail of TIDieR (Lite) interventions is held in Appendix 2. Contextually important intervention strategies operating within the interventions identified in the TIDieR (Lite) were synthesised to three levels of intervention namely, system, organisational, and service levels and linked to each of the three programme theories in Table 10.

Table 9: Summary of interventions using TIDieR (Lite)

TIDieR (Lite) Interventions[67]
Ambulance/paramedic response car[101]
Compassionate care & leadership [126,134, 135, 136]
Crisis house[133]
Crisis resolution team [15, 103, 102]
Culture of care barometer[127]
Integrated services [108, 144, 147, 153, 154, 156, 157, 161]
Interagency services [27, 28, 30, 149, 152, 155, 160]
Joint crisis planning [116, 117, 118, 119, 120, 121, 122, 123]
Liaison mental health [100, 110]
The Mental Health Act, Section 136 (England & Wales) [95, 141]
Mental Health Triage [93, 94, 107, 148,
Models of crisis care [91]
Recovery focused care planning [129]
Risk Management [137]
Schwartz Rounds [125]

Short hospital stay [105]
Street triage [98, 146, 150, 151]
Suicide Triage [104]
Telephone/video call [90, 113, 114, 115,]
Team Working [129]
Voluntary sector crisis services [10]
Waiting times [89, 109, 111, 112, 132,]

Table 10: Summary of contextually important intervention strategies by system level linked to programme theory

Contextually important intervention strategies[a]		
System level	***Organisational level***	***Service level***
Information sharing (1) [102, 118, 121, 123]	Co-response, co-location & parallel assessment (1, 3) [10, 84, 95, 98, 100, 101, 108, 109, 110, 141, 146, 148, 149, 150, 151, 152.]	Continuity of care (1) [10, 105, 107, 108]
Interagency meetings (3)[10, 27, 28, 98, 153]	Team working (2) [126]	Therapeutic relationships (2)[129]
Referral processes (1)[10,15,89,91,100, 103, 104, 105]	Leadership (2, 3) [118, 125, 126, 134, 135, 136]	Individualised care (2)[118, 129]
Shared decision making (1)[10, 95, 105, 115, 116, 117, 118, 119, 120, 121, 122, 123]	Peer support (2, 3) [132]	Safety planning (2) [129]
Staff training, supervision and support (1, 2, 3) [10, 93, 94, 104, 107, 123, 129]	Psychologically safe models of care (2) [10, 129, 132, 133]	
Tele-health (1) [15, 93, 94, 98, 113, 114, 115]	Safe environments (2) [132]	
Immediate supportive interventions (1) [93, 94, 95, 104, 105, 110]	Support for family and friends (2)[10, 129]	
Triage and prioritisation (1) [91, 93, 94, 100, 104, 109, 110]	Role clarity & role allocation (3)[98, 118, 147, 153]	
Waiting time standards (1) [111, 112]		
Joint training, job shadowing & networking (3) [10, 15, 27, 147, 149, 150, 153, 154]		
Care coordinators & system navigators (3) [144, 147, 153]		

Programme theory number in brackets[a]

6.2 Comparison with existing literature

The literature on community mental health crisis services is predominantly descriptive. This facilitates an exploration of contextual variation but offers less evidence to resolve debate about the most effective interventions with which to address the needs of service users or the outcomes produced. This synthesis can add to the important developing body of literature identified for the review by contributing a realist perspective, thus considering contextual and generative mechanisms across diverse processes and stages potentially relevant to community crisis services across provider agencies.

We acknowledge that this report conceives a mental health crisis as an urgent event with a limited time window within which the first point of contact must demonstrate accessibility and a circumscribed view within which a responding organisation must reveal its response as compassionate and caring. Others have chosen to represent a mental health crisis as a biographical disruption[10]. While some of this difference may be attributed to contrasting individual and service provider perspectives, and further explained by differing emphases on a collective interagency versus voluntary organisation response, we contend that, once beyond the initial issue of access, a compassionate and supportive environment can similarly accommodate a biographical disruption model.

When considering the pathway of a service user through a crisis service (The "therapeutic itinerary"), as delivered by multiple agencies, one can assume one of three perspectives;[164] the first focused on the patient's perception about illness and how it affects help seeking (patient viewpoint); and another focused on identifying barriers and gaps in health system accessibility and referral arrangements (system viewpoint). Finally, a third integrative approach situates patient actions within a socio-economic context that iteratively produces the preferred choices for service users, carers and service providers (contextual approach).

6.3 What this study adds to existing knowledge

Our analysis and synthesis of the literature revealed several important theoretical constructs associated with our programme theories. These constructs helped us to develop our thinking and to establish the relevance of our inquiry within a wider body of theoretical literature beyond the documents reviewed. We identified relevant theories by iterative reading of our data, alongside theoretical literature from across multiple disciplines, and through discussions within the research team and with the ESG. By mapping how our programme theories correspond with substantive theories, we were able to strengthen our propositions regarding causal explanations. This section presents mid-range theory relevant for each of the three reviews (Table 11).

Interpersonal communication and therapeutic relationships, as central in understanding the relationship between the mental health practitioner and the service user are confirmed in the mid-range theory of Goffman (Forms of Talk)[165]. Outram and colleagues (2004)[166] have observed that attitudinal barriers are more likely to prevent individuals from seeking

treatment than structural barriers. Framed in terms of our programme theory, the *perception* of whether a service and service providers are accessible carry more of an inhibitive effect than *the way that the service is actually organised.* Further work might therefore usefully examine how intervention components and service configurations (different contexts) are perceived by service users rather than trying to isolate which permutation of intervention components is most likely to achieve optimal effectiveness. Past encounters with services carry a strong imprint in relation to perceived future accessibility and urgency. The relational aspect of service provision is further affirmed by a mid-range recovery alliance theory[167]. With an emphasis on rapport and compassion, professionals are encouraged to exhibit positive behaviours that mitigate against the dehumanising and stigmatising attitudes that service users may perceive when they encounter a service and that may precipitate or exacerbate a crisis.

A further mid-range theory, feeling in control[83], also serves to highlight the key role of first contact within crisis management services. People perceive a crisis when they feel overwhelmed and anxious and when they perceive that they lack a sense of control. Familiar contacts and a welcoming environment, coupled with reassurance, can help to shape their perception of the service but, more importantly, can help to reduce agitation and aggression thereby making them more likely to respond to suggested strategies or inter-agency referrals. This theory is very much reinforced by the work of Caplan[168], from the mid-1960's who similarly asserted that crisis occurs when the stress being encountered by an individual exceeds their capacity to cope. Viewed in this way crises represent a particular "breaking point" at which an individual feels unable to manage without extra support. From this perspective, complex systems theory would not only recognise the need for a service to recognise the urgency of this breaking point, and to be accessible at this critical time, but would see an important role in delaying or preventing this breaking point, or diverting the need to mitigating resources for coping, whether from the individual themselves or from informal care networks. These latter resources constitute an important contributor to a strengths perspective, such that past service users are empowered to access and use inner and environmental resources.

Fundamental to our programme theories is the role of compassion. While this characteristic may be incorporated within specific interventions, such as the Compassionate Mind Training

model[86], the focus of our programme theory is not on the individual therapeutic encounter itself, although undoubtedly important[87], but on the contribution that leadership can make towards becoming a compassionate organisation. Focusing on compassion at this level helps to shape a context within which many different interventions might operate. A leader's contribution to compassionate care entails providing a welcoming environment, promoting bidirectional compassion, providing training in compassion, and creating supportive organisations[86]. Strong enabling leadership is similarly important in inter-agency working such that escalation can take place when organisational barriers are encountered[169].

The fact that a leader can shape the culture or environment within which care is delivered recognises the potential insights that can be gained from social innovation. In meeting the social demand from service users, service leaders can increase the capacity of their organisation to allow the "innovation" (in this case, compassionate care) to take place[170]. This may extend to building collaborations, making contacts, and broadening networks for interagency working. One reason why the impact of the Crisis Care Concordat has proved less than anticipated may be a focus on the characteristics required, such as compassion, at the possible expense of mechanisms such as compassionate leadership and social innovation that might disrupt the current context and therefore increase the likelihood of change and innovation.

As an intervention to facilitate interagency working, joint learning can engage with socio-cultural learning theory, joint training represents a practical instance of boundary crossing[169], further enhanced by shadowing and job swaps, that improve understanding of other agencies and help to envisage the physical and situational context within which partner agencies are having to respond and reciprocate. Outside of the learning context, the intergroup contact hypothesis (see Table 11) attests to the value of contact between partner agencies. However, contact by itself is not sufficient; it must be strengthened by certain prerequisites such as equal status, common goals, intergroup cooperation, and external support[171-173].

In the absence of these enabling factors any interagency initiative may simply provoke the unintended consequences of reinforcements of stereotypes and existing cliques, causing lasting damage to future working. At a more instrumental level, interagency cooperation requires such practicalities as information sharing, joint decision making and coordinated

intervention[81]. Noticeably, Polivka's model of community interagency collaboration (1995)[82] operates across the same three (environmental, organisational and task (i.e. intervention) levels as highlighted in our programme theories (Table 10).

Table 11: Programme Theories and associated Mid-Range Theories

Programme Theory/ies	Mid-Range Theory	Explanation
PT1 – Crisis services can be accessed urgently	Goffman's (1981) sociological theory, Forms of Talk [165]. Outram et al., (2004) Accessing professional help for psychological distress [166].	The talking encounter entered into by mental health practitioner and patient is an example of interactional talk, an arrangement whereby people come together, sustaining conversation and mutual attentiveness that holds them in an intersubjective world[165]. The social setting for their encounter sets the scene providing not only context, but also partially determining the structure of the interaction. For a potentially sensitive discussion to take place successfully certain conditions, individual to those within the encounter must be fulfilled. Previous unsuccessful interactions, if unsuccessful, can set the tone for future attempts [165]. Service users could become disinclined to express themself and reluctant to seek help[166].
PT1 – Crisis services can be accessed urgently	Ball et al., (2005) Theory of mental health crisis. Feeling in Control [83].	Underlying vulnerability sets the stage for crisis occurrence which involves feeling overwhelmed and lacking control and manifests as agitation/anger/aggression, being low, feeling anxious, or euphoria. Immediate responses to crises involve getting help or managing alone and numerous factors contribute to crisis resolution and prevention [83].
PT1 – Crisis services can be accessed urgently	Caplan's (1964) crisis theory. Breaking point [168]. Subsequent theory development by: Hobbs (1984)[174], Caplan (1989) [24], Ball (2003) [175], Ball et al (2005) [83], Brennaman (2012) [176] and Boscarato et al., (2014) [84].	Crises can occur when a person encounters an overwhelmingly stressful situation that might exceed their capacity to cope, resulting in feelings of helplessness and tension [84]. Disorganization and confusion might be subsequently experienced, leading to a 'breaking point', characterized by psychological decompensation and disturbed or destructive behaviour [174]. When this occurs, crisis intervention might be required. Ball (2003) [175] extended Caplan's (1989) [168] crisis theory to differentiate the experience of crisis for Individuals With Severe, Persistent Mental Illnesses (SPMI) from the rest of the population [83]. Ball identifies an underlying vulnerability that mental illness creates as the primary precipitating factor. His explanation of crisis is comparable to Caplan's crisis theory, although SPMI usually require professional care [176]. Opportunities for growth and the development of new coping skills are present in the resolution of the crisis [24, 175].
PT1 – Crisis services can be accessed urgently	Mirabito (2017) [85] Strengths perspective. Breaking point	Crisis intervention uses the strengths perspective to help individuals mobilize their own strengths, assets, and capacities as well as to identify the resources and supports that exist in their environments, including within families, social networks, neighbourhoods, and communities. In combination with the strengths perspective, an empowerment approach is used to help clients access and use inner and environmental resources [85].
PT1 – Crisis services can be accessed urgently	Recovery Alliance theory	Stresses the importance of therapeutic rapport and compassion. The issue of common humanity has been shown as being essential in the recovery process [177]. Individuals are social beings who share a common humanity which, via interaction with

and PT2 -Compassion and leadership	Shanley & Jubb-Shanley (2007) [167] and Wright, Haig and McKeown (2007) [177]	others, helps us to develop as individuals [167]. If professionals exhibit de-humanising behaviour, the resultant social rejection and professional distance merely serves to increase the likelihood of harmful behaviour.
PT2 -Compassion and leadership	Protection Motivation Theory Allen & Campbell (2018) [88]	The protection motivation theory proposes that people protect themselves based on four factors: the perceived severity of a threatening event, the perceived probability of the occurrence, or vulnerability, the efficacy of the recommended preventive behaviour, and perceived self-efficacy [88].
PT2 -Compassion and leadership	The Compassionate Mind Training (CMT) model McEwan et al., (2020) [86] and Gilbert (2014) [178]	Humans are profoundly social beings with compassion linked to caring and attachment [178]. Since compassion operates through and depends on social bonds and relationships, it is also context dependent. Different organisational systems can either facilitate or inhibit it. Compassion in mental health means the creation of contexts within which compassion competencies can flourish. Compassionate care involves providing a welcoming environment, promoting bidirectional compassion, providing training in compassion, and creating supportive organizations [86]
PT 2 Compassion and leadership	Compassion in psychotherapy Vivino et al., (2009) [87]	Compassion in psychotherapy is a broad construct that encompasses elements of therapy process, therapist variables, and other important components of psychotherapy and functions to facilitate client change [87].
PT 2 Compassion and leadership PT3 Community crisis agencies work together	Social Innovation Model (specifically the Ecosystem for Innovation model) Bason (2010) [179] and Hartley (2005)[170].	Social innovation involves taking new knowledge, combining existing knowledge in new ways or applying it to new contexts. It seeks to create positive social change, and improving social relations and collaborations to address a social demand, defined by an emphasis on public value and social need [170]. The Ecosystem for Innovation model [179] sets out four interdependent dimensions: Consciousness: Degree to which organizational leaders are aware of "innovation" and consciously strive towards achieving innovation when developing new interventions. Capacity: Degree to which structures within organizations allow social innovation to take place. Co-creation: Collaborative processes that allow the cross fertilization of ideas across different agency perspectives and which are necessary for innovative ideas to develop. Courage: the leadership environment required to facilitate the above dimensions [179]. Professionals may be considered social innovators, implementing and expanding on new ideas within their own organizations and across systems [170].
PT3 – Community crisis agencies work together	Activity System Framework evolved from Socio-cultural Learning Theory	The learning that takes place during an activity is not only a function of the individual's own cognition[180]. It is also mediated by factors external to the individual within the social world. Activity theory (systems), and boundary crossing that operationalises this theory [181] have been used to underpin joint training workshops[182].

	Vygotsky (1978) [180], Engeström, (2001) [181] and Hean et al., (2009) [182].	
PT3 – Community crisis agencies work together	The intergroup contact hypothesis Carpenter & Hewstone (1996) [171], Hewstone et al., (1996) [173] and Dickinson & Carpenter (2009) [183]	Establishing contact between agencies is a recognized mechanism in building relationships and minimizing intergroup stereotypes and prejudice. However, contact alone is not enough[173, 183]. Interagency placements, visits, and shadowing opportunities provide contact. Positive effects of contact require four key conditions: equal status, common goals, intergroup cooperation and support by social and institutional authorities [171]. If contact opportunities are left unmanaged, then contact may have unintended consequences, with stereotypes being reinforced and interagency relationships harmed [173].
PT3 – Community crisis agencies work together	Interagency collaboration models Parker et al., (2018) [81]	Interagency collaboration involves three core principles of information sharing, joint decision making and coordinated intervention. Interagency collaborations involving the police aim to improve health and social care outcomes for individuals with mental ill health and the cost and effectiveness of services[81].
PT3 – Community crisis agencies work together	Polivka's (1995) theoretical model of community interagency collaboration [82].	Collaboration is a function of environmental conditions, organizational situations, and task characteristics. Discusses transactional patterns including intensity, formalization, inter-relational patterns, and structured relationships as well as outcomes pertaining to organizations, interorganizational relations, clients, and communities [82].

6.3.1 How does urgency and accessibility of services determine what happens during a mental health crisis?

Although urgency (linked to perceived need) and accessibility (linked to a response that meets that need) are conceptually different they are very closely related in the minds of service users. Service users adopt strategies to negotiate access to mental health care when emotions become overwhelming and harmful behaviours become likely[184]. These strategies may include contact with police services where health services fall short of the response times that users themselves expect. Urgency may increase when there are delays in accessing services. Services that are seen as accessible are less likely to be accessed prematurely or on a "just in case" basis. Dissatisfaction with access to crisis care in England has driven a national service improvement programme and the introduction of the Crisis Care Concordat in 2014. New models aimed at offering improved access are discussed elsewhere within this report and include "crisis cafés" ("safe havens" or "recovery cafés"): walk-in services, stand-alone community crisis assessment teams; and 24-hour crisis lines. Inconsistency of coverage remains an important issue with some people having improved access to numerous alternative forms of community crisis care whilst others have access to the same crisis resolution teams that have been standard in the UK over the past 20 years.

However, where services are designed to be accessible, they may be accessed for convenience at the expense of those who most need them at that specific point in time. Conversely access to regular health services, for example to GPs, by mental health service users may be limited in respect for appointment requests by other patient [162]. Queuing theory suggests that services that are accessible will be increasingly accessed until they stop being accessible, after which usage will drop until the service is little enough used to once more offer a timely response. In reality, service users want a just in time, not a just in case response. However, a further complication in planning the accessibility of services is the fact that needs that are not addressed early may become exacerbated and require a more extensive, prolonged or resource intensive response. Managing these processes is challenging because it not only requires a knowledge of the needs of an individual service user, but it also requires an overview sit-rep of the current usage and availability of the service as a whole.

With new crisis care models, with the potential to improve access and service user satisfaction, continuing to emerge it remains important to establish the evidence base for these models and, in line with the complexity approach assumed by this review, to explore the implications of these new models within the broader local crisis care system[185].

6.3.2 What is compassionate care during a mental health crisis and why is it important?

This review has confirmed that compassionate care is an important feature of a crisis management response. Kindness and compassion are highly valued by people in crisis:

> *"A kind, compassionate, caring, and effective response followed by the right support can transform lives for the better". (Lynch & Persaud. Lived Experience commentary. In: Dalton-Locke et al, 2021[185])*

Yet, these attributes are often lacking in mental health crisis care[12]. It is worth noting that the Francis Inquiry put much store on remedial documentation and communication when users reported a basic "lack of compassion"[186]; crisis mental health services would do well to avoid a similar pitfall. In particular, police services may resort to coercive powers in transporting service users to a location where they can access mental health services. This initial contact may serve to 'frame' the service users' subsequent perceptions of crisis mental health services.

According to the theoretical model associated with compassion, compassion includes offering a welcoming environment. This link between Programme theories 1 (urgent and accessible services) and 2 (compassionate leadership) suggests that the identity of an organisation as compassionate can be perceived from early contact and contributes positively to impressions of accessibility. Similarly, recovery alliance theory, which requires professional and service user rapport can be seen as a facilitator of access to staff and requires a compassionate environment. Person-centred care approaches strongly resonate with our analysis (e.g. recovery alliance theory[167], Goffman's sociological theory, Forms of Talk[165], and Compassion in psychotherapy[87]).

Perhaps what is unique from these findings is the realisation that compassion is not simply an attribute of individual staff with whom service users come into contact. Organisation leaders hold the potential to influence the culture of their organisation – to make it more

compassionate. Routes to achieving culture change lie within Social Innovation theory whereby organisation leaders consciously strive to innovate, they do this within structures that facilitate change, they are open to cross-fertilisation of ideas – including from other agencies, and they drive forward the movement towards change.

6.3.3 How does interagency working influence the service response to people experiencing a mental health crisis?

Our findings suggest that a fragmented and disjointed cross-agency response may serve to exacerbate the challenges of the first response[187]. This can operate at a practical level in terms of delays in referral[2] or in having to repeat one's history multiple times to different agencies. When police officers contribute to a mental health response, service users experience agencies working in isolation and being hastily referred from one agency to the next[2]. Equally, a disjointed response may be perceived to symbolise that the concerns of the service user or their significant others are not important or are not being taken seriously[2]. The transfer of mental health care into emergency health services or police custody has seen increasing interest in how services work together to offer help seeking pathways to support people in crisis with mental health disorders[149].

Two approaches to help seeking pathways have been distinguished: the "contingency" approach, that describes and correlates service usage with clinical and sociodemographic profiles of patients, and the "process oriented" view, that focuses on social and interpersonal processes that affect help seeking behaviour in the community and in the health system[188]. The same research has shown that client pathways to mental health services are divergent and can be a product of choice, coercion or simply 'muddling through'; these latter approaches conflict with the demand for urgent and accessible service responses[189].

Evidence from novel models of police collaboration, such as Crisis Intervention Teams and Street Triage[84, 190, 191] suggest that collaborative models between police and health care professionals may achieve some success in improving service user experience.

6.4 Strengths and limitations

We recognise that this synthesis holds several limitations. First, the quality of any review is only as robust as the primary studies on which the synthesis is based. A major constraint is

that the majority of the studies included in our review give only a cursory description of the context and content of the crisis management services described. Outcomes extracted, particularly at an individual level, were highly theoretical and often based on methodologically limited studies. Unlike systematic reviews, analysis requires purposive approaches to retrieval and analysis of included studies. Nevertheless, our use of iterative searching and citation tracking and our close adherence to documented realist search methodologies has increased our confidence that we have optimised data inclusion. Familiar caveats relate to the limited extent to which all aspects of the explanatory theories identified in this report can be applied to all contexts in which crisis management is delivered. Examination of internal records and service specifications, not in the public domain, might have yielded richer, detailed descriptions of the interventions and permitted a more nuanced analysis of contextual barriers and facilitators. Subsequently, our testing our middle-range theories and propositions may have been more selective than greater detail would have permitted. Nevertheless, we have been able to focus our inquiry on those areas considered as most important to stakeholders, including service users and commissioners, and we have been able to identify mid-range theories to explain how these interventions might work.

Realist synthesis, being a largely interpretative process, may have been influenced by the composition and individual expertise and disciplinary background of the team. In answering the same research questions, a different group of researchers may have prioritised different primary sources and made different judgements about their rigour, richness and relevance. Reflexivity is not yet considered a key component of realist reporting and yet lessons remain to be learned for interpretative variants of qualitative evidence synthesis. While each lead author steered the direction of one of the three individual programme theories the wider team put in place procedures to mediate the individual effects of each author's idiosyncratic approach. These included using common procedures and presentation structures, themed meetings where each lead author presented on a shared aspect of activity and close liaison and communication among the lead authors during analysis and write up. However, we continue to acknowledge, as highlighted above, that each programme theory addresses a different interventional, organisational, social, or environmental context. This may have required different approaches to the evidence base and diverse analytical procedures. Most importantly, each reviewer's interpretive judgements are integral to the synthesis process

and can never fully be “controlled” or rationalised. The presence of several procedures for “sense-checking” as effected throughout the synthesis process does, however, allow for resonance with stakeholder and larger research team experience and expertise.

6.4.1 Deviations from protocol

The original plan to interview up to 50 experts in crisis care from across the UK was modified, after postponement of interview recruitment, planned to include 25 participants and recruited a total on 19 participants to 20 interviews. In addition, issues related to gaining ethical approval during the COVID pandemic restricted recruitment to three NHS health trusts and one NHS ambulance trust in England. The planned six pen portraits were reduced to three linked to each of the three prioritised programme theories. The original plans to support the ESG members to produce a short animation to share the findings with a wide audience has not been achieved due to delays earlier in the project delivery and funding limitations.

Our plans to engage with UK wide stakeholders was limited by the impact of COVID19. Difficulties obtaining ethics approvals delayed recruitment to interviews and a pragmatic decision was taken to recruit participants via three NHS Trusts and one Ambulance Trust in England. Attempts to recruit lived experience participants from across the UK were also hampered by the pandemic. We made a pragmatic decision to continue to work with the stakeholders already recruited to the ESG to provide a stable and familiar online environment for discussion.

6.5 Concluding the Discussion

This chapter has briefly synthesised findings from the three programme theories and sought mid-range theory that seeks to explain at least one, if not, multiple theories. It is noticeable that no one mid-range theory seeks to explain all three programme theories. This is not a rare occurrence within the context of realist synthesis although it is partly explained in this instance by the fact that the three chosen programme theories lie across the system, organisation and intervention levels of our analysis.

7 General Conclusions and Recommendations

7.1 General conclusions

The pathway to help in a crisis is complex and this is unlikely to change, due to varied definitions of crisis and the heterogeneous nature of the population and the mental health concerns they face in a crisis. Our findings told us that this complexity can be managed through greater clarity at the boundaries of services and how they operate together, making referral and transition seamless and timely. This would also enable crisis responses to be guaranteed, easy to navigate and trusted by the people and communities they serve.

Interagency working is known to improve accessibility of crisis care but requires commitment and leadership to succeed. Interagency crisis care works best when there is a strong steer at policy level, and delivery is driven by local commissioning enabling service delivery that supports collaboration within and between different agencies. When interagency crisis care is designed to meet the needs of the local population it serves within the local geography, more attention can be paid to the specific local needs of individuals and communities, with particular attention to those who are marginalised from crisis services due to stigma, racial stereotypes and diagnostic labels.

Our synthesis shows that a shared acknowledgement that there is no single definition of a mental health crisis and that crises are rarely single events, may help facilitate interagency working , thus accommodating different values and facilitating support for people who require interventions from more than one source. However, a lack of role clarity (for agencies and individual staff within them), coupled with resource pressures, fuels disputes about responsibility. As a result, people in crisis may find themselves circling the system while staff lose their ability to provide compassionate responses.

Compassionate care is central to positive outcomes in crisis care and relies on staff having appropriate support to enable them to respond with compassion and hope. Those who respond first in a crisis require interpersonal skills and values that help to calm and reassure the person. This includes acknowledging the person's sense of urgency, explaining any waiting, and being clear about what the person is waiting for. When staff respond in this way, people in crisis trust the service and their sense of urgency is reduced.

It is unrealistic to expect stressed staff to retain their compassion, but resourcing pressures can create barriers for staff who might otherwise have access to support to prevent stress,

burnout, and compassion fatigue. Compassion starts with leaders who have influence over the culture of organisations. Therefore, compassion is as relevant from commissioning processes through leaders and frontline staff, as it is to the service user experience.

Interpersonal contact between frontline staff within an interagency system through joint training, cross agency meetings and job shadowing can improve communication, generate positive values, as well as an understanding of different responsibilities and roles across the whole crisis delivery landscape. Co-location, co-response models and parallel assessments provide a platform for staff to share information, build relationships, share knowledge and skill making access to services smoother and more timely. When service respond together in these ways, crisis care can avoid the added trauma of multiple assessments.

7.2 Research recommendations

7.2.1 Interagency working

This study identified several important causal links between interagency models of crisis care and optimal outcomes. These outcomes are at times theoretical and have been subjected to limited testing in primary research. There are a number of different models of interagency working operating in UK crisis services providing an opportunity for mixed method case study approaches to evaluate these to facilitate implementation of models that produce optimal outcomes in different contexts. An important but neglected area of focus for this research should be on efficacy of models for rural populations.

7.2.2 Technology

Interagency models involving police and other 'blue light' responders are rapidly evolving. Whilst, crisis interventions involving police and mental health services have a growing body of evidence, there is however a lack of evidence for co-response models involving ambulance paramedic staff or emergency control rooms.

Information sharing and communication are important to facilitate interagency working, involvement and shared decision making. A lack of effective and shared technology was identified as a barrier to implementation of these important intervention strategies.

Stakeholders talked about the use of mobile apps and webpages to support self-care and self-management during a crisis, but no evidence was located on their use or efficacy. Research

evaluating implementation of technology such as this would be a useful addition particularly to support people as they wait for call backs, visits, or referrals.

The use of telephone and videocall technology has increased during the Covid19 pandemic for initial contact and triage. Although some evidence was included in the review to show that important mechanisms such as relational safety and trust can be established using telehealth approaches in crisis care, there is a lack of UK evaluations of crisis lines, single point of access, telephone triage or videocall assessment.

7.2.3 Meaningful stakeholder involvement

Meaningful co-production with service users and other expert stakeholders enhances the relevance of research and of should be incorporated routinely into research design and delivery.

7.2.4 Marginalised populations accessing crisis services

Initial searches did not identify data at a granular enough level to allow explanation of the experiences of on black and minority ethnic people and their experience of accessing crisis services within the scope of this study. Despite this, it has been possible to identify some important contexts and mechanisms improving outcomes of crisis care for these populations including through shared decision making, open access and non-clinical safe spaces. A realist evaluation is needed to explore in more depth the factors influencing access to and transition through crisis care for black and minority ethnic populations.

Whilst psychiatric or any other diagnoses have not been used to contextualise data in this study, some of the included evidence pointed to some diagnoses, or health conditions generating additional barriers to access e.g., those with substance use or alcohol use problems, personality disorders, physical health conditions and autistic spectrum disorders. There is a need to design research to identify effective crisis interventions for people marginalised by these diagnostic complexities.

7.2.5 Evaluating individual level outcomes

It was notable in the conduct of this review that outcomes from crisis care are largely expressed in service outcomes such as reduction in hospital admissions, use of sections of the mental health act and attendances in A&E. There is a lack of focus on individual or recovery outcomes. This review highlights the importance of mechanisms such as psychological and

relational safety, compassion, and trust in producing optimal crisis outcomes. Research is needed to develop evaluation approaches to measure the presence and impact of these mechanisms in crisis care.

7.2.6 Mental health triage

Mental health triage appears to be a promising approach but has a limited evidence base. Future research could explore and test the implementation and effect of mental health triage systems. There is a paucity of research exploring the link between decisions in triage and access to appropriate crisis responses across an interagency system and how this is experienced by people in crisis and their family or friends. Taking an interagency approach to such research may uncover important insights into differences in values driving decisions and support closing of gaps and delays between services.

7.3 Implications for practice

7.3.1 Interagency working

Interagency working is very important to the delivery of optimal community mental health crisis care. Policy makers might consider strengthening national leadership of interagency crisis care, such as previously provided by the Crisis Care Concordat[27], to provide a framework for development of agreed standards, to drive improvement and importantly to provide a platform where expectations for interagency working can be shared. Within a national policy framework, support for local decisions about commissioning of community crisis services ensures the needs of local populations are served, cognisant of local demographic characteristics, population size, and dispersion. Further research could help improve understanding of how the geographic location of crisis services impacts on service delivery. There is, for example, limited evidence focused on interagency models of crisis care in rural UK communities.

Within an interagency crisis care system, cross agency agreements about how services operate across traditional service boundaries, including information sharing agreements, trigger mechanisms such as affiliation and shared goals that the evidence suggested improved experiences of receiving crisis care. Advances in digital and telehealth technology used in crisis care, fast tracked due to the impact of the COVID19 pandemic[90], provide additional flexibility needed to improve cross boundary information sharing. Evidence focused on the use of technology to support delivery of crisis care was however sparse and often not based

on UK service designs. Future research could focus on understanding if telehealth is an acceptable intervention strategy and how these technologies contribute to producing optimal crisis outcomes. Whilst current technology provides a means for intervention and information sharing, our review found that information was not shared evenly across the crisis system and that limitations with the technology itself led to frustrations amongst frontline staff. We also located very little in the evidence about how information sharing supports families (or friends) during a crisis, with or without technology, despite availability of guidance for carer support in England[192], and the knowledge that families take a great deal of responsibility for providing support during crises.

Policy makers and researchers might consider how interagency working can trigger distal outcomes such as stigma reduction, increased likelihood of co-production and reduction in restrictive responses. Co-production triggers mechanisms such as community engagement. When communities are engaged in local crisis services, people recognise the crisis service as 'designed for them' and this may reduce stigma and fear. When there is less fear, especially in marginalised and minority communities, the evidence suggests that people access to crisis care sooner. When people access crisis care sooner, they may be less distressed at first contact, and this could be a way for services to reduce the likelihood of using restrictive approaches to care.

Co-production provides opportunities to design services that that can accommodate the diverse ways in which people define mental health crises including the different values and expectations people have about crisis responses. The evidence suggests that, in order to accommodate this diversity within any interagency crisis system, service commissioners might consider designing interagency crisis services that include services perceived as 'clinical' including for example CRT and A&E liaison, those perceived as 'non-clinical' such as safe havens, crisis cafes as well as 'non-health' such as interventions delivered by the police.

Our findings suggest that interagency services are more likely produce optimal outcomes when they are designed in ways that facilitate cooperation across service boundaries such as between statutory and voluntary sectors, primary and secondary care, urgent care and crisis care, health and social care, justice systems, and local authority. The evidence suggests that when crisis services prioritise opportunities for joint endeavour across agencies (including shared meeting structures, shared service evaluation, joint training), mutual understanding between leaders and staff in different agencies may improve. At the frontline of service

delivery, parallel assessment provides opportunity for joint working, but also improves the accuracy of assessment and reduces the likelihood of traumatic re-telling, known to risk further harm to those in crisis. Our findings conclude that joint working in these ways provides a platform for delivery of interagency crisis care that may reduce the stress, distress, delays, and service gaps caused by boundary and responsibility disputes.

Whilst our synthesis identified important mechanisms triggered by interpersonal contact between staff in different agencies, mid-range theory identified that contact alone may not be sufficient to generate co-operative interagency working. What is also needed is equal status across different providers, common goals and external support such as through national policy coordination. Without these, there is a risk of reinforcing difference, siloed thinking leading to lasting damage to interagency working[82, 169, 170]. This is not to suggest that interagency working requires services to operate with the same values, but rather the approach to interagency collaboration may be required to accommodate different values to optimise outcomes. Our synthesis also identified the importance of retaining the unique identity of services (particularly the voluntary sector) thereby facilitating challenge and debate that may protect the crisis care system from unhelpful attitudinal barriers to service delivery.

7.3.2 Stability and continuity

We concluded from evidence that commissioners of interagency crisis care are faced with the challenge of on one hand enabling voluntary sector providers (for example) to retain their unique identity, and therefore their ability to challenge attitudes, and on the other hand enabling these services to have a stable presence in the crisis care landscape. Policy makes and commissioners might therefore consider novel ways to sustainably fund voluntary sector services whilst also enabling them to retain their values and independence. The stable presence of different crisis services across an interagency system may also enable the system level mechanism of continuity through stable thresholds for access to services, that enable people in crisis to navigate to timely help.

Continuity was identified in the evidence as an important mechanism for optimal crisis care and was often conceptualised in our synthesis in terms of individual frontline workers who are known, trusted and co-ordinate service responses. Whilst care co-ordination is an existing feature of UK mental health services, and provides a degree of continuity, further

consideration of how care co-ordination operates to support people to navigate crisis services, especially for those new to mental health services, may help to provide the sense of continuity people in crisis seek.

Whilst we located limited evidence focused on the role of family and friends during a mental health crisis, it was clear from our synthesis that where family and friends are present and available for support, people in crisis often seek their help first and as a result continuity may be best provided by them. Where family support is not available, our review identified that peer support in non-clinical services may be conceptualised as providing a proxy for family support, further emphasising the importance of non-clinical crisis services having a stable presence in the crisis care system.

7.3.3 Compassion

Our focused review of compassionate leadership identified the importance of compassion throughout the crisis care system. The mechanism activated by compassionate leadership was that leaders set the tone for service delivery influencing the culture of services and as a result how staff operate at the frontline. If compassionate leadership supports frontline staff to retain their compassion, it may logically lead to improved experience for those accessing crisis care. The causal link between compassionate leaders and improved service outcomes is somewhat theoretical, in part because compassion is not easily measured. Future evaluation of compassionate leadership might focus on the support needs of leaders as well as frontline staff. Furthermore, evaluation of crisis services more generally may be most impactful when conducted across the interagency crisis system, as people in crisis often encounter multiple agencies, thus providing a more complete picture of crisis services.

7.3.4 Decision making, referral and transition

The evidence focused on accessing crisis care showed that first impressions of crisis services have a lasting impact on how people perceive crisis services (stigma and fear) and seem to then impact on how individuals and families choose their route to help in future crises. These attitudinal barriers may be maintained by services having complex referral systems coupled with service boundaries and thresholds that lack transparency seem to lead to more people circling the system (multiple assessments and no intervention) or accessing help via the urgent care pathway. Designing services that guarantee that the person will access a service

(such as A&E, voluntary sector walk-in services currently provide) increases the likelihood of people in crisis prioritising that service for first contact.

Continued emphasis on commissioning of community crisis services with streamlined access routes, transparent thresholds for access and cross boundary agreements may facilitate earlier access to crisis support for anyone in crisis but be very important to people from minority ethnic groups for whom stigma and fear present the greatest barrier to access. Whilst this review located limited evidence focused on crisis care for people who are black or are from minority ethnic backgrounds in the UK, the use of joint crisis planning to facilitate shared decision making showed more promising results in trials for black and minority ethnic populations than other ethnic groups and may be an important consideration for future intervention development and evaluation.

Difficulties accessing crisis care appropriate to perceived need was linked to inconsistent application of decision processes between services, often resulting in disputes about responsibility. Decision tools used in crisis care lack robust evidence regarding their measurement efficacy and is an area recommended for future research. Support from leaders who operate close to the frontline of crisis service delivery was an important mechanism to improve decision making and confidence of frontline staff enabling them to feel more in control of workload and retain their compassion. Commissioning of crisis service might consider development of clinical leadership roles and design these roles in ways that assure their availability to provide support to frontline crisis staff.

7.4 Final remarks: Delivery of study objectives

The study achieved its objectives despite unexpected difficulties resulting from the effects of the Covid19 pandemic, due to an agile and committed research team and support from the funders. Project milestones were adjusted to accommodate the changing context of the study.

Table 12: Delivery of Study objectives

Objective		Outcome	Reported
1	Use stakeholder expertise, current practice and research evidence to develop programme theories to explain how different crisis services work to produce the outcome of resolution of mental health crises.	Diverse sources of expertise and information about community mental health crisis services were synthesised to prioritise three programme theory components: urgent and accessible, compassionate leadership; interagency working.	Chapters 2-6
2	Use a Context, Intervention, Mechanisms, Outcome framework (CIMO), to construct a sampling frame to identify subsets of literature within which to test programme theories.	A sampling frame, developed using the CIMO framework, was used during the realist searches to steer identification and selection of literature for theory testing.	Chapter 2
3	Iteratively consult with stakeholders via a series of Expert Stakeholder Groups and individual interviews with diverse stakeholders to test and refine programme theories.	Expert Stakeholders were actively and meaningfully involved in selecting, testing and refining the programme theories. A range of interviews generated further insights for theory testing and refining.	Chapter 2
4	Identify and create pen portraits of UK crisis services that provide exemplars of the programme theories to explain how mental health crisis interventions work in order to explore and explain contextual variation.	Each programme theory component generated a pen portrait that may be used as an exemplar to illustrate how mechanisms trigger outcomes in different contexts linked to aspects of crisis care intervention and the service user perspective and experience.	Chapter 2
5	Synthesise, test and refine the programme theories, and where possible identify mid-range theory, to explain how crisis services work to produce the outcome of resolution of the crisis; and hence to provide a framework for future empirical testing of theories in the pen portraits and for further intervention design and development.	Insights into context, mechanisms and outcomes for prioritised theory components presented in relation to three focused reviews, generating an overall synthesis. Pen portraits illustrate the mechanisms required for optimal crisis service delivery from a real-world perspective. Synthesised CMO configurations provide a framework for empirical testing in chapter 6.	Chapters 3-6

6	Produce dissemination materials that communicate the most important mechanisms needed to trigger desired context-specific crisis care outcomes in order to inform current and future crisis care interventions and service designs.	A number of in-project dissemination activities have been undertaken. These include methodological papers and posters, webinars to lay and professional audiences and presentations to clinical and commissioning teams. A twitter presence has been maintained throughout the project delivery and two blogs have been posted online during the project. Post-project dissemination materials are in development including international conference presentations and academic journal papers.	

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8.2 Study Sponsor

Sheffield Health and Social Care NHS Foundation Trust

8.3 Contribution of authors

Dr Nicola Clibbens (Associate Professor Mental Health Nursing) Chief investigator led the project, contributed to the development of initial programme theories, led and conducted one focused review, contributed to stakeholder consultation, conducted individual interviews, contributed to report and led dissemination activities.

Dr John Baker (Professor of Mental Health) Co-applicant provided leadership support to new CI, contributed topic expertise to the development of candidate programme theory, focused reviews, and development of dissemination materials.

Dr Andrew Booth (Professor in Evidence Synthesis) Co-applicant provided expert methodological advice on realist evidence synthesis, contributed to the development of candidate programme theory, supported the delivery of three focused reviews, led the delivery of synthesis to mid-range theory, report writing and dissemination materials.

Dr Kathryn Berzins (Senior Research Fellow) Co-applicant led on administration and ethical approvals process, provided mentorship to consultant and research assistant, contributed to stakeholder consultations, conducted individual interviews, developed candidate programme theory, delivered one focused review, led on in-project communications with stakeholders, contributed to report writing and dissemination materials.

Mr Michael Ashman (Independent Consultant and Visiting Research Assitant) Co- applicant co-chaired the expert stakeholder group, contributed to the development of programme theory, focused literature reviews, report writing and dissemination.

Dr Leila Sharda (Research Assistant) contributed to stakeholder consultations, recruited to and conducted individual interviews, developed candidate programme theory, delivered one focused review, contributed to mid-range theory synthesis, contributed to report writing and dissemination materials.

Dr Jill Thompson (Lecturer) Co-applicant co-chaired the expert stakeholder group, conducted individual interviews, contributed to development of candidate programme theory, focused reviews, report writing and dissemination materials.

Dr Sarah Kendal (Research Fellow) led and contributed to report writing.

Dr Scott Weich (Professor of Mental Health) Co-applicant provided leadership support to new CI, provided topic expertise to the development of candidate programme theory, focused reviews, and development of dissemination materials.

8.4 Other acknowledged contributions

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Georgia Greaves, (Undergraduate Student) University of Sheffield, undertook a review of the data held in the Crisis Care Concordat webpages.

8.5 Data sharing statement

All available data relevant to this report is either included as an appendix to the report or can be obtained from the corresponding author.

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10 Appendices

10.1 Appendix 1 Data Extraction Templates

10.1.1 Appendix 1.1 Identification of Initial Programme Theory Template (example)

Document ID				Relevance		Theory ID			Rigour	Screening & Extraction			
Author	Year	Country	Search ID	Focus	Intervention/s	If (C)	Then (M)	Leading to (O)		KMB	LS	AB	NC
Frisna and Evans IN Nichols & Doberstein	2016	Canada	rw theory v3	logic model for street dwelling youth MH services for 16–21-year-olds -page 228.	refers to specific pathways that include DBT, global functioning focus, skills for life, psycho-ed	referreal and triage approach feeds into a stepped care system with defined pathway of care	Resource- resources can be used effectively to meet individual needs despite complexity, Response- provide a service that is responsive to need and specific population,	Increased ability to reach hard to reach group, increased capacity to endure challenging situations, manage emotional instability, improved QoL	Book chapter reporting ethnographic study page 221				✓· 07.11.19
Frisna and Evans IN Nichols & Doberstein	2016	Canada	RW theory v3	logic model for street dwelling youth MH services for 16–21-year-olds -page 228.	refers to specific pathways that include DBT, global functioning focus, skills for life, psycho-ed	if the referral and triage process uses a range of communication approaches	Resources- in-person communication, email, text messaging and social media reposnse- people more likely to be able to maintain contact with the service	Increased ability to reach hard to reach group,	Book chapter reporting ethnographic study page 221				✓· 07.11.19

10.1.2 Appendix 1.2 Focused review data extraction template (example)

*Reproduced from single row of Excel sheet

Initial Programme theory 1 urgent and accessible						
Date	Extracted by	Report title	Document type	Author	Year	Origin
15.7.20	NC	Embedding and evidence-based model for suicide prevention in the National Health Service: A service improvement initiative.	Research paper	Brown	2020	UK & USA

Intervention	Context	Mechanism: resources	Mechanism: responses	Proximal Outcome	Distal Outcome
Suicide triage	People presenting in A&E or to crisis mental health services as suicidal	Staff training in suicide risk assessment, history taking, urgent medical treatment, help-seeking behaviour and pathways through services.	Staff more objective about suicide and rating of risk.	Improved decisions and accurate signposting to follow up	Faster access to mental health service.

10.2 Appendix 2- Table of Interventions-TIDieR (Lite)

Intervention Name	**Document ID**	**Detail of intervention** (What?)	**Where is it used** (Where?)	**When is it used? Dose?** (When? How much?)	**Who uses it?** (Who?)	**IPT**
Ambulance/ paramedic response car	NHSE/I, (2020)[101]	Mental health joint response car with additional staffing. Responded to call from control centre to people experiencing a mental health crisis. Aimed to use the skills of the mental health nurses and paramedics to provide a complete biopsychosocial assessment at the earliest point pre-hospital. Convey or refer to most appropriate services avoiding hospital where possible.	South London.	Six cars ran 11a.m to 11p.m seven days a week from 2018.	13 mental health staff seconded to the am balance service working alongside 22 paramedics. Paired mental health nurses with paramedics in a vehicle.	1
Compassionate care & leadership	NHSE (2014)[136]	Ten most important characteristics of compassionate leadership: Emotional intelligence, integrity, listening, trust, authenticity, openness, caring, reflective, committed, genuine.	Health services UK	Not reported	All health services leaders	2
	Cole-King & Gilburt (2011)[134]	Multi-modal compassionate mind training.	Not reported	Not reported	For all health care staff	2
	Firth Cozens & Cornwell (2012)[135]	Components of compassion.	UK acute hospitals	Not reported	For all acute hospital healthcare staff	2
	Royal College of Psychiatrists, (2015)[126]	Ten components of compassionate care. Description of evidence-based actions to deliver on compassion. As an individual: mindfulness; improve self-awareness; self-compassion. Organisationally: compassionate organisations; culture change;	UK mental health services	Advocated for everyday practice	For organisations, leaders and healthcare staff.	2
Crisis House	Prytherch et al (2020)[133]	Trauma informed approach in an NHS commissioned crisis house. Alternative to hospital admission. Staff trained in trauma informed approaches and recruited based on attitudes and values rather than qualifications. Work closely with local crisis team. Risk is managed	London	24/7, 4 weeks maximum stay, average stay 2 weeks.	For women with a previous history of hospital admissions who are vulnerable due to trauma. Female staff in crisis house and requested for all external liaison staff.	2

		through psychological interventions, safety planning, check-ins, and one-to-one time with staff. The service is co-designed. Self-referral. Staff receive support and supervision.				
Crisis Resolution Team	Begum & Riordan (2016)[103]	Mental health crisis response service with responsibility for decision making on the most appropriate treatment and pathway of care. The gatekeeping role aims to reduce hospital admissions and facilitate early discharge. Provides assessment, involvement of family and the person in crisis, referral, liaison and negotiation of care with multi-agency mental health services, avoiding hospital admission when possible.	Crisis resolution and home treatment services.	All crises where there is a risk of hospital admission.	Health professionals working in crisis resolution mental health services.	1
	Chilman et al (2021)[102]	To provide intensive community support to people experiencing a mental health crisis and to reduce the need for hospital admission.	UK model, intervention not fully reported	Not reported	Not reported	1
	Morant et al (2017)[15]	Crisis resolution team provided rapid assessment and intensive home treatment for people experiencing a mental health crisis. Direct access, multi-disciplinary, gatekeeping referrals for in-patient care, providing a range of interventions including medication, practical help with daily tasks, family/carer support and interventions to increase resilience and prevent relapse.	Provided in community settings across England.	24 hours 7 days per week	Delivered by a multi-professional team in a mental health organisation to people experiencing a mental health crisis.	1
Culture of care barometer	Rafferty et al (2017)[127]	Culture of Care Barometer. A measurement tool to assess the culture of care in health settings. A 4-factor scale focusing on macro-organisational culture, meso team culture and micro relationships with colleagues and micro constraints of job.	Scale developed and validated in UK	Not reported	For use in healthcare organisations.	2

Integrated services	Association of Mental Health Providers (2021)[156]	An alliance between voluntary sector providers to support the two-way flow of information between communities, the voluntary sector and policy leads.	England	Not reported	NHS England, Voluntary organisations delivering health and wellbeing interventions.	3
	National Voices (2013)[154]	Good integrated care included: Care co-ordination; information sharing; shared decisions and care planning; support for medicines and self-management; transitions managed; supported at home; residential care options.	Across all healthcare and healthcare settings	Not reported	All agencies/staff involved in delivery of health and social care	3
	National Health Service (2018)[157]	Integrated mental health first response service. A collaborative, multi-agency partnership approach to out of hours crisis response services. Local crisis care concordat group developed a shared vision. First responses closer to home through crisis response lines, single point of referral.	Bradford District Care NHS Trust	24/7 availability of first response	Co-ordinated responses from all services providing crisis care in the Bradford district. Involved all mental health services, police, voluntary sector, emergency departments, occupational health, commissioners and local authority.	3
	RAND et al., (2012)[153]	Integrated care pilots. Each site provided different population focus and approach to integration for evaluation. Approaches to integration included macro-organisational level, meso level and micro level. Most integration was horizontal between community services rather than vertical e.g. between primary and secondary services.	Bournemouth & Poole, Cambridge, Sunderland, North Cornwall, Cumbria, Durham, Northamptonshire, Newquay, Norfolk, North Tyneside, Northumbria, Nottinghamshire, Tameside & Glossop, Torbay, Tower hamlets, Wakefield.	Not reported	Not reported	3
	Jespersen et al., (2016)[108]	A service re-design to integrate crisis mental health services within general community mental health teams.	Victoria, Australia.	Not reported	All patients are seen by the same team regardless of their stage of treatment.	1
	Goodwin et al (2012)[144]	Integrated healthcare approaches. Modelling a focus on resolving policy and organisational barriers.	UK	Needs large populations (cover large geography)	Advocating wide systemic involvement of multiple stakeholders.	3
	Mental Health Foundation (2013)[147]	Nine factors that facilitate good integrated care: information sharing; shared protocols; joint funding and commissioning; co-located services;	UK	Not reported	Advocating wide systemic involvement of multiple stakeholders.	3

		multidisciplinary teams; liaison services; navigators; research; reduction in stigma.				
	Bowles and Jones (2005)[161]	Refocusing acute mental health services. Whole systems working that enables systemic understanding for staff. People are able to use their specialist skills; warm networking.	UK mental health in-patient wards	Not reported	All professional staff working across the whole system of acute mental health care across in-patient and community.	3
Interagency crisis services	Boscarato et al (2014)[84]	Integrated mental health responses including Ride-Along Model; Crisis Intervention Team model; Embedded Model; Separate Response Model	Community settings Police setting Police and community setting	Response to crisis calls. When police encounter a person experiencing a mental health issue. Specialist mental health services based in police setting provide immediate crisis responses. Bi-directional referral between police and crisis services as needed.	People experiencing a mental health crisis. People who encounter police when experiencing a mental health crisis. All people experiencing a mental health crisis in a police setting. As needed referral in a mental health crisis.	1
	Crisis Care Concordat (2014)[27] Crisis Care Concordat (2021)[30]	A joint statement from all stakeholders in mental health crisis delivery in England. Signatories agreed to deliver the principles agreed in a national document and to drive local implementation plans shared via an open access website.	England, all mental health crisis services across agencies.	Concordat signed 2014.	Association of Ambulance Chief Executives; Association of Chief Police Officers; Association of Directors of Adult Social Services; Association of Directors of Children's Services; Association of Police and Crime Commissioners; British Transport Police; Care Quality Commission; College of Emergency Medicine; College of Policing; The College of Social Work; Department of Health; Health Education England; Home Office; Local Government Association; Mind ; NHS Confederation; NHS England; Public Health England; Royal College of General Practitioners; Royal College of Nursing; Royal College of Paediatrics and Child Health; Royal College of Psychiatrists	3
	Gibson et al., (2015)[28]	An England wide agreement between different agencies and services involved in responding to people experiencing or at risk of experiencing a mental health crisis. Agreed formally through a multiagency signatory.	England. Across health, social care, voluntary sector, social enterprise, local authority, and criminal justice services.	Signed in 2014. The agreement had been in place for 12 months at the point of evaluation.	Evaluated by an independent organisation.	3

	Healthy London Partnerships (2016)[155]	Combined urgent care and crisis care to provide clarity on the crisis pathway and a more consistent approach across London. Collection of baseline data on places of safety, bed use and S136 detentions. Implementation of health needs assessment.	London, crisis care pathway.	Not reported	NHS England and NHS Mental Health Trusts and Justice system strategic clinical network.	3
	Hollander et al (2012)[149]	Mobile crisis assessment and treatment teams (CATT). CATT teams operate independently from police but are responsive to requests from police for shared management. Protocols exist for delivery of the service not stated in this document. Police had received additional training in mental health.	Melbourne, Australia.	Not reported	Multidisciplinary community based mental health crisis service (CATT) and local police.	3
	McKenna et al., (2015)[152]	Northern Police and Clinician Emergency response (NPACER). Operates a 'second response' model where a mental health clinician and police officer response to an initial 'first response' that identifies a need for a joint assessment. NPACER provide assessment and intervention to reduce behavioural escalation and provide a better outcome for people with mental health needs. Focused on diversion away from emergency departments.	Australia.	7 days a week between 3p.m and 11.30 p.m.	Team consists of 1 police officer and 1 nurse on duty, drawn from a wider pool of appropriately skilled mental health staff and police personnel.	3
	Parker et al., (2018)[160]	Pre-arrest diversion- first response police ; Co-response model Post booking jail diversion & court diversion; Information sharing agreement models; Co-location model; Comprehensive systems model; Consultation model; Service integration model ; Special protective measures; Re-entry programmes	Delivered mostly in developed countries including UK, USA, Canada, Australia and Mainland Europe.	Availability of models varied by country and type.	Delivered in collaboration between police, and mental health services. Many models engage with wider health, social care, local authority and criminal justice services.	3
Joint Crisis Planning	Barrett et al., (2013)[116]	Development of a joint crisis plan to provide advance decisions about what the person wishes to happen should	Generic and specialist community mental health teams in three	Two meetings convened by the JCP facilitator between nurse and participant to develop the	Adults over 16 years with a history of relapsing psychotic illness with at least one admission to hospital in	1, 2

	Farrelly et al., (2014)[118] Farrelly et al., (2014)[120] Farrelly et al., (2015)[119] Thornicroft et al., (2013)[123] (CRIMSON study)	they experience a crisis/relapse in the future. JCP is disseminated to MDT and anyone else nominated by the participant. JCP facilitators received one week of training in JCP facilitation and received weekly supervision. Control- Treatment as usual received via a community mental health team delivered to both the treatment participants in JCP arm and the control.	geographical areas in England.	JCP. Meetings were at least one week apart. A review meeting was offered after 9 months. Meeting 1- introduction to principles of JCP and the JCP menu which included a list of items the participant may wish to include in their JCP. Meeting 2-the JCP is finalised	previous 2 years and registered under the Care Programme Approach as requiring enhanced care. Delivered by senior mental health nurses. A relative of the participant could also attend the meetings. Treatment as usual delivered by any staff in community mental health team.	
	Borschmann et al., (2013)[117]	Participants provided with a blank JCP template and a list of topics to be considered for inclusion. The participant chose if family or other key workers attend the meeting where content of the JCP was discussed. The JCP was finalised by the participant and written in their words and distributed to individuals stipulated by the participant and attached to their medical record with consent. Participants in the JCP intervention also received standard care. Control- treatment as usual from community mental health team.	Community mental health team in London, UK.	One week after the participant received a JCP template and a list of suggested topics for inclusion an hour-long meeting to agree content of the JCP held. Within 24 hours of the meeting, the JCP is distributed to all agreed individuals and if the person agrees, attached to the medical record.	People who experienced crises, self-harming behaviour in the past 12 months with a diagnosis of borderline personality disorder (DSM-IV-TR). Accessing community mental health teams in UK aged 18 or over,	1
	Lequin et al., (2021)[121]	Joint crisis plan intervention not described in detail.	In-patients in Switzerland	Not reported	In-patients	1
	Ruchlewska et al., (2014)[122]	Focused on crisis prevention and the provision of practical information for future psychiatric emergency care. The information is summarised on a small 'crisis card'. The crisis plan is not legally binding. Compared two types of crisis plan; 1. Created between a patient advocate and the patient and 2. created between a clinician and a patient. Both had the same format. Covered four domains: 1. relapse indicators and daily functioning, 2.	Mental health teams and mental health hospitals in Rotterdam, Netherlands	Meetings with clinician or advocate at least twice to develop plan. Annual review of plan.	Clinicians who were mostly registered nurses and advocates who were social workers. Delivered with patients who had psychosis or bipolar disorder and had contact with mental health services over the previous 2 years (crisis contact or hospital admission).	

		what to do in times of crisis, 3. Medical information including medication, 4) information about all relevant people involved in the crisis plan including family, friends and services. All participating clinicians and advocates received training in the crisis plan. The completed plan was signed by the patient, and all involved in their crisis plan. The plan was then summarised on a crisis card.				
Liaison mental health	Eales (2013)[110]	Mental health liaison service in general acute hospital setting.	Based in acute general acute hospitals covering accident and emergency and acute general wards.	24-hour access by referral	Delivered to any person in an acute hospital setting requiring a mental health assessment or intervention. Delivered by specialist mental health practitioners in a mental health liaison service based in the acute hospital.	1
	Evans et al., (2019)[100]	Models of mental health liaison: Co-located in accident and emergency departments Arrangements for response from existing in-hospital mental health service Emergency mental health services delivered at a specialist mental health site.	Accident and emergency department Hospital wide mental health service Specialist emergency mental health unit.	24-hour	All models were delivered by specialist mental health staff including psychiatrists, nurses, and social workers.	1
Mental Health Act (England and Wales) Section 136	Bendelow et al., (2019)[95]	Police power of detention for a person suspected to be experiencing a mental health condition requiring treatment in a public place. Police can convey a person to a place of safety for assessment of their mental health.	In a public place in England and Wales	When a person comes into contact with the police in a public place and required assessment of their mental health.	Police in a public place	1
	Griffith, (2018)[141]	Collaborative care from district nurses related to the use of emergency sections of the mental health act including s136 and s135.	In a public place or private residence in England and Wales	When a person is being cared for by district nurses and is subject to s135 or s136.	District nursing.	3

Mental health triage	Edmondson & Cummins (2014)[148]	Rapid Assessment and Discharge (RAID) team based in mental health liaison available to community police officers who needed mental health advice during attendance at an incident.	Telephone triage service delivered in Oldham from Royal Oldham hospital near accident and emergency department for local community police officers attending an incident where they suspect a person is experiencing a mental health problem.	24-hour telephone triage	Telephone triage service staffed by mental health liaison RAID team. Telephone advice provided to community police.	3
	Grigg et al., (2007)[107]	Mental health triage used to rapidly assess the acuity and deployment of resources to meet needs in a mental health crisis. Applied in a range of setting where an urgent response is needed.	Australian mental health services. Three case studies where triage decisions are made.	24 hours face-to-face and telephone	Any person seeking urgent help in a mental health crisis. Delivered by specialist mental health staff from a range of professional groups.	1
	Sands et al., (2013)[93] Sands et al., (2013)[94]	Mental health triage services provide a single point of access to specialist mental health services. Provide access to assessment, support, advice, and referral for people of all ages experiencing a mental health problem. Referrals to triage are made after an initial screening assessment by telephone to determine the nature and urgency of the problem and the best course of action. Mental health triage scale to assess urgency in three domains 1. Urgency 2. Response time 3. Descriptor. Cases are divided into 7 categories from emergency immediate response through to advice only with no stated response time.	Co-located in either mental health teams, emergency departments, psychiatric units or in call centres in Australia.	24 hours a day	People of all ages experiencing a mental health problem. Delivered by a multidisciplinary team of mental health expert clinicians.	1
Models of crisis care	Sunderji et al., (2015)[91]	Ten programmes of care. Hospital based: Rapid response outpatient team; Rapid response model; Urgent consultation clinic; Urgent follow-up clinic; Paediatric crisis clinic; ED mental	Based in mental health services or emergency departments. Hospital based: Quebec; Ontario; Sydney; New York.	Response times for hospital-based programmes ranged between 2 and 10 days, average 7 days. Community services	Psychiatry, nursing & social work; Psychiatry; Psychiatry, psychology, nursing & social work; Nursing, psychiatry, psychology; Psychiatry;	1

		health nurse practitioner outpatient service; Interim crisis clinic. Community based: Mental health urgent care service; Quick response team; Urgent assessment service	Community based: Alberta; UK	were similar, one service provided walk-in.	Nursing; Psychiatry, psychology; Nursing, psychiatry; Nursing; Nursing, psychiatry. Heterogeneous population and inability to safely wait routine ambulatory care due to suicide risk, self-harm or clinical deterioration.	
Recovery focused care planning	Simpson et al., (2016)[129]	A case management approach to delivery of care planning. Requires providers to comprehensively assess health and social care needs, develop a written care plan in collaboration with the service user and carer, allocate a care co-ordinator and regularly review care. Care panning should be personalised and recovery focused.	Community mental health teams in England and Wales.	All eligible people receiving secondary mental health care.	Staff in mental health services and all eligible people with a mental health condition requiring a care plan.	2
Risk management	Faulkner (2012)[137]	Approaches to risk management focused on key components including: a rights based approach; responsibility; regulation of services; adult safeguarding; balancing power; co-production.	UK mental health services	Not reported	Multiple stakeholders engaged in understanding their role in management of risk.	2
Schwartz Rounds	Farr & Barker (2017)[125]	Interdisciplinary reflective groups to enable staff to share experiences and vulnerabilities, to support each other and to enhance connections between caregivers and patients. The Rounds standard procedure starts with a mixed staff panel discussing a patient or a work-related theme, to which all participants can then respond. Rounds use an evidence-based model with trained facilitators moderating the group discussion. A steering group oversees the development and process of running Rounds.	Community and mental health services. Case A -a large Foundation Trust, delivering mental health, community, and specialist services to adults and children. Case B - a large and complex community Foundation Trust covering a wide, rural geographical area. Case C- a Foundation Trust that provided mental health services. It had a mixed rural and urban geography.	Monthly Schwartz rounds. Observed for 1 hour although duration of rounds unclear.	Multidisciplinary clinical staff. Schwartz Rounds are open to all staff including non-clinicians and may focus on themes made up of a number of stories or different perspectives on one particular case.	2
Short hospital stay	Gudde et al., (2013)[105]	People known to mental health services can choose to have a short	Norwegian acute mental health acute services for	Short hospital admission of 1-5 days.	service users choose an admission if they identify a mental health crisis.	1

		hospital admission of 1-5 days if they experience a mental health crisis.	people with psychosis or bi-polar disorder experiencing a crisis.			
Street Triage	Carson (2018)[146]	Street triage added to existing RAID model in crisis services in emergency departments (Rapid Assessment, Intervention and Discharge). Telephone response to request for immediate support and advice on mental health from police on scene.	By telephone via emergency department.	24 hours 7 days per week	All mental health presentations encountered by police in Oldham and Greater Manchester. Intervention delivered by mental health nurses and social workers.	3
	Horspool et al., (2016)[150]	Street triage interventions that have departed from the UK department of health initial pilot models implemented and evaluated as part of the Crisis Care concordat.	England, two locations. Urban and urban/rural. Study location 1- joint response car, integrated recovery programme for high users of police time, joint training. Study location 2- joint response car, mental health workers in the emergency control room, joint training.	Availability of the interventions was reliant on opening times which varied for the different components of the service in each area. The availability of the intervention was also linked to the density of the population, the geography, and the complexity of boundaries between different health and social care organisations in each location.	Delivered by specialist mental health staff from a range of professions and the police.	3
	Lancaster et al., (2016)[151]	Overview of different models of joint police and health responses to mental health crisis. Joint responses or rapid referral between mental health and police to people experiencing a mental health crisis. NPACER, DeKalb CSB, COAST, Street Triage	Australia USA Canada UK	3p.m to 11p.m 3p.m to 11p.m 24 hours 2p.m to midnight	NPACER- 1 police officer and 1 mental health clinician. DeKalb CSB- 4 police and 2 nurses. COAST- 1 police officer and 1 psychiatric nurse. Street Triage- psychiatric nurse paired with unknown number of police officers.	3
	Reveruzzi & Pilling (2016)[98]	Nine pilot sites delivering five models of street triage in England. 1. Control room telephone response 2. Control room and face-to-face 3. Mental health practitioner responding when requested by an officer 4. police officer and mental health practitioner responding together 5. Mental health practitioner, police and paramedic responding together.	British transport police Devon and Cornwall police; London mental health trust, West Yorkshire police, North Yorkshire police Sussex police, Thames valley police, Derbyshire constabulary, West midlands police.	Not reported	Control room staff, mental health staff, police, paramedic.	1, 3

Suicide Triage	Brown et al., (2020)[104]	Collaborative Assessment and Management of Suicidality (CAMS). Completion of a Suicide status form (SSF) includes self-completion section and therapist assessment section. A treatment plan is generated and the SSF is used as a progress measure. When three SSF measures show self-management of suicidal thoughts, feelings and behaviours, intervention stops. CAMS training for staff with clinical supervision.	Crisis and home treatment services and mental health liaison in one region of England.	Presentations at crisis services and MH liaison provided CAMS triage for all suicidal and self harm presentations. High risk service users received CAMS intervention. Suicide management intervention targets individual defined suicide risks over 4 to 12 sessions.	All high risk suicide and self harm presentations at crisis and MH liaison services. Staff who have received the CAMS training and supervision.	1
Telephone crisis line	Cambridge & Peterborough NHS (2016)[113]	Mental health advice, support and treatment to anyone experiencing a mental health crisis. Phone NHS111 and select option 2. Direct contact, no referral needed. Refer, make an appointment or dispatch a first responder urgently. Provide support, prescribe medication and refer to a Sanctuary run by Mind. Link to children's services, learning disability services and older people's services. The service is confidential. Interpreters are available.	By telephone in Cambridgeshire, England.	24-hour 7 day per week. Refer to a Sanctuary run by Mind 6p.m to 1a.m.	Anyone in Cambridgeshire who feels they need urgent mental health support including service users, family and friends. Calls answered by a 'telecoach' who was a psychological wellbeing practitioner . First responders are mental health nurses and social workers sometimes accompanied by an emergency services worker.	1
	NHSE (2021)[90]	Crisis helplines for anyone experiencing a mental health crisis or friends & family making a call on behalf of someone in crisis. The lines are also open to professionals such as police and paramedics when they encounter someone in crisis. Connected to NHS111. Provides immediate response and refer to other services that may include phone, video and in person consultations.	England	Implemented in 2020, available 24/7	For family friends or person in crisis. Professional staff encountering someone in crisis such as police and ambulance. Staffed by mental health professionals.	1
	Trondsen et al., (2014)[115]	On call video conferencing in rural Norway for psychiatric emergencies. Rural areas without access to a local psychiatrist can have real-time video	. Video call facilities installed in three psychiatric centres (offices	Available 24/7	Access to psychiatrist in consultation with rural mental health centres that included nurses. Psychiatrist 24-hour rotational on	1

		consultations Available to consult following referral by regional ambulatory mental health teams or hospital wards.	or homes of six psychiatrists) in Norway.		call system. Direct consultations carried out supported by nurses at the centre with the patient.	
	Saurman et al., (2014)[114]	Telehealth intervention where there are no local mental health specialist staff or services. Existing telehealth access to specialist mental health services for rural communities extended to support access in an emergency mental health situation. The service operates a 'no wrong door' philosophy where no caller is turned away. Four private video rooms are available from the control room to take emergency calls. Calls are initiated by a triage assessment and followed up by video interventions to provide a more comprehensive assessment, information, advice, help with medication, wellbeing, and safety. Onward referral can be to emergency services including flying doctors, police, and ambulance or to mental health services for follow up or further assessment.	Rural and remote mental health services in western New South Wales, Australia. Calls handled from a mental health triage control room. Callers must be in a local hospital facility to receive the video assessment.	24 hours every day of year.	Delivered by mental health nurses and psychiatrists based in a mental health service in the same state. Staff work 12 hour shifts with 8 hours overlapping. Two nurses on duty at any one time. Support provided by a manager, a nurse consultant and administrator.	1
Team working	Simpson (2007)[129]	Components of good team working: structure and procedures; interpersonal communication and contact between members of MDT; humour and social encounters used to relieve tension in the team; safe environment to explore difficulties; support from team members;	Community mental health teams, London, England	Not reported	Multi-professional teams working in community mental health.	
Voluntary sector mental health crisis services	Newbigging et al., (2020)[10]	Voluntary sector services providing crisis care. Five types of voluntary sector crisis service:	England. 1. Helplines, crisis houses, safe spaces, and sanctuaries.	Varied availability across the sector, type and location of the service.	Delivered by a range of specialist staff, volunteers, peer support workers.	1, 2, 3

		1. Provides crisis support. Provides peer support, listening services, safe spaces, signposting and liaison. 2. General MH support and crisis support. Wide range of services including courses, counselling, skills development, welfare and benefits advice, advocacy and awareness raising. 3. General support to a specific population including crisis support. Promoting rights, welfare support, counselling, accessing health and social care, campaigning and education, interpreters. 4. Support for specific life event or social issue which can be associated with a crisis. Counselling, welfare support, housing and health advice. Signpost to local health and social care. 5. Community and social organisations. Wide range of social support including welfare, housing, social connection. Signposting to health and social care.	2. Covering a specific geography or population (defined by characteristics such as age, ethnicity, or MH condition). Open access at an identified location. 3. Covering specific population (defined by age, gender, ethnicity, faith, health condition). Open access. 4. Addressing specific issues including rape, domestic violence, bereavement, gambling, homelessness, pregnancy. 5. Societies, clubs, faith groups.			
Waiting times	Haslam (2019)[111]	The 4-hour emergency department wating time standard and its applicability to people experiencing a personality disorder attending emergency departments.	Emergency departments in UK	Waiting times in emergency departments for people attending who have a personality disorder.	People attending emergency departments who have a personality disorder.	1
	Judkins et al., (2019)[132]	4-hour wait in emergency departments.	Australia	Not reported	Focus on people presenting to emergency departments with mental health needs.	2
	NHSE (2021)[112]	Policy outline: For an 'urgent' referral to a community based mental health	Crisis services and emergency departments	Urgent within 24 hours Very urgent within 4 hours	Crisis services and mental health liaison staff.	1

		crisis service, seen within 24 hours from referral, across all ages. For a 'very urgent' referral to a community based mental health crisis service, seen within four hours from referral, for all age groups. Patients referred from Accident and Emergency should be seen face to face within one hour, by mental health liaison or children and young people's equivalent service		Emergency department 1 hour		
	National collaborating Centre (2020)[89]	Crisis care services provide an immediate, short-term response to alleviate a crisis and prevent hospital admission. Crisis services are described in four ways: 1. Community based: crisis resolution teams, phone lines, primary care, voluntary sector, drug and alcohol services, homelessness services, social care, NHS111, crisis cafes. 2. Blue light services- Police, ambulance, fire and rescue. 3. Liaison mental health- provided in physical care settings including hospitals and emergency departments. 4. Age specific services- children and young people and older adults.	Online access to support, and the ability to receive online support. Local crisis telephone numbers, helplines or text lines run by either statutory or non-statutory services. Local crisis team directly using their telephone number. Walk-in crisis services. Single point of access. NHS 999 or NHS 111. Presenting in person to A&E.	24 hours 7 days a week	Delivered by a range of statutory and voluntary sector services and the 'blue light' services including police, ambulance and fire and rescue.	1,3
	Duggan et al., (2020)[109]	Standard setting for accident and emergency departments to address the excessively long waiting times for people presenting with mental health issues. Appropriate resources to respond with urgency. Equal priority to physical health. Integrated services.	Australia	Not reported	All age mental health responses in emergency department.	1

10.3 Appendix 3 Summary Search Strategy

10.3.1 Appendix 3.1 Search strategy initial theory scoping searches

Google Scholar

Concept	Terms
A logic model filter*	V1- "logic model" OR "theory of change" OR "theory of action" OR "outcomes chain" OR "program* theory" OR "program* logic“ OR “logical framework*” V2- “model”
AND	
Mental health	Mental health OR mental health
AND	
Setting	1. NHS 111 2. NHS Direct (Wales) 3. 24 hour 4. Helpline 5. Crisis line 6. Accident & emergency (A&E) 7. Hospital 8. 999 9. GP 10. Liaison psychiatry service 11. Local on-call mental health services 12. Social services 13. Community 14. Local community mental health team 15. Crisis houses 16. Crisis teams (CRHT) 17. Café 18. Drop in 19. Day services 20. Day treatment 21. Police 22. Street triage 23. Crisis resolution teams (CRT) 24. Community 25. Decision

Summary Google Scholar search strings- (full version in Supplementary materials 1)

1. (("logic model" OR "theory of change" OR "theory of action" OR "outcomes chain" OR "program* theory" OR "program* logic“ OR “logical framework*”) AND ("mental health crisis") AND (communit*)
2. to 30. ((AND ("24 hour*"); AND ("crisis house*"); AND ("helpline*"); AND ("crisis teams"); AND ("day service" or "day treatment"); AND ("police"); AND ("street triage"); AND ("home"); AND ("cafe*"); AND ("drop in"); AND (crisis or crises or acute or emergenc*); AND ("crisis line"); AND (GP); AND ("Accident and Emergency"); AND ("NHS 111"); AND ("NHS direct"); AND "hospital"; AND "liaison psychiatry"; AND "on-call"; AND "social service*"; AND "community mental health*"; AND "crisis team*"; AND "day service*"; AND "street triage"; AND "crisis resolution team*"; AND "crisis team*"; AND triage; AND crisis AND triage; AND crisis AND decision*

10.3.2 Appendix 3.2 Summary search strategy focused reviews IPT 1-3

Summary search strategy focused reviews IPTs 1-3 (full search strategy in Supplementary Materials 1)

Three focused programme theories were searched between February and March 2020:

1. Urgent and accessible care
2. Compassionate and therapeutic care
3. Interagency working

Academic databases:

1. MEDLINE (Ovid, 1946 to 2020)
2. Embase (Ovid, 1974 to 2020)
3. Web of Science Core Collection (Clarivate Analytics)
    a. Science Citation Index Expanded (1900-2020)
    b. Social Sciences Citation Index (1956-2020)
    c. Conference Proceedings Citation Index - Science (1990-2020)
    d. Conference Proceedings Citation Index - Social Science & Humanities (1990-2020)
4. Cochrane Library
    a. Cochrane Database of Systematic Reviews (1996 to 2020)
    b. Cochrane Central Register of Controlled Trials (1898 to 2020)
5. Cumulative Index to Nursing & Allied Health (EBSCO, 1974 to 2018)
6. PsycINFO (Ovid, 1806 to 2018)
7. Applied Social Science Index (ProQuest, 1987 to 2018)
8. ProQuest Dissertations & Theses A&I (ProQuest, 1743 to 2020)
9. HMIC (NICE HDAS, 1979-2020)

Database search limits:

- A highly sensitive filter (Ayiku et al., 2017) was applied to all database searches except ASSIA, ProQuest Dissertations & Thesis A&I and HMIC.
- All searches were restricted to English Language studies.
- 2000- present

Grey literature searches:

Anxiety UK https://www.anxietyuk.org.uk/get-help/crisis-support/
Breathing Space (Scotland) — 0800 83 85 87 https://breathingspace.scot/
C.A.L.L. Helpline (Wales) — 0800 132 737 http://www.callhelpline.org.uk/
Centre for Mental Health https://www.centreformentalhealth.org.uk
College of Paramedics https://www.collegeofparamedics.co.uk/
Cornerstone counselling service https://www.ccscounselling.org.uk/
Exclusive Secure Care Services https://www.securecareservices.co.uk/
Inspire Mental Health Inspire advocacy service https://www.inspirewellbeing.org/
Lifeline Helpline (Northern Ireland) — 0808 808 8000 https://www.lifelinehelpline.info/
Live Well Leeds https://livewellleeds.org.uk/crisis-support/
Mental Health At Work https://www.mentalhealthatwork.org.uk
Mental Health Crisis Care Concordat https://www.crisiscareconcordat.org.uk
Mental health crisis helplines in the UK (2018) https://www.youthemployment.org.uk/list-of-mental-health-crisis-helplines-in-the-uk/
Mental Health Foundationhttps://www.mentalhealth.org.uk/
Mental Health Resource https://www.mentalhealthresource.org.uk/
Mental Health Today https://www.mentalhealthtoday.co.uk/
Mind https://www.mind.org.uk
New hope Mental Health https://www.newhope.org.uk/mental-health
NHS England publications https://www.england.nhs.uk/publication/
NVIGO https://www.navigocare.co.uk/
PAPYRUS Prevention of young suicide HOPEline UK — 0800 068 41 41 https://papyrus-uk.org/hopelineuk/
Porthedon https://portheden.org/
Protect Life 2 – Suicide Prevention Strategy https://www.health-ni.gov.uk/protectlife2
Royal College of Psychiatrists https://www.rcpsych.ac.uk/
Samaritans — 116 123 https://www.samaritans.org/
SANE http://www.sane.org.uk/
Shout for support in a crisis https://www.giveusashout.org/
Stress Project http://www.stressproject.org.uk/
Sunflowers Suicide Support http://www.sunflowerssuicidesupport.org.uk/
Touchstone https://www.touchstonesupport.org.uk/
Turning Point Crisis Support https://www.turning-point.co.uk/services/mental-health/crisis-support.html
Young Minds https://youngminds.org.uk/

Search terms- Medline (full database searches and supplementary searches in Supplementary Materials)

IPT1 Urgency and accessibility

#	Searches	Results
1	(mental* or psychiatric or psychotic or schizophren* or bipolar or personality disorder* or anxiety or anxio* or panic or suicid*).mp.	1115928
2	((deliberat* or self*) adj2 (destruct* or harm* or injur* or mutilat* or poison*)).mp.	20760
3	(crisis or crises or acute or emergenc* or urgen*).tw.	1587418
4	(1 or 2) and 3	77045
5	Health Services Accessibility/	72509
6	(access or accessible or accessing or accessibility).tw.	417262
7	(availab* adj2 (service* or staff)).tw.	6287
8	or/5-7	461036
9	(emergency adj2 service*).tw.	16230
10	(emergency care or urgent care or rapid).tw.	644928
11	(after-hour* or 24 hour* or 24hour* or twenty-four-hour* or out-of-hour*).tw.	155691
12	(open* hour* or open* time* or operating hour*).tw.	2985
13	(walk-in or walk in or drop-in or drop in).tw.	26792
14	((place based or place-based) adj5 (care or service*)).tw.	23
15	(local care or local service* or community service* or community care or immediate care or responsive service*).tw.	10291
16	(telephone* or phone or hotline* or helpline* or call centre*).tw.	77735
17	(nhs 111 or nhs111 or "999" or "accident and emergency" or ambulance* or paramedic* or "blue light" or "crisis resolution team*" or police* or triag* or liaison).tw.	82165
18	or/9-17	989130
19	4 and 8 and 18	902
20	Case report.tw.	304411
21	Letter/	1065756
22	Historical article/	356956
23	20 or 21 or 22	1711557
24	19 not 23	888
25	limit 24 to english language	843
26	exp Great Britain/	361115
27	(national health service* or nhs*).ti,ab,in.	188463
28	(english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab.	94070
29	(gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in.	2021964
30	(bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not	1370356

	("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in.	
31	(bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in.	53786
32	(aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in.	204042
33	(armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in.	25305
34	or/26-33	2601287
35	(exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp oceania/) not (exp great britain/ or europe/)	2818198
36	34 not 35	2457091
37	25 and 36	165

IPT2 Compassionate and therapeutic care

#	Searches	Results
1	(mental* or psychiatric or psychotic or schizophren* or bipolar or personality disorder* or anxiety or anxio* or panic or suicid*).mp.	1117876
2	((deliberat* or self*) adj2 (destruct* or harm* or injur* or mutilat* or poison*)).mp.	20798
3	(crisis or crises or acute or emergenc* or urgen*).tw.	1590953
4	(1 or 2) and 3	77228
5	(compassion* adj3 (care or caring or therapeutic or therapy or treatment*)).tw.	2106
6	((understanding or empathy or listened or listening or genuineness or helping or helpful or kind or kindness or respect or dignity or keeping privacy or tolerance or acceptance or affirmation) adj3 (compassion* or care or caring or therapeutic or therapy or treatment*)).tw.	37020
7	((support* or non-judgemental or non-stigmatising or anti-stigma or unprejudiced) adj3 (compassion* or care or caring or therapeutic or therapy or treatment*)).tw.	64955
8	((good or friendly or trust-based or appropriate or efficient) adj3 communication).tw.	4075
9	(staff adj1 (attitude* or skill*)).tw.	1564
10	(cultural* adj2 sensitiv*).tw.	4820
11	(values based care or recovery orientated practice or recovery-orientated practice).tw.	20
12-32	As IPT1	228

IPT3 Interagency working

#	Searches	Results
1	(mental* or psychiatric or psychotic or schizophren* or bipolar or personality disorder* or anxiety or anxio* or panic or suicid*).mp.	1110148
2	((deliberat* or self*) adj2 (destruct* or harm* or injur* or mutilat* or poison*)).mp.	20589
3	(crisis or crises or acute or emergenc* or urgen*).tw.	1578178
4	(1 or 2) and 3	76533
5	Interinstitutional Relations/	10621
6	(interagenc* or inter-agenc* or interinstitution* or inter-institution*).mp.	13935
7	((integrated or joint) adj commission*).tw.	3556
8	((coordinated or co ordinated or joint* or joined up) adj3 (care or healthcare or service* or partnership* or working)).tw.	5275
9	(colocat* or co-locat*).tw.	2660
10	((policy or policies or procedure* or agreement*) adj2 (joint or share* or sharing)).tw.	1931
11	(strategic adj (collaboration or service*)).tw.	62
12	whole system*.tw.	2398
13	concordat.tw.	25
14	integrat* governance.tw.	28
15	((share* or sharing) adj2 (working or training or technolog* or "point of access")).tw.	545
16	((interprofession* or inter profession*) adj2 (work* or relation*)).tw.	1025
17-36	As IPT1	68

10.4 Appendix 4 Retained Records

10.4.1 Appendix 4.1 Retained Records theory scoping searches

1.	Amrhein C, Barber-Rioja V. Jail diversion models for people with mental illness. 2010. In: Service Delivery for Vulnerable Populations: New Directions in Behavioral Health [Internet]. New York: Springer Publishing Company; [329-52].
2.	Aubry T, Pantin S, Riesin E, Runnels V, Swenson R, MacPhee C, et al. An Evaluation of the Ottawa Shared Mental Health Care (SHARE) Project. 2006.
3.	Aubry T, Lebel M, Hodgson S, Bouchard D. Development of an outcome monitoring system for crisis telephone services of the Distress Centre of Ottawa and Region &Tel-Aide Outaouais Ottowa: Distress Centre of Ottawa and Region & Tel-Aide Outaouais; 2005.
4.	Ball JS, Links PS, Strike C, Boydell KM. "It's overwhelming... everything seems to be too much:" A theory of crisis for individuals with severe persistent mental illness. Psychiatr Rehabil J. 2005;29(1):10-7.
5.	Bird KS, Vigurs C, Quy K. What works: Crime Reduction Systematic Review Series No. 7: Police Pre-Arrest Diversion of People with Mental Health Issues: A Systematic Review Of The Impacts On Crime And Mental Health. EPPI Centre, UCL Department of Social Science, University College London, UK; 2017.
6.	Brennaman L. Crisis emergencies for individuals with severe, persistent mental illnesses: a situation-specific theory. Arch Psychiatr Nurs. 2012;26(4):251-60.
7.	British Columbia Schizophrenia Society. Police Intervention In Emergency Psychiatric Care: A Blueprint For Change. British Columbia: British Columbia Schizophrenia Society 2006.
8.	Chan P. Consumers' Mental Health Recovery in a Psychiatric Outreach Program: A Process and Outcome Evaluation. https://scholars.wlu.ca/etd/861 Wilfrid Laurier University, Waterloo, Canada; 2008.
9.	Clark F, Khattak S, Nahal J, Linde K. Crisis Resolution and Home Treatment: The Service User and Carer Experience. London: National Audit Office; 2008.
10.	Collin B. Outcomes for mental health services What really matters? : The Kings Fund; 2019.
11.	Connery L, Brekke J. A Home-Based Family Intervention for Ethnic Minorities with a Mentally Ill Member. Alcoholism Treatment Quarterly. 1999;17(1-2):149-67.
12.	Rockar E, Yurkow S. A Turning Leaf on Mental Illness: A Formative Evaluation of a Community-Based Response. Winnipeg, Mannitoba: University of Manitoba; 2014.
13.	de Boer C. Right Here, Right Now Drop-In Counselling Clinic: Program Evaluation. St John's, Canada: St. John's Status of Women Council/Women's Centre and the School of Social Work, Memorial University; 2017.
14.	Engel RS, Worden RE, Corsaro N, McManus HD, Reynolds D, Cochran H, et al. Alternatives to Arrest. The Power to Arrest: Lessons from Research. Cham: Springer International Publishing; 2019. p. 75-122.
15.	Frisina C, Evans C. 2.7 Vignette: A Transdisciplinary Community Mental Health Program Providing Clinical Care to Street-involved Youth in Hamilton. In: Nichols N, Doberstein C, editors. Exploring Effective Systems Responses to Homelessness. Toronto, Canada: Canadian Observatory on Homelessness Press; 2016.
16.	Gibson S, Hamilton S, James K. Evaluation of the Crisis Care Concordat implementation: Final Report London, England: McPin Foundation for Mind; 2016.
17.	Godrey M. Leeds Partnership for Older People Pilot: Whole System Change in Later Life Mental Health: Final Report Leeds, UK: Leeds Institute of Health Sciences, University of Leeds; 2009.
18.	Graham BA. Documenting and analyzing the contribution of the gatekeeper strategy for enhancing health care access in a midwestern city. ProQuest Dissertations Publishing (3185157): Kansas; 2005.
19.	Healthy London Partnership. London's Mental Health Crisis Care Programme Update. Healthy London Partnership; 2018.
20.	Heyeres M, Kinchin I, Whatley E, Brophy L, Jago J, Wintzloff T, et al. Evaluation of a Residential Mental Health Recovery Service in North Queensland. Frontiers in Public Health. 2018;6(123).
21.	Department of Health and Concordat signatories. Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis. London, England: HM Government; 2014. p. 1-54.
22.	(MHICFRS) HMsIoCaFRS. Policing and Mental Health: Picking Up the Pieces 2018.
23.	House A, Guthrie E, Walker A, Hewsion J, Trigwell P, Brennan C, et al. A programme theory for liaison mental health services in England. BMC Health Services Research. 2018;18(1):742.
24.	Johnson S. Crisis resolution and home treatment teams: an evolving model. Advances in Psychiatric Treatment. 2013;19(2):115-23.
25.	Lamb D, Lloyd-Evans B, Fullarton K, Kelly K, Goater N, Mason O, 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(2):187-201.
26.	Maguire R, Baraki B. Blue Light Programme Impact on the Public: Exploratory Research. London, England: Mind; 2018.
27.	King County MIDD Advisory Committees. Mental Illness and Drug Dependency 2 Evaluation Plan: Attachment A. Washington State, US: King County; 2017.

28.	Miewald CG. Process Evaluation on Crisis Services in Northern Idaho. Boise State University, US: Boise State University; 2016.
29.	Mind. Mental health crisis care: commissioning excellence: A briefing for Clinical Commissioning Groups. London, UK: mind.org.uk/crisiscare; 2012.
30.	Molfenter T, Connor T, Ford JH, 2nd, Hyatt J, Zimmerman D. Reducing Psychiatric Inpatient Readmissions Using an Organizational Change Model. Wmj. 2016;115(3):122-8.
31.	Murphy G, Draper J, McKeon R. Following Up With Individuals At High Risk For Suicide: Developing A Model For Crisis Hotline And Emergency Department Collaboration. . https://suicidepreventionlifeline.org: The National Suicide Prevention Hotline; 2010.
32.	Murphy SM, Irving CB, Adams CE, Waqar M. Crisis intervention for people with severe mental illnesses. Cochrane Database of Systematic Reviews. 2015(12).
33.	Naylor C, Taggart H, Charles A. Mental health and new models of care: Lessons from the vanguards. London, UK: The King's Fund and Royal College of Psychiatrists; 2017.
34.	Murdoch C, Farmer P, Cumisky S. NHS Mental Health Implementation Plan 2019/20 – 2023/24. London, England: NHS England; 2019.
35.	East Midlands West Midlands and East of England Mental Health Clinical Networks. Urgent and Emergency Mental Health pathway compendium of case studies 2018/19. East Midlands Clinical Network; 2019.
36.	National Institute for Health and Care Excellence, National Collaborating Centre for Mental Health, NHS England. Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance. London, England: NHS England; 2016.
37.	Quinnett P. QPR Gatekeeper Training for Suicide Prevention: The Model, Rationale and Theory: QPR Institute; 2007.
38.	Reifels L, Too LST, Ross A, Reavley N, Pirkis J. Evaluation of the Lifeline 'Pause.Call.Be Heard' Campaign in the Rail Environment. TRACKsafe Foundation and Lifeline Research Foundation, Centre for Mental Health MSoPaH, University of Melbourne; 2018.
39.	Rodgers M, Thomas EWS, Dalton JE, Harden M, Eastwood AJ. Police-related triage interventions for mental health-related incidents : a rapid evidence synthesis. Health Services and Delivery Research. 2019.
40.	Sjølie H, Karlsson B, Kim HS. Crisis resolution and home treatment: structure, process, and outcome - a literature review. J Psychiatr Ment Health Nurs. 2010;17(10):881-92.
41.	Stolk Y. Development and evaluation of a training program in cross-cultural psychiatric assessment for crisis assessment and treatment teams (CATTs) 2005.
42.	Sylvestre J, Sundar P, Jamshidi P, Manion M. Evaluating the early implementation of a community crisis bed program for people experiencing a psychiatric emergency using key component scaling. Canadian Journal of Program Evaluation. 2009;24:157-78.
43.	Trewin M. We need to talk about social care: Social care and the mental health forward view: ending out of area placements. London, England: Centre for Mental Health; 2017.
44.	Vingilis E, Hartford K, Diaz K, Mitchell B, Velamoor R, Wedlake M, et al. Process and Outcome Evaluation of an Emergency Department Intervention for Persons with Mental Health Concerns Using a Population Health Approach. Administration and Policy in Mental Health and Mental Health Services Research. 2007;34(2):160-71.
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10.4.2 Appendix 4.2 Summary table of included documents IPT1 urgent and accessible crisis services

Document authors	Year of publication	Study setting	Country	Participant number & characteristics	Method of data collection	Date of data collection	Method of analysis
Barrett et al [115]	2013	Community mental health services	UK	Participants over 16 years with relapsing psychosis, at least one hospital admission over previous 24 months. Excluded if under Mental Health Act. Sample analysed in treatment n=285 and control n=284.	Economic evaluation within randomised controlled trial. Adult Service Use Schedule (AD-SUS) at 3 months prior to randomisation and 18 months after.	August 2008 to September 2011	Economic analyses adjusted for site and baseline costs. Cost effectiveness calculated through incremental ratios.
Begum and Riordan [102]	2016	Crisis resolution team	UK	Six nurses working in two crisis resolution teams.	Semi-structured individual interviews.	Unclear	Thematic analysis
Bendelow et al.,[94]	2019	Police, street triage	UK	62 people with lived experience of being detained using section 136 of the UK Mental Health Act in 2012, three of whom were family members. Police, mental health services and voluntary sector staff took part in interviews and focus groups, sample size unclear.	Mixed methods: individual interviews with services users, carers and staff, focus groups, 250 hours of observed practice, data from medical record of all patients detained on S136 in 2012 in one region of England.	Qualitative data 2013-2016 and quantitative data 2012. Stakeholder focus groups and workshops unclear.	Retrospective analysis anonymised patient data. Qualitative thematic analysis. Stakeholder involvement.
Boscarato et al.,[83]	2014	Police and crisis assessment teams	Australia	11 mental health consumers who had experienced at least one crisis that involved a response from police and mental health services.	Individual semi-structured interviews using open questions and a vignette and visual images to stimulate responses.	Unclear	Thematic analysis.
Borschmann et al.,[116]	2013	Community Mental Health Teams	UK	Community dwelling people aged over 18 with personality disorder (DSM-IV-TR). Target population had experienced crises and engaged in self harm in the previous 12 months. Randomised into treatment + TAU n=46 and control TAU n=42.	Parallel group TAU controlled randomised trial. Self-report questionnaire and secondary clinical outcomes measured in interview using nine standardised questionnaires.	Unclear	Primary outcome assessed using a logistic regression model with treatment and stratification factors including alcohol use and depression. Results were summarised as odds ratios and effect sizes at 6 month follow up with 95% confidence intervals. Cost variables were compared descriptively with no statistical analysis.

Brown et al.,[103]	2020	Crisis resolution and home treatment service	UK	14 interviews (7 service users and 7 clinical staff) who had delivered or received the suicide triage intervention.	Mixed method, recording and reporting suicide rates in one region of UK. Standard healthcare service use data. Interviews with service users and clinical staff.	Quantitative data unclear, qualitative data collected starting October 2019.	Pre and post suicide triage model implementation statistical analysis of service data and suicides. Qualitative analysis not reported.
Cambridgeshire & Peterborough NHS Trust [112]	2016	Crisis telehealth	UK	Information bulletin	Not applicable	Not applicable	Not applicable
Chilman et al.,[101]	2021	Crisis resolution services	UK	500 randomly selected Tweets relevant to crisis resolution teams Qualitative data from previously published study of CRT with services users n=41, carers n=20 and CRT clinical staff n=137.	Twitter advanced search using hashtags related to CRT	Tweets collected after June 2018 for the date range January 2010 to June 2018. Qualitative data collection date unclear.	Tweets were selected at random and 100 tweets at a time were organised into descriptive categories following principles of content analysis. Thematic analysis of tweets. Refutational synthesis was used to compare themes emerging from Tweets and the qualitative study of CRT.
Duggan et al., [108]	2020	Emergency departments	Australia	A summit of over 170 delegates representing health professionals and those with lived experiences.	Unclear	October 2018	Unclear
Eales[109]	2013	Mental health liaison in emergency departments	UK	17 people who has accessed liaison mental health services in one emergency department. Time between attendance and interview was between 3 and 25 weeks.	Semi-structured interviews	September 2000 to June 2001	Grounded theory secondary analysis.
Evans et al.,[99]	2019	Mental health liaison in emergency departments	UK	Systematic review of impact of liaison mental health services on emergency departments. N= 17 papers included	Systematic review	September 2016 and repeated April 2018.	Data extraction by two independent blinded researchers. Risk of bias assessment. Mixed method synthesis.
Farrelly et al.,[117]	2014	Community mental health services	UK	n=221 participants from a control group with a history of psychosis.	Audit of Joint crisis plans using a bespoke assessment tool.	Unclear	Summary statistics were calculated for levels of individualisation in the JCP and compared with clinical data from the trial.
Farrelly et al., [119]	2014	Community mental health services	UK	n=50 joint crisis plans	Records from meetings between the service user,	Unclear	Inductive thematic analysis of service user treatment preferences.

					psychiatrist and a JCP facilitator.		
Farrelly et al.,[118]	2015	Community mental health services	UK	n=51 services users, n=29 care coordinators, n=16 psychiatrists. All participants had taken part in the trial of joint crisis plans.	Focus groups Individual semi-structured interviews	Unclear	Constructivist grounded theory analysis.
Grigg et al.,[106]	2007	Mental Health Triage	Australia	Three case studies. Individual interviews sample size unclear.	Routine data related to mental health triage in three case study sites. Semi-structured interviews with staff, consumers, general practitioners.	Unclear	Mixed methods analysis not fully described.
Gudde et al.,[104]	2013	Crisis services	Norway	N= 19 people with major mental disorder and have experienced a crisis.	Semi-structured interviews.	August 2010 to May 2011	Giorgi's phenomenological analysis.
Haslam[110]	2019	Emergency departments	UK	Clinical commentary	Not applicable	Not applicable	Not applicable
Jespersen et al.,[107]	2016	Integrated CMHT with crisis services	Australia	Service data baseline 2006/7 and comparator 2007/8- 2012/13. Survey services users n=26 ; carers n=31 ; (service user & carer n=9) staff n= 55. Focus groups staff n=38.	Mixed method: routine service data, postal surveys to staff, service users and carers. Staff focus groups.	Unclear	Descriptive statistical analysis of service data and survey responses. Analysis approach to focus group data qualitative but not fully described.
Lequin et al.,[120]	2021	JCP	Switzerland	184 joint crisis plans. 12 patients and 12 providers were interviewed. No family members were included.	Data extracted from records of joint crisis plans. Semi-structured interviews.	2016 and January to April 2017	Qualitative and quantitative content analysis of JCPs. Inductive and deductive analysis of content of interviews. Descriptive statistical analysis of sample characteristics.
Mind[2]	2011	Acute and crisis mental health services	UK	350 responses from people with experience of receiving acute and crisis care and their family members or carers, nurses, social workers, managers, advocates and organisations.	Web-based survey of experiences. Panel meetings with experts.	Survey: September to November 2010 and April to May 2011. Panel meetings: August 2011 Individual consultations: March to June 2011	Analysis unclear.

Mind[105]	2013	Acute and crisis mental health services	UK	All mental health trusts in England	Freedom of Information requests. Mental Health Minimum Data Set 2011-2012	August 2012	Analysis unclear
Morant et al.,[15]	2017	Crisis resolution team	UK	20 carers and 42 service users who had experience of crisis resolution services within previous 3 months. 147 practitioners with experience of delivering crisis resolution services. From 10 mental health Trusts in England. Stakeholder group 13 service users, 7 carers and 8 clinicians.	Individual semi-structured interviews with carers service users and 9 staff. 26 focus groups with staff. Consultations with stakeholder steering group.	Unclear	Thematic analysis using indictive and deductive reasoning with support of stakeholder group.
National collaborating centre [88]	2020	Crisis mental health services	UK	Multi-agency, user-led collaborative of 75 UK organisations. All age crisis care.	Methods not reported	Unclear	Methods not reported
Newbigging et al.,[10]	2020	Voluntary sector crisis mental health services	UK	171 voluntary sector MH crisis organisations; between 13 and 27 stakeholder individual interviews in each of four case study sites. Two focus groups n= 30 service users and n= 22 carers. Narrative interviews n=47 service users and 11 carers. Brief questionnaire n=43 service users.	Mixed method: National survey Mapping services, case studies	Survey: May 2017 to August 2018. Other data collection not stated.	Database analysis, thematic analysis, framework analysis. Descriptive statistical analysis of database and survey data.
NHS England[111]	2021	Mental health access standards	UK	Not applicable- web based policy	Not applicable	Not applicable	Not applicable
NHS England[89]	2021	Telephone access in a crisis	UK	Not applicable- web page content	Not applicable	Not applicable	Not applicable
NHSE &I [100]	2020	Joint-response ambulance car	UK	240 cases	Routine data from one NHS ambulance service. Clinical notes from staff attending mental health cases	January to July 2020	Mixed method analysis of routine health data, descriptive statistics presented with summaries of qualitative data. Health economic descriptive summaries. Methods not fully outlined.
O'Cathain et al.,[96]	2020	Emergency department	UK	32 + 29 documents included	Realist evidence synthesis	Feb to March 2017	Realist evidence synthesis according to RAMESES standards

Olasoji et al.,[95]	2017	Community mental health	Australia	19 caregivers of people living with mental illness.	Five focus groups	Unclear	Inductive thematic analysis
Reveruzzi et al.,[97]	2016	Street triage	UK	Nine pilot street triage scheme reports and related service data. N=6 individual interviews with senior staff.	Routine service data, documentary evidence of the service designs, interviews with health and police staff, service users and family members.	Unclear (data from pilot services 2013- 2018)	Retrospective statistical analysis of service data from nine teams. Synthesis of qualitative service data from nine pilot schemes reports. Thematic analysis of additional interviews with senior organisation staff.
Ruchlewska et al.,[121]	2014	Community mental health services	The Netherlands	212 joint crisis plans (JCP).	Randomised study of comparison of scores between clinician facilitated JCP and patient advocate facilitated JCP using a JCP checklist score.	November 2007 and March 2011	Statistical analysis using a statistical software package to measure internal consistency, distribution and group and individual differences. Descriptive statistical mean score were used to compare quality of completion of JCP. Effect size calculated using pooled variance of the two means.
Sands et al.,[92]	2013	Mental health triage	Australia	18 clinicians, 16 nurses, 2 social workers. 197 observations of telephone calls	Inter-rater reliability testing on 42 validated hypothetical mental health triage scenarios. Observations of calls to a mental health telephone triage service using a 58-item data collection tool.	Observations January to March 2011	Inferential statistical analysis of reliability between raters, descriptive analysis of observational data, qualitative data subject to qualitative content analysis.
Sands et al.,[93]	2013	Mental health triage	Australia	197 observations of telephone calls	Observations of calls to a mental health telephone triage service using a 58-item data collection tool.	January to March 2011	Descriptive analysis of observational data, qualitative data subject to qualitative content analysis
Saurman et al.,[113]	2014	Mental health emergency care rural access programme	Australia	11 days of observations of 14 staff	Routine service data, notes from live observation, documentary evidence from policy and services.	April 2013	Qualitative ethnographic observational analysis.

Sunderji et al.,[90]	2015	Urgent ambulatory psychiatric assessment	Canada	16 documents included	Scoping review of studies describing a specific programme providing rapid access to psychiatric assessment.	Unclear (document included Jan 1993-June 2014.	Donabedian's framework for quality of care.
Thornicroft et al.,[122]	2013	Community mental health team	UK	569 participants randomised to 2685 in intervention and 284 control. Participants had at least one psychiatric admission within 2 years and were on enhanced Care Programme Approach register.	Data collected at baseline and 18 months. Rating of JCP meetings using Likert scale; Clinical records to measure primary outcome; psychometric measures via four questionnaires; DSMIV global assessment of functioning. Semi-structured interviews and focus groups.	Unclear	Statistical analysis modelled on intention-to-treat principles. Comparison between groups used t test and logistic regression carried out. Linear regression for continuous outcomes. Controlled for site and missing data. Analysis repeated for black subgroup. Inductive thematic analysis using constant comparative methods.
Trondsen et al.,[114]	2014	Rural telehealth assessment	Norway	29 patients, psychiatrists and nurses who had taken part in video call psychiatric assessment	Semi-structured interviews	July 2012 and June 2013	Exploratory, stepwise deductive-inductive analysis to identify themes.
Wise-Harris et al.[98]	2017	Emergency departments	Canada	166 adults with five or more visits to ED in previous 6 years with at least one visit for mental health or substance use. 20 participants who had received the intervention were interviewed.	Service utilisation and baseline self-report data. In-depth interview.	August 2013 – December 2013.	Descriptive statistics to summarise baseline self-report data and ED utilisation. Thematic analysis.

10.4.3 Appendix 4.3 Summary table of included documents IPT2 Compassionate leadership

Document authors	Year of publication	Study setting	Country	Participant number & characteristics	Method of data collection	Date of data collection	Method of analysis
Bögle & Boden [128]	2019	Mental health charities providing peer support	UK	7 people with recent first crisis in psychosis and attended peer support group	Semi-structured interviews	Unclear	Hermeneutic phenomenological, multimodal qualitative analysis.
Cole-King, and Gilburt [132]	2011	Health services	UK	Not applicable	Not applicable	Not applicable	Not applicable
Dixon-Woods et al., [136]	2014	English NHS services	UK	304 staff interviews; 650 hours observation; 715 survey responses; 2 focus groups and 10 interviews with patients and service users; performance data from 621 clinical teams; 793 documents from 71 NHS trusts over 18 months.	Interviews; observation; survey; focus groups, performance data, NHS documents	Post Mid Staffordshire report publication, dates unclear	Narrative synthesis of findings from mixed method study
Farr, and Cressey [137]	2015	Primary care NHS trust covering urban and rural communities	UK	21 health care staff	In-depth interviews	Unclear	Grounded theory thematic analysis
Farr & Barker [123]	2017	Community mental health	UK	22 staff interviews; 206 evaluation forms; observations of 5 Schwartz rounds within three case study sites.	Interviews, observations and evaluation forms	2014-2015	Realist evaluation
Farrelly et al., [117]	2014	Community mental health teams	UK	n=50 joint crisis plans	Records from meetings between the service user, psychiatrist and a JCP facilitator.	Unclear	Inductive thematic analysis of service user treatment preferences.
Faulkner [135]	2012	Adult social care	UK	17 stakeholder discussions	Discussions with stakeholders from diverse backgrounds and review of published evidence.	Unclear	Synthesis of personal reflections, stakeholder discussions and published literature.
Firth-Cozens & Cornwell [133]	2009	Hospital care	UK	Unknown	Literature review, data from written anonymized contributions of participants at a workshop	2008	Unclear

Judkins et al., [130]	2019	Emergency Departments	Australia	Not applicable	Not applicable	Not applicable	Not applicable
Newbigging et al., [10]	2020	Voluntary sector crisis mental health services	UK	171 voluntary sector MH crisis organisations; between 13 and 27 stakeholder individual interviews in each of four case study sites. Two focus groups n= 30 service users and n= 22 carers. Narrative interviews n=47 service users and 11 carers. Brief questionnaire n=43 service users.	Mixed method: National survey Mapping services, case studies	Survey: May 2017 to August 2018. Other data collection not stated.	Database analysis, thematic analysis, framework analysis. Descriptive statistical analysis of database and survey data.
NHS England [134]	2014	National Health Services England	UK	Not applicable	Not applicable	Not applicable	Not applicable
O'Connor & Glover [129]	2017	Hospital staff	UK	9 included papers	Literature review	Feb 2015	Qualitative meta-synthesis
Prytherch et al., [131]	2020	NHS crisis house	UK	8 women with experience of the crisis house	Semi-structured interviews	Unclear	Thematic analysis
Rafferty et al., [124]	2017	Hospital and community healthcare	UK	Item generation n=34 healthcare staff; pilot test n=467; full validation n=1698	Mixed method: focus groups and questionnaires	Full validation- June to August 2014	Factor analysis; Cronbach's Alpha reliability test
Royal College of Psychiatrists [125]	2015	Mental health services	UK	Not applicable	Not applicable	Not applicable	Not applicable
Rees et al., [126]	2017	Ambulance paramedic services	UK	11 paramedics	Semi-structured interviews	unclear	Grounded theory constant comparative analysis
Simpson [138]	2007	Community mental health teams	UK	200 interviews with CMHT staff and service users. Observations of 71 meetings and analysis of service documents.	Non-participant observation; semi-structured interviews; questionnaire	Jan 1999 and Feb 2001	Constant comparative analysis to generate themes.
Simpson et al., [127]	2016	Acute in-patient mental health	UK	19 mental health wards on 6 NHS sites in England; interviews with n=301 service users and n= 290 staff; case study interviews with mixed stakeholders n=76, n=51 care plans; n=12 meetings.	Mixed method: narrative synthesis of policy and evidence; service user survey; staff survey; embedded case study interviews; documentary review of care plans and meetings.		Quantitative analysis of measures from surveys at site level, cross-site comparisons, covariance and correlational analyses provided outcomes related to recovery. Qualitative analysis using framework approach within and across sites.

10.4.4 Appendix 4.4 Summary table of included documents IPT3 Interagency working

Document authors	Year of publication	Study setting	Country	Participant number & characteristics	Method of data collection	Date of data collection	Method of analysis
Association of Mental Health Providers (AMHP)[154]	2021	Voluntary Sector	UK	Not applicable	Not applicable	Not applicable	Not applicable
Bowles & Jones[159]	2005	Mental health acute in-patient	UK	14 healthcare staff from different professional backgrounds with experience of acute mental health care	One focus group and field notes	Unclear	Thematic analysis
Carson[144]	2018	Street Triage	UK	3 individuals with experience of accessing street triage	Individual narrative interviews	Unclear	Narrative analysis
Crisis Care Concordat[30]	2021	All crisis mental health service providers in England	UK	Not applicable	Not applicable	Not applicable	Not applicable
Department of Health and Concordat signatories. Mental Health Crisis Care Concordat[27]	2014	All crisis mental health service providers in England	UK	Not applicable	Not applicable	Not applicable	Not applicable
Edmondson & Cummins[146]	2014	Street Triage	UK	6 months of service data including 673 incidents referred to pilot intervention; 17 individual interviews with police and health staff; group interviews unclear sample.	Mixed methods: Qualitative service data; individual and group interviews and consultations.	Dec 2013- May 2014.	Descriptive statistical analysis of service data; Thematic constant comparative analysis.
Gibson, Hamilton & James[28]	2016	All crisis mental health service providers in England	UK	32 crisis service action plans; observations of 8 key meetings in 4 local areas; 16 interviews with local and national steering group stakeholders; two surveys of crisis experiences. Survey 1 n=391; survey 2 n= 140.	Service level crisis action plans; observations of meetings; two surveys of experiences using crisis services.	Observations July to October 2014 Survey Oct 14-Dec15.	Thematic analysis of action plans. Descriptive analysis of change over time in survey data.
Goodwin et al., [142]	2012	Integrated healthcare	UK	Not applicable	Not applicable	Not applicable	Not applicable
Griffith[139]	2016	Primary Care	UK	Not applicable	Not applicable	Not applicable	Not applicable

Healthy London Partnership[153]	2016	National Health Services London	UK	Not applicable	Not applicable	Not applicable	Not applicable
Hollander et al., [147]	2012	Police and crisis services	Australia	44 police and 13 crisis services staff	Questionnaire	unclear	Descriptive statistical analysis of Likert responses. Non-parametric tests to control for differences is sample size between groups.
Horspool et al., [148]	2016	Street Triage	UK	14 police and mental health staff involved in delivering street triage interventions	Semi-structured interviews	Sept 14- Jan 15	Framework analysis
Iacobucci[156]	2015	National Health Service	UK	Not applicable	Not applicable	Not applicable	Not applicable
Lancaster[149]	2016	Joint police and mental health crisis responses	UK	Not applicable	Not applicable	Not applicable	Not applicable
McKenna et al., [150]	2015	Northern Police and Clinical Emergency Response Team	Australia	17 participants with experience of NPACER model (6 service user/carer and 11 staff from police and health).	Individual interviews	Jan-Jul 2014	Inductive thematic analysis
Mental Health Foundation[145]	2013	Integrated mental health care	UK	31 seminar participants; 1200 responses to a call for evidence	Literature review; seminar; call for evidence	Apr 12- Jun13	Unclear
National Collaborating Centre for Mental Health[88]	2020	Crisis mental health services	UK	Multi-agency, user-led collaborative of 75 UK organisations. All age crisis care.	Methods not reported	Unclear	Methods not reported
National Voices[152]	2013	Integrated Care	UK	Not applicable	Not applicable	Not applicable	Not applicable
Newbigging et al., [10]	2020	Voluntary sector crisis mental health services	UK	171 voluntary sector MH crisis organisations; between 13 and 27 stakeholder individual interviews in each of four case study sites. Two focus groups n= 30 service users and n= 22 carers. Narrative interviews n=47 service users and 11 carers. Brief questionnaire n=43 service users.	Mixed method: National survey Mapping services, case studies	Survey: May 2017 to August 2018. Other data collection not stated.	Database analysis, thematic analysis, framework analysis. Descriptive statistical analysis of database and survey data.
NHS England[155]	2018	Integrated 24/7 multiagency mental health first response service	UK	Not applicable	Not applicable	Not applicable	Not applicable

NHS[141]	2020	Webpage advice on seeking help in a crisis	UK	Not applicable	Not applicable	Not applicable	Not applicable
Parker et al., [80]	2018	Interagency mental health with police	UK	N=125 studies included	Systematic scoping review	Unclear	Arskey's literature mapping framework.
Public Health England[143]	2017	Mental health and alcohol/drug use	UK	Not applicable	Not applicable	Not applicable	Not applicable
RAND Europe, Ernst & Young LLB, University of Cambridge[151]	2012	Integrated Care	UK	16 sites included: 223 interviews with staff and 82 with patients; cost estimate proforma to 16 sites.	Mixed methods: staff interviews; patient questionnaires; staff questionnaires; routine health data, service documents and local evaluations conducted on included sites; cost analysis.	Autumn 2009-autumn 2011	Quantitative regression analysis and McNemar's test for clustering. Costs calculated using 12 months of categories of cost and resources.
Rees et al., [140]	2014	Ambulance paramedic services	UK	11 paramedics	Semi-structured interviews	2014-2016	Evolved grounded theory approach
Reveruzzi et al., [97]	2016	Street triage	UK	Nine pilot street triage scheme reports and related service data. N=6 individual interviews with senior staff.	Routine service data, documentary evidence of the service designs, interviews with health and police staff, service users and family members.	Unclear (data from pilot 2013-2018)	Retrospective statistical analysis of service data from nine teams. Synthesis of qualitative service data from nine pilot schemes reports. Thematic analysis of additional interviews with senior organisation staff.

10.5 Appendix 5 Synthesised CMO configurations

(Context) **IF…**	*(Mechanism)* **THEN…**	*(Outcome)* **LEADING TO…**	**PT**
People in crisis have physical health concerns [83, 117.]	People in crisis seek help from known and easy to access services that they trust [10, 96.]	There is Increased likelihood of people in crisis attending A&E or GP or phoning NHS 111/ NHS 999 [83, 88, 96, 98, 107, 141.]	1, 3
People in crisis or their family members lack information about sources of help in a mental health crisis [88.]			1
People in crisis or their family members believe that the crisis service guarantee a response [96, 109, 142.]	People in crisis have a reduced sense of urgency, feel safer [2, 10, 95] and trust that the service can help [10,15, 95, 96, 107] engage with the service and tolerate waiting.	There is reduced A&E use [83, 88, 96, 98, 107].	1
People in crisis can access help in a safe space [128 153] away from home [10.]	People in crisis are less fearful and can take stock of their situation [10.]	People in crisis can regain control [117] over their situation, manage their distress [131,] and have improved experiences of crisis services [136.]	1,3
Non-clinical, safe spaces in communities have open access (e.g crisis café, haven) that include peer support [10, 128, 130, 153.]	People in crisis access a service as a proxy for family and friends that provides a sense of safety and belonging [10, 153] and being understood [118.] People seek support sooner in the crisis [10, 105.]	Engagement with the service is improved and distress reduced [109]. Reduced use of A&E [130.]	1, 2, 3
People successfully navigate to crisis help in the early stages of a crisis [2, 10, 15, 96, 97,111, 145.]	People in crisis and their family members feel believed and hopeful [109.]	People in crisis can regain control over their situation and manage their distress [109]. There is increased willingness from people in crisis to seek help in a future crisis [2.]	1
People in crisis receive a response that fits around their personal circumstances with minimal disruption to usual life and accessing causes no financial or social burden [10, 89, 96, 97, 100, 107, 113, 144.]	People in crisis or the person seeking help (often family) perceive the service to be easy to access [96] and designed for them [1] prompting them to make contact sooner in the crisis [10, 105.]	People in crisis and those seeking help on their behalf have a sense of personal control [114.] Reduced urgent care use [94, 107, 109.]	1, 2
Crisis services can be accessed without complex referral routes (particularly important to black men who often experience stigma, fear and racial stereotyping) [1, 10, 15 88, 89, 91, 94, 103, 111.]	The service is perceived as easy to access, [96] available, and designed to meet the needs [1] of people in crisis. People in crisis experience less fear and crisis responses are accessed sooner.	People in crisis, particularly black and minority ethnic people and men, are less distressed at first contact and the response is less likely to be coercive [10, 129, 128, 130, 131.]	1, 2
Frontline staff in crisis services (particularly in statutory services) value referral that includes gatekeeping [2, 102, 104, 107, 111.]	Frontline staff are less fearful of being overwhelmed [15, 102.]	Reduction in hospital admissions [102.] Reduction in inappropriate referrals and controlled workload [15.]	1

		Resource pressures are managed [94, 102.]	
Black and minority ethnic people in crisis have been involved in shared decision making [105, 122.]	Black and minority ethnic people experience trust and personal control [116, 121.]	Improved relationships between services and between services and people in crisis [121, 116.]	1, 2
Decisions are reached through negotiation between staff in different agencies and involve the person in crisis (shared decision making) [115, 121, 122.]	The person's (and family's) interpretation of the crisis is acknowledged [2, 95, 101, 102, 117, 118] there is a shared commitment to decisions [114, 115.]		
The organisational culture is centred on therapeutic relationships (over professional power) [122, 129.]	Frontline staff trust joint decision making to produce appropriate crisis plans and take a collaborative (rather than paternalistic) approach to shared decisions [120, 122, 117, 118,] that they prioritise [115, 121, 122.] People in crisis are hopeful and feel respected encouraging them to engage with services [114, 115, 116, 121.]	There is improved service user experience of services [131.]	1, 2
Frontline staff have therapeutic skills and ability to provide compassionate crisis interventions [127, 131, 135, 136.]	Frontline staff deliver care that is balanced between focusing on mitigating risk and relational safety [10, 127, 131.] People in crisis are involved in decisions about their care [135.]	There is improved satisfaction with crisis care [10, 145.]	1, 2
Black and minority ethnic people received peer support [10.]	People who are black or identify as from an ethnic minority, learned about themselves and gained a new perspective [10.]	People who are black or identify as from an ethnic minority have an immediate sense of being understood and a distal recognition of opportunities to contribute that gave meaning and hope [10.]	1
The support of family and friends is not available, (or perceived to not be available) [95] people can access a proxy via peer support, often provided via voluntary sector non-clinical services [10, 153.]	People in crisis have a sense of connectedness, trust, and safety [10, 118.]	The person feels safe with reduced guilt about causing a burden to family and friends [10, 117, 118, 131.]	1, 3
People have access to support from family or friends and they are available for support, the person believes that accessing their support is reasonable rather than burdensome [10, 95, 96 102, 109, 114.]	People in crisis experience connectedness, trust and a sense of safety. People in crisis can collaborate in decisions, there is respect [92, 93, 96, 103, 109, 117.]	The person in crisis seeks help from family and friends first and secures support quickly [10.] People in crisis experience continuity of support.	1
Frontline staff have skills that enable them to provide immediate supportive	People in crisis experience relational safety, hope and	The person in crisis can communicate their needs, regain control, manage their	1, 2

responses such as active listening and counselling [92,101, 127, 136.]	encouragement. Staff are more flexible and responsive [10.]	distress, and believe that the service can help [10, 116, 117, 121, 131.] In the longer term the person in crisis is more likely to contact the service again [2, 10, 109.]	
Frontline staff are compassionate in their responses (in person or via telehealth) to people in crisis and their family & friends [10, 112, 117, 125, 127, 128, 130, 131, 132, 138.]	People in crisis feel valued, believed, respected [10, 128,] and involved in their care [114, 121].	People in crisis experience relational safety and stabilisation of the immediate crisis [10, 101, 128]. People in crisis report improved experience of crisis services [131.] Improved job satisfaction for crisis services staff [123, 137.]	1, 2
Crisis services are available 24/7 [2, 10, 89 94, 97] and provide same day responses [15.]	The expectations of people in crisis (and their family) for an urgent response are met, they trust the service and have a reduced sense of urgency [96, 109, 115, 117, 118, 119.]	People in crisis access a mental health assessment more quickly and are less likely to circle the system [10, 99.]	1
Crisis services provide co-response models that include parallel assessment [97, 141, 147.]	People in crisis experience less fear (of traumatic re-telling) and a greater sense of personal control [117, 131.]	People in crisis experience a reduced number of assessments and related traumatic re-telling [110]. People in crisis experience faster access to a mental health assessment that is holistic and more accurate [99, 100.]	1, 2, 3
Mental health staff are co-location in emergency control rooms [97.]	Non-mental health specialist staff (e.g police, ambulance) are more confident in responding to crises and feel supported in decisions [97.]	Cost effective and sustainable crisis services [97.] Faster response to mental health calls with improved decision making and onward referral [97, 99, 100, 109.] Reduced likelihood of people in crisis being taken to or choosing to go to A&E or coercive responses being implemented (e.g Mental Health Act) by clinical staff or police [97, 100.]	1, 3
Frontline staff have access to clinical leaders and systems of support [10, 92, 103, 114.]	Frontline staff are less fearful of blame and seeking support is an accepted norm[103]. There is acceptance and tolerance between staff [103.]	Frontline staff sustain compassion, are more confident in decision making and staff stress is reduced. Staff turnover is reduced and job satisfaction increased [106, 123, 125, 137.]	1, 2, 3
Decision making is supported by evidence-based decision aides that are understood across interagency system of crisis care (e.g triage tools) and	Frontline staff have confidence in decisions and there is mutual trust across agencies [10, 97, 100.] Frontline staff have less fear in referring to other agencies and	Interagency service co-ordination [97, 100] is improved and leads to accurate resource allocation. Accurate identification of urgency and	1, 3

are linked to available services (e.g service access thresholds)[15, 92, 93, 97, 103.]	have a sense of role clarity within the crisis system [103, 122.]	need (e.g suicidality) [92, 93, 97, 103.] Reduced disputes about responsibility between staff and between agencies [10.]	
Frontline staff in 'first response' roles (the first staff member to speak with the person in crisis) have immediate access to clinical leaders to support and manage resource pressures and disputes about responsibility across the interagency system [10, 103, 127, 133, 137, 150.]	Leaders focus on buffering external demands and pressures [125.] Frontline staff are confident in decisions and can focus on the person in crisis [134.]	Disputes about responsibility are reduced and frontline staff retain compassion [10]. Decisions are collaborative and safe [10, 92, 101, 106, 114.]	1, 3
Multiple definitions of crises are understood and accepted across agencies [10, 95, 108.]	Frontline staff accept, have a sense of ownership of, and work with different values across the crisis care system [10, 105, 125, 137, 138.] Commissioners and leaders design services that accommodate different approaches to crises. There is challenge and debate [10, 154.]	Interagency affiliation facilitates improved communication, information sharing and engagement [10, 124, 125.] Staff work flexibly across agencies reducing gaps and delays [10, 136, 145.]	1, 3
Mental health crises are conceptualised as part of a recovery journey rather than as single events [10, 94, 108.]	People in crisis feel confident when contacting crisis services more than once without fear of rejection [94, 109, 110.] Frontline staff are more accepting of people who may require multiple crisis interventions and are confident to refer and liaise across the crisis system [108, 109.]	Frontline staff retain compassion irrespective of how frequently a person has attended the service [93, 98.] People in crisis requiring multiple crisis responses are more likely to engage and less likely to become desperate and escalate risky behaviour [88, 109, 110, 114, 122.] Reduction in repeat attendances [109, 110] and people leaving the service without treatment [130.]	1, 2, 3
Frontline staff have positive attitudes that are not labelling or stereotyping people in crisis irrespective of the number of times they have attended [2, 10, 105.]			
Frontline staff have time to assess people in crisis [104.]	Staff focus on the person's interpretation of the crisis and involvement in decisions [2, 95, 101, 117, 118.]	Reduce the number of attendances for crisis support [93, 98, 109, 110.] Reduce escalation of distress and harm [94.] Improved cost effectiveness and service user experience [10, 98, 108, 109.]	1
Organisational strategy and operational leadership drive sustained engagement with information sharing and shared decision making [122.]	Frontline staff engage in information sharing and shared decision making and adopt changes into practice. People in crisis feel able to engage in their care and that the service	Improved service co-ordination, faster responses for people who attend services frequently or are known to services [116, 120.] Sustained change [122.]	1, 3

	knows something about them [118, 120.]		
A focus on compassionate and psychologically safe crisis care drives proactive management of waiting at strategic, operational, and clinical levels [10, 90, 93, 104, 109.] Frontline staff provide information about waiting times, what the wait is for and what the person can do to stay safe during the wait [109.]	There is a shared understanding of waiting time policy and staff act to meet the standard. People in crisis and their family can tolerate waiting, the sense of urgency is reduced [96, 109, 110.] Frontline staff use systems of prioritisation to support decision making about appropriate waiting time based on urgency of need [92, 93.]	People in crisis are less likely to disengage from services without treatment or circle the system [2, 10, 15, 104, 130.] Distress and harmful behaviour are less likely to escalate [109, 128, 131.]	1, 2
Commissioning takes account of how complex boundaries between agencies (e.g between urgent care, police, crisis services, voluntary sector services) including how thresholds for access impact on service delivery and service user and carer experience (e.g transport, transitions, service thresholds) [10, 15, 94, 113, 139, 155.]	Commissioners and policy makers lead a systemic drive for interagency agreement about geographic and service remit boundaries [145.] Staff believe in the service and act to collaborate across organisational and geographic boundaries [140, 149.]	Gaps, delays and disputes about responsibility are reduced [10, 147.] Staff morale is improved. [103.] There is improved service delivery and cost effectiveness [155.] There is a reduction in use of coercion [27, 144, 148.]	1, 3
Crisis services are commissioned to provide continuity and have a stable presence in communities [2, 10, 94, 104, 156.]	Frontline staff are responsive to the needs of people in crisis (rather than focused on protecting scarce resources) [126.] People in crisis know their local crisis services and navigate to them [10, 115, 117, 118, 119.] Frontline staff are familiar with available services [10, 145.]	Gaps, delays and disputes about responsibility are reduced [10, 147]. Staff morale is improved. [103.] There is improved service delivery and cost effectiveness [155.] Quality of crisis care is improved [137.]	1, 3
Co-production (including co-design of training) is actively resourced [2, 10, 105, 156.]	The aspirations of service users is incorporated into design, delivery and evaluation of services across the interagency system [135.] Service users recognise the service as designed for them, there is ownership and affiliation [88, 145.]	Quality of crisis care is improved [137.] There is reduced fear and shame about accessing services (stigma) [2, 117.]	2, 3
Services are designed with the communities they serve and reflect their diversity [88, 105.]	People from minority groups recognise the service as being for them, staff use language and communication that avoids racial and other stereotypes [10, 88, 105.]	Quality of crisis care is improved [137]. There is reduced fear and shame about accessing services (stigma) [2, 117.]	3
Diverse data is used to monitor services and inform decision making, including data drawn from across	End users of services are involved in evaluating services from multiple perspectives [135] and commissioners and leaders	Quality of care is understood from multiple perspectives including priorities of service users and communities served [136, 137.]	2, 3

agencies and including aspects of service delivery that are harder to measure (e.g relational safety, compassion) [10, 143].	are focused on shared priorities [136] (rather than competing priorities).		
Technology operates across crisis agencies [141, 145, 148.]	Information sharing facilitates communication and confidence between staff in different agencies, staff buy into the system and trust is established [10, 93, 97, 145.]	Improved information sharing [145, 148.] Reduced number of assessments and reduced trauma [97]. Reduced barriers caused by rules about confidentiality and boundary disputes [10, 95]. Faster access and transition through agencies [97.]	1, 3
There is equal emphasis between the leadership of, and relationships between staff across agencies, and the structure of the interagency system [127, 136, 138.]	Leaders of crisis services balance the day-to-day demands of service delivery with attention to the needs of staff. Workloads allow leaders to be available to staff [134]. Staff are clear about lines of accountability and seek support with clinical decisions [136, 138.]	Frontline staff retain compassion [132, 138.] Improved morale in leaders and staff, staff retention is improved [125, 136, 137.] Change is initiated and sustained [132, 136, 137.] Resources are managed effectively sustaining clinical priorities [133, 136.] Staff are empowered (rather than helpless) [134.]	2, 3
There are shared values and objectives between leaders, who model compassion [136, 137.]	There is affiliation within and between teams [124, 125,] there is a flat structure and leaders make themselves accessible and visible [125,] expectations are clear [129]. There is staff development and (joint) training that fosters growth [127, 129, 137.]	Staff are regarded compassionately [133] humanely [123] and respected [138.] Cost effectiveness through streamlined processes and referral [97, 151.] People in crisis experience reduced distress and increased satisfaction with crisis services [151.]	2, 3
There are system navigators and co-ordinators with knowledge of the whole crisis system [136, 142, 145, 151.]	People in crisis experience continuity through trusted points of liaison [152.]	Reduced time for police dealing with crises [146.] People in crisis experience transition through agencies seamlessly [152.]	3
There is a system-wide approach to commissioning crisis services [151, 159.]	There is stability in funding and resources [4, 10,] smaller organisations have a stable presence. There is a system wide understanding of the resources required and agencies operate to manage complexity across the system (rather than operating in silos to protect resources) [80, 145.]	Services are cost effectiveness through streamlined processes and referral [97, 151.] People in crisis experience reduced distress and increased satisfaction with crisis services [151.]	3
Crisis care operates to national standards with local implementation [27, 30, 88, 150.]	Crisis services operate to meet standards and expected outcomes from crisis care	Crisis services have potential for cost improvements [155].	3

	nationally and locally [27, 28, 30] and attention to local populations drives commissioning that is responsive to local need [30, 91].	People in crisis are less likely to attend A&E [97, 144].	
Staff understand how their role fits within an interagency system [140, 147, 149].	Staff across agencies have confidence (rather than concern) that the spectrum of care is available across the interagency system [10, 15].	Suspicion and mistrust between different agencies and staff groups is reduced and there is improved communication between staff and between agencies [10, 159].	1, 3

10.6 Appendix 6 GRADE-CERQual assessment of confidence in findings- full assessment

Summary finding	Studies	Methods	Coherence	Adequacy	Relevance	CERQUal assessment	Explanation of CERQual
Routes into crisis services 1. (C_1) People in crisis who have physical health concerns or (C_2) lack information about crisis services (M) seek help from services they know, trust and are easy to access (O) making it more likely that they will attend A&E, call 999 or 111 or see GP.	10, 83, 88, 96, 98, 107, 117, 141	Moderate methodological limitations. (Two studies with moderate methodological limitations in analysis; one study minor methodological limitations in analysis; one study reported no method)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Minor concerns about adequacy. (six studies that together offered rich or very rich data, one report moderately rich data)	Minor concerns about relevance. (one study setting not mental health)	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy, and relevance.
Guaranteed service response 2. (C) If people in crisis believe a service provides a guaranteed response, (M) they have a reduced sense of urgency, feel safer and trust that the service can help. The guarantee of a response makes them more likely to choose the service and tolerate waiting. (O) If crisis services guarantee a response, then people are less likely to attend A&E.	2, 10, 15, 83, 88, 95, 96, 98, 107, 109, 142	Moderate methodological limitations. (Two studies with moderate methodological limitations in analysis; two studies minor methodological limitations in analysis; three studies reported no or limited method)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	No concerns about adequacy.	Minor concerns about relevance. (two studies setting not mental health)	Moderate confidence	Moderate methodological limitations, no concerns about adequacy and minor concerns about coherence and relevance.
Safe spaces 3. (C) When people in crisis access safe spaces away from home, (M) they are less fearful and can take stock of their situation thereby regaining control over their situation, managing their distress and (O) have improved experiences of services.	10,117, 128, 131, 136, 153	Moderate methodological limitations. (One study with moderate methodological limitations in analysis; two studies minor methodological limitations in sample and analysis; one study reported no method)	Moderate concerns about coherence. (Concerns about the fit of two studies to the review finding)	Moderate concerns about the adequacy of the outcomes in this review finding.	Minor concerns about relevance.	Low confidence	Moderate methodological limitations, moderate concerns about coherence and adequacy and minor concerns about relevance.
Non-clinical safe spaces, open access and peer support 4. (C_1) Non-clinical safe spaces in communities (C_2) have open access and (C_3) include peer support, (M) the service seems to act as a proxy for family support by providing a sense of safety, belonging, and being understood. People in crisis seek this support sooner (O_1) improving engagement, reducing distress and (O_2) attendance at A&E.	10, 105, 109, 118, 128, 130, 153	Moderate methodological limitations. (One study with moderate methodological limitations in analysis; three studies reported limited or no method)	No concerns about coherence.	Minor concerns about adequacy (One study thin data)	No concerns about relevance.	Moderate confidence	Moderate methodological limitations, minor concerns about adequacy and no concerns about coherence or relevance.

Early navigation to help 5. (C) People in crisis successfully navigate to help in the early stages of a crisis (M) they feel believed and hopeful, they regain control over their situation and manage their distress. (O) People in crisis have Increased willingness to seek help in the future.	2, 10, 15, 96, 97, 109, 111, 145	Moderate methodological limitations. (Two studies with moderate methodological limitations in analysis; two studies reported limited or no method)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Minor concerns about adequacy. (Two studies offered thin data)	Minor concerns about relevance. (One study setting not mental health)	Moderate confidence	Moderate methodological limitations, minor concerns about coherence, adequacy, and relevance.
Services fit around personal circumstances 6. (C) People in crisis receive a response that fits around their personal circumstances with minimal disruption to usual life with no social or financial burden. (M) They perceive the service to be easy to access, designed for them prompting help seeking sooner in the crisis. (O_1) People have personal control and are (O_2) less likely to access crisis support via the urgent care pathway.	1, 10, 89, 94, 96, 97, 100, 105, 107, 109, 113, 114, 144	Moderate methodological limitations. (Eight studies with minor methodological limitations in analysis, sampling and mixed method synthesis; three studies reported limited or no method)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Minor concerns about adequacy. (Three studies offered thin data)	Minor concerns about relevance. (One study setting not mental health)	Moderate confidence	Moderate methodological limitations, minor concerns about coherence, adequacy, and relevance.
Ease of access and referral 7. (C_1) Crisis services can be accessed without complex referral routes (C_2) this was particularly important for black men who prefer open access services. (M) People in crisis, especially black men, perceive open access services to be easy to access and designed for them. More generally, people in crisis who find access easy, experience reduced fear and services are accessed sooner. (O_1) People are less distressed at first contact and (O_2) particularly black men are less likely to experience coercive responses.	1, 10, 15,88, 89, 91, 94, 96, 103, 111, 128, 129, 130, 131	Serious concerns regarding methodological limitations. (Six studies reported limited or no method, one study had serious methodological limitations in reporting of design, sampling, and analysis, and one study had minor limitations in analysis and synthesis)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Moderate concerns about adequacy. (Although nine studies together provided rich or very rich data, five studies provide thin data)	Minor concerns about relevance. (One study setting not mental health)	Low confidence	Serious concerns regarding methodological limitations, moderate concerns about adequacy of data and minor concerns about coherence and relevance.
Gatekeeping 8. (C) Frontline crisis staff (particularly in statutory services) value gatekeeping. (M) Gatekeeping seems to provide reassurance to staff who are less fearful of being overwhelmed, they feel able to control their workload (O_1) minimising the impact of inappropriate referrals and (O_2) reducing the number of hospital admissions. (O_3) Resource pressures are managed.	2, 15, 94, 102, 104, 107, 111	Minor methodological limitations. (Two studies report limited or no method, two studies have minor limitations in analysis)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Minor concerns about adequacy (One study provided thin data)	No concerns about relevance.	High confidence	Minor methodological limitations and minor or no concerns about coherence and adequacy and relevance.

Shared decision making 9. (C) Decisions are reached through negotiation between staff across agencies and involve the person in crisis, especially important for black people. (M) People in crisis trust the service, have personal control, the person and family perception of the crisis is acknowledged and there is a shared commitment to decisions (O) improving relationships between services and people in crisis.	2, 95, 101, 102, 105, 114, 115, 116, 117, 118, 121, 122	Minor methodological limitations. (Three studies reported limited or no methods, three studies had minor methodological limitations related to intervention fidelity and analysis)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Minor concerns about adequacy (Trial studies reported limited data to inform mechanism)	No concerns about relevance.	High confidence	Minor methodological limitations and minor or no concerns about coherence and adequacy and relevance.
Organisational culture and therapeutic relationships 10. (C) The organisational culture is centred on therapeutic relationships. (M_1) Frontline staff trust shared decision making, take a collaborative approach and prioritise shared decisions. (M_2) People in crisis feel respected, and engage, (O) improving people's experience of crisis services.	114, 115, 116, 117, 118, 120, 121, 122, 129, 131.	Moderate methodological limitations. (Five studies report minor methodological limitations related to sample variation and analysis; three studies report moderate methodological limitations related to intervention fidelity, selection bias and blinding).	Moderate concerns about coherence in relation to the specific fit of the studies to the finding.	Minor concerns about adequacy.	Minor concerns about relevance (studies not centrally focused on organisational culture)	Low confidence	Moderate methodological limitations and concerns about coherence. Minor concerns about adequacy and relevance.
Therapeutic skills, risk and relational safety 11. (C) Frontline staff have therapeutic skills and provide compassionate crisis interventions. (M) Frontline staff deliver care that is balanced between mitigating risk and providing care that promotes relational safety. (O_1) People in crisis are more likely to be involved in decisions and (O_2) have improved experience of and satisfaction with crisis care.	10, 127, 131, 135, 136, 145.	Minor methodological limitations. (Two studies reported limited or no method, two studies reported minor methodological limitations related to appraisal and analysis.)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Minor concerns about adequacy. Studies provide rich data but are limited in number.	No concerns about relevance.	Moderate confidence	Minor methodological limitations and minor or no concerns about coherence and adequacy and relevance.
Peer support 12. (C_1) Peer support is available, (C_2) particularly important to black and minority ethnic people, who (M_1) believe that they have learned about themselves and gained a new perspective giving a sense of being understood and a (M_2) recognised opportunities to contribute that (O) gave hope and meaning.	10	Minor methodological limitations.	Serious concerns about coherence.	Serious concerns about adequacy. (Single study with very rich data)	No concerns about relevance.	Very low confidence	Minor methodological limitations, serious concerns about coherence and adequacy and no concerns about relevance.
A proxy for family 13. (C) When the support of family and friends is not available, or perceived to be	10, 95, 117, 118, 131, 153.	Minor methodological limitations. (One study reported limited or no	Minor concerns about coherence. (Some concerns about the fit	Minor concerns about adequacy. (One study provides thin data)	Minor concerns about relevance.	Moderate confidence	Minor methodological limitations and minor concerns about

unavailable, people can access a proxy for family via peer support provided in non-clinical safe spaces. (M) People in crisis have a sense of connectedness and trust. (O) The person in crisis feels safe and has reduced guilt about being a burden to family and friends.		method, three studies reported minor methodological limitations related to sampling and analysis.)	from studies and the review finding)				coherence, adequacy, and relevance.
Family and friends first 14. (C) When people have access to support from family and friends, (M) they have a sense of connectedness, trust and safety that enables collaboration in decisions and mutual respect. The person seeks help from family and friends first and (O) secure help quickly.	10, 92, 93, 95, 96, 102, 103, 109, 114, 117	Moderate methodological limitations. (Moderate concerns in one study related to analysis and reporting of method; six studies had minor limitations in analysis)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	No concerns or minor concerns about adequacy. (Studies report rich data)	No concerns about relevance.	Moderate confidence	Moderate methodological limitations and minor or no concerns about coherence, adequacy, or relevance.
Immediate supportive responses 15. (C) Frontline staff have skills that enable them to provide immediate supportive responses including active listening and counselling. (M^1) Staff are more flexible and responsive. (M^2) People in crisis experience relational safety, hope and encouragement and can communicate their needs, regain control, manage their distress, and believe that the service can help. (O) The person is more likely to contact the service again in the future.	2, 10, 92, 101, 109, 116, 117, 121, 127, 131, 136	Moderate methodological limitations. (One study reported limited or no method, moderate limitation in one study related to blinding and validity of measures, minor limitations in four studies related to sampling and analysis)	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	No concerns or minor concerns about adequacy. (Studies report rich data)	No concerns about relevance	Moderate confidence	Moderate methodological limitations. Minor or no concerns about coherence, adequacy, or relevance.
Compassionate crisis responses 16. (C) Frontline staff are compassionate in their responses (in person or via telehealth) to people in crisis and their family & friends. (M) People in crisis are valued, believed, respected, and involved in their care. (O^1) People in crisis experience relational safety, (O^2) stabilisation of the immediate crisis, (O^3) improved service user experience and (O^4) there is improved job satisfaction for staff.	10, 101, 112, 114, 117, 121, 123, 125, 127, 128, 130, 131, 132, 137, 138	Minor methodological limitations. Four studies reported limited, or no method and five reported minor methodological limitations related to sampling and analysis.	Minor concerns about coherence. (Some concerns about the fit from some studies and the review finding)	Minor concerns about adequacy. Most documents provide rich data, limited to thin data in two studies)	Minor concerns about relevance (one study not focused on mental health setting)	Moderate confidence	Minor methodological limitations. Minor concerns about coherence, adequacy, or relevance.
24/7 access and same day responses 17. (C) Crisis services are available 24/7 and provide same day responses. (M) The expectation of people in crisis (and their family) for an urgent response are met,	2, 10, 15, 89, 94, 96, 97, 99, 109, 115, 117, 118, 119	Minor methodological limitations. (Two studies report limited or no method, minor limitations related to analysis in five	Minor concerns about coherence. (Some concerns about the fit from studies and the review finding)	Minor concerns about adequacy. (One study provides thin data)	Minor concerns about relevance (one study not focused on mental health setting)	Moderate confidence	Minor methodological limitations. Minor concerns about coherence, adequacy, or relevance.

they trust the service and have a reduced sense of urgency. (O) People in crisis access a mental health assessment quickly.		studies and moderate limitation related to blinding in one study).					
Trauma informed parallel assessment 18. (C) Crisis services provide co-response models that include parallel assessment. (M) People in crisis experience less fear (of traumatic re-telling) and a greater sense of personal control. (O_1) People in crisis experience a reduced number of assessments and related traumatic re-telling and (O_2) have faster access to a mental health assessment that is holistic and more accurate.	97, 99, 100, 110, 117, 131, 141, 147,	Moderate methodological limitations. (Lack of methodologically robust studies. Studies with no or limited reported method or minor methodological limitations related to sampling and analysis)	Moderate concerns about coherence. (Concerns about the fit from the studies and the review finding)	Moderate concerns about adequacy. Studies report single site evaluations and others report thin data)	Minor concerns about relevance.	Low confidence	Moderate methodological limitations. Moderate concerns about coherence and adequacy, minor concerns about relevance.
Interagency co-location 19. (C) Co-location of mental health staff in emergency control rooms where non-mental health specialist staff (e.g police, ambulance) and specialist mental health staff share workspaces. (M) Non-mental health specialist staff are more confident in responding and feel supported in decisions. (O_1) Services are more cost effective and sustainable. (O_2) People in crisis experience faster responses to mental health calls because of improved decision making and appropriate onward referral. (O_3) There is a reduced likelihood of people in crisis being taken to (or choosing to attend) A&E or coercive responses being implemented (e.g., Mental Health Act) by clinical staff or police.	97, 99, 100, 109	Minor methodological limitations in all studies related to sample and analysis	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Serious concerns about adequacy. Limited number of studies, some with thin data	Minor concerns about relevance	Low confidence	Minor methodological limitations. Serious concerns about adequacy, minor concerns about coherence and relevance
Supportive clinical leaders 20. (C) Frontline staff have access to clinical leaders and systems of support (e.g., clinical supervision). (M) Frontline staff are less fearful of blame and seeking support is an accepted norm that facilitates acceptance and tolerance between staff. (O_1) Frontline staff sustain compassion, are more confident in decision making and staff stress is	10, 92, 103, 106, 114, 123, 125, 137	Moderate methodological limitations. (One study reported no method, one study had serious limitations in analysis and reporting of method, one study had moderate limitations in analysis and three studies had minor limitations related to analysis.	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Minor concerns about adequacy.	Minor concerns about relevance.	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy and relevance.

reduced. (O_2) Staff job satisfaction is increased, and staff turnover is reduced.							
Decision making 21. (C) Decision making is supported by evidence-based decision aides that are understood across the interagency crisis care system (e.g., triage tools) and decisions are linked to available services. (M_1) Frontline staff have confidence in decisions and there is mutual trust across agencies. (M_2) Staff have less fear in referring to other agencies and a sense of role clarity. (O_1) Accuracy in identification of urgency and need (e.g., suicidality) is improved. (O_2) Improved decisions enable improved interagency service co-ordination and more accurate resource allocation. (O_3) There are reduced disputes about responsibility between staff and agencies.	10, 15, 92, 93, 97, 100, 103, 122	Moderate methodological limitations. (One study serious concerns in analysis and reporting, five studies with minor limitations in relation to analysis and intervention fidelity)	Moderate concerns about coherence. (Concerns about the extent to which the data provide a convincing explanation)	Minor concerns about adequacy, studies provide rich data although few in number.	No concerns about relevance.	Low confidence	Moderate methodological limitations and moderate concerns about coherence. Minor or no concern about adequacy and relevance.
Leaders buffer external demands 22. (C_1) Frontline staff in 'first response' roles have immediate access to clinical leaders to support and manage resource pressures and disputes about responsibility across the interagency system. (C_2) Leaders focus on buffering external demands and pressures. (M) Frontline staff are confident in decisions, have role clarity and can focus on the person in crisis. (O_1) Disputes about responsibility are reduced. (O_2) Frontline staff are focused on the person in crisis rather than resource pressures and disputes enabling them to retain their compassion and make decisions that are collaborative and safe.	10, 92, 101,103, 106, 114, 125, 127, 133, 134, 137, 150	Moderate methodological limitations. (No or limited method reported in three studies, serious and moderate limitations in two studies related to analysis and minor limitations in analysis in two studies)	Moderate concerns about coherence. (Concerns about the extent to which the data provide a convincing explanation)	No concerns about adequacy, all studies provided rich data.	Minor concerns about relevance (one study not focused on mental health settings)	Moderate confidence	Moderate methodological limitations and moderate concerns about coherence. Minor or no concern about adequacy and relevance.
Definitions, values, and interagency affiliation 23. (C) Multiple definitions of crises are understood across agencies. (M_1) Frontline staff accept, have a sense of ownership of, and work with different values across the crisis care system. (M_2) Commissioners and leaders design services that accommodate	10, 95, 105, 108, 124, 125, 136, 137, 138, 145, 154	Serious methodological limitations. (Five studies report no or limited methods, three have minor methodological limitations related to analysis and appraisal)	Moderate concerns about coherence. (Concerns about the extent to which the data provide a convincing explanation)	Moderate concerns about adequacy. Rich data related to this finding in three studies. Remaining studies report thin data.	Minor concerns about relevance (two studies are not reporting a mental health setting)	Low confidence	Serious methodological limitations. Moderate concerns about coherence and adequacy and minor concerns about relevance.

different approaches to crises allowing healthy challenge and debate (that challenges e.g., unhelpful stereotyping and operational or professional silos). (M_3) Interagency affiliation facilitates improved communication, information sharing and engagement. (O) Staff work flexibly across agencies reducing gaps and delays.							
Crises as part of recovery 24. (C) Mental health crises are conceptualised as part of a recovery journey rather than as single events. (M_1) Frontline staff are accepting of people who may require multiple crisis interventions and confident to refer and liaise across the crisis system. (M_2) People in crisis feel confident when contacting crisis services more than once without fear of rejection. (O_1) Frontline staff retain compassion. (O_2) People in crisis requiring multiple crisis responses are more likely to engage and less likely to escalate risky behaviour. (O_3) There is a reduction in repeat attendances and people leaving the service without treatment.	2, 10, 88, 93, 94, 98, 105, 108, 109, 110, 114, 122, 130	Serious methodological limitations. (Six studies report no or limited methods, two studies report moderate limitations related to analysis and synthesis, four studies report minor limitations related to analysis)	Moderate concerns about coherence. (Concerns about the extent to which the data provide a convincing explanation)	Moderate concerns about adequacy. Rich data related to this finding in eight studies. Remaining studies report thin data.	Minor concerns about relevance (two studies have limited focus on the finding)	Low confidence	Serious methodological limitations. Moderate concerns about coherence and adequacy and minor concerns about relevance.
Time for assessment 25. (C) Frontline staff have time to assess people in crisis. (M) Staff are less pressured for time and enabled to focus on the person's interpretation of the crisis and involve them in decisions. (O_1) Comprehensive assessment is more likely to be accurate with appropriate onward referral, reducing the need for repeat attendances. (O_2) People in crisis are more likely to reach an appropriate intervention and experience a reduced likelihood of escalation of distress and harm. (O_3) There is improved cost effectiveness and service user experience.	2, 10, 93, 94, 95, 98, 101, 104, 108, 109, 110, 117, 118,	Minor methodological concerns. (Three studies reported limited or no methods, seven studies had minor concerns related to analysis and recruitment bias)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Minor concerns about adequacy.	No concerns about relevance	Moderate confidence	Minor methodological limitations and no or minor concerns about coherence, adequacy and relevance.
Implementation and change 26. (C_1) Organisational strategy and operational leadership drive sustained engagement with information sharing and shared decision making. (C_2) Crisis planning	116, 118, 120, 122	Moderate methodological limitations. (Two studies moderate limitations related to blinding, sampling and selection	Serious concerns about coherence. (Concerns about the fit from the studies and the review finding)	Moderate concerns about adequacy. (Small number of studies)	Minor concerns about relevance.	Very low confidence	Moderate methodological limitations. Serious concerns about coherence, moderate

and information sharing are particularly important for people known to services or who attend services frequently. (M_1) Frontline staff are engaged and adopt changes into practice. (M_2) People in crisis perceive that the service knows something about them, and they are more engaged in their care. (O) There is improved service co-ordination, faster responses, and sustained change.		bias, one study minor limitations related to intervention fidelity).					concerns about adequacy and minor concerns about relevance.
Managed waiting 27. (C) A focus on compassionate and psychologically safe crisis care drives proactive management of waiting at strategic, operational, and clinical levels. (M_1) Frontline staff provide information about waiting times to people in crisis, what the wait is for and what the person can do to stay safe during the wait. (M_2) There is a shared understanding of waiting time policy and staff act to meet the standard. (M_3) People in crisis and their family can tolerate waiting and the sense of urgency is reduced. (O_1) People in crisis are less likely to disengage from services without treatment or circle the system. (O_2) People in crisis experience reduced distress and harmful behaviour is less likely to escalate.	2, 10, 15, 90, 92, 93, 96, 104, 109, 110, 125, 128 130, 131	Moderate methodological limitations. (Four studies report no or limited methods, five studies have minor limitations related to sampling, analysis, and recruitment bias)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Minor concerns about adequacy.	Minor concerns about relevance.	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy and relevance.
Boundary management 28. (C) When commissioning takes account of how complex boundaries between agencies (including thresholds for access) impact on service delivery and service user and family experience. (M_1) Commissioners and leaders drive interagency agreement about geographic and service remit boundaries. (M_2) Staff believe in the service and act to collaborate across organisational and geographic boundaries. (O_1) Gaps, delays and disputes about responsibility are reduced. (O_2) Staff morale is improved. (O_3) There is improved service delivery and cost effectiveness. (O_4)	10, 15, 27, 94, 103, 113, 139, 140, 144, 145, 147, 148, 149, 155	Serious methodological limitations. (Five studies report no method, one study has serious limitations related to analysis and reported method, three studies have minor limitations in analysis and synthesis)	Moderate concerns about coherence. (Concerns about the extent to which the data provide a convincing explanation)	Minor concerns about adequacy.	Minor concerns about relevance.	Low confidence	Serious methodological limitations, moderate concerns about coherence and minor concerns about adequacy and relevance.

People in crisis are less likely to experience coercive crisis responses.							
Continuity and stability 29. (C) Crisis services are commissioned to provide continuity and have a stable presence in communities. (M) People in crisis and crisis staff know their local crisis services and can navigate to them. (O_1) Frontline staff are responsive to the needs of people in crisis (rather than focused on protecting scarce resources). (O_2) Resources are available to provide continuity at service and individual levels.	2, 10, 94, 104, 115, 117, 118, 119, 126, 145, 147, 156	Minor methodological limitations. (Three studies report no or limited methods, three studies have minor limitations related to analysis, one study has moderate limitations related to blinding)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Moderate concerns about adequacy. Rich data related to this finding in six studies. Remaining studies report thin data.	No concerns about relevance	Moderate confidence	Minor methodological limitations. Moderate concern about adequacy, minor or no concern about coherence or relevance.
Co-production and stigma reduction 30. (C) Co-production (including co-design of training) is actively resourced. (M_1) The aspirations of service users (communities) are incorporated into design, delivery, and evaluation of services across the interagency system. (M_2) People in crisis recognise the service as designed for them and have a sense of ownership and affiliation and talk positively about crisis care. (O_1) People in communities become aware of local crisis services. (O_2) There is reduced fear and shame about accessing crisis services (stigma). (O_3) The quality of crisis care is improved.	2, 10, 88, 105, 117, 135, 137, 145, 156,	Serious methodological limitations. (Six studies report no or limited methods, one study report minor limitations related to analysis)	Serious concerns about coherence. (Unclear that the data provide a convincing explanation)	Minor concerns about adequacy. (Most studies provide rich data)	Moderate concerns about relevance. Studies are inconsistently related to the finding.	Very low confidence	Serious methodological concerns. Serious concerns about coherence, moderate concerns about relevance and minor concern about adequacy.
Diversity and inclusion 31. (C) Crisis services are designed and delivered with involvement from the communities they serve, and the staff reflect local diversity. (M_1) Staff use language and communication that avoids racial and other stereotypes. (M_2) People from black and minority ethnic populations recognise the crisis service as being for them. (O_1) There is reduced fear and shame about accessing services (stigma). (O_2) The quality of crisis care is improved.	2, 10, 88, 105, 117, 137,	Moderate methodological limitations. (Two studies report limited or no methods, one study minor limitations related to retrospective data)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Serious concerns about adequacy. (Two studies report rich data related to this finding. Remaining studies report thin data)	Moderate concerns about relevance.	Low confidence	Moderate methodological limitations, minor concerns about coherence, moderate concerns about relevance and serious concerns about adequacy.
Evaluating interagency crisis services 32. (C) When diverse data are used to monitor services and inform decision making, including data from across	10, 135, 136, 137, 143,	Moderate methodological limitations. (Two studies report limited or no methods, a review	Moderate concerns about coherence. (Concerns about the extent to which the	Serious concerns about adequacy. (Two studies report rich data related to this finding. Remaining	Moderate concerns about relevance.	Low confidence	Moderate methodological limitations, concerns about coherence and

agencies and aspects of service delivery that are harder to measure (e.g., relational safety and compassion). (M) End users of services are involved in evaluating services from multiple perspectives and commissioners and leaders are focused on shared priorities (rather than competing priorities). (O) Quality of care is understood from multiple perspectives including priorities of service users and communities served.		provided inadequate appraisal)	data provide a convincing explanation)	studies report thin data. There are a small number of studies related to this finding)			relevance. Serious concerns about adequacy.
Technology and information sharing 33. (C) Technology operates across crisis agencies to support information sharing. (M) Frontline staff are confident to communicate across different agencies, they 'buy into' the system and trust is established. (O_1) Improved information sharing reduces the number of assessments and related risk of trauma. (O_2) Improved communication systems help to reduce barriers to information sharing caused by rules about confidentiality and boundary disputes. (O_3) People in crisis experience faster access and transition through different agencies.	10, 93, 95, 97, 141, 145, 148,	Moderate methodological limitations. (Two studies report limited or no methods, three studies report minor limitations related to sampling, analysis and retrospective data).	Moderate concerns about coherence. (Concerns about the extent to which the data provide a convincing explanation)	Moderate concerns about adequacy. Rich data related to this finding in three studies. Remaining studies report thin data.	Moderate concerns about relevance.	Low confidence	Moderate methodological limitations and concerns about coherence, adequacy and relevance.
Interagency staff support 34. (C_1) There is equal emphasis on interagency leadership and staff relationships as there is to the operational structure of the interagency system. (C_2) Clinical leaders and middle managers are focused on support that balances the day-to-day demands of service delivery with attention to the needs of staff. (C_3) Workloads allow leaders to be available to staff. (M) Staff are clear about lines of accountability and seek support with clinical decisions. (O_1) Improved morale in leaders and staff, staff retention is improved. (O_2) Frontline staff retain compassion. (O_3) Resources are managed effectively sustaining clinical priorities. (O_4) Staff are empowered (rather than helpless).	125, 127, 132, 133, 134, 136, 137, 138,	Serious methodological concerns. (Four studies report limited or no method, two minor limitations related to a lack of appraisal in a review and analysis)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	No concerns about adequacy.	No concerns about relevance	Low confidence	Serious methodological limitations. Minor or no concerns about coherence, adequacy or relevance.

Compassionate leadership 35. (C) There are shared values and objectives between leaders, who model compassion. (M_1) There is affiliation within and between teams, there is a flat structure and leaders make themselves accessible and visible, expectations are clear. (M_2) Staff are regarded compassionately, humanely, and respected, there is staff development and (joint) training that fosters growth. (O_1) Compassionate leaders set the tone for compassionate care and people in crisis experience reduced distress and increased satisfaction with crisis services. (O_2) There is greater likelihood that services are cost effective.	97, 123, 124, 125, 127, 129, 133, 136, 137, 138, 151.	Moderate methodological limitations. (Four studies report no or limited method, three studies minor limitations related to sampling, retrospective data and analysis)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Minor concerns about adequacy although most document provide rich data, three are thin on data for this finding.	Minor concerns about relevance.	Moderate confidence	Moderate methodological limitations and minor concerns about coherence, adequacy and relevance.
System navigators 36. (C) There are system navigators and co-ordinators with knowledge of the whole crisis system. (M) People in crisis experience continuity through trusted points of liaison. (O_1) Reduced time for police dealing with crises. (O_2) People in crisis are more likely to transition through agencies seamlessly.	136, 142, 145, 146, 151, 152	Serious methodological limitations. (Four studies report no or limited methods, one study minor limitations related to reporting of methods and one study moderate concerns related to analysis)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Moderate concerns about adequacy. Few studies and thin data.	Minor concerns about relevance.	Very low confidence	Serious methodological limitations, moderate concerns about adequacy and minor concerns about coherence and relevance.
Interagency commissioning 38. (C) There is a system-wide approach to commissioning crisis services. (M) There is a system wide understanding of the resources required and agencies operate to manage complexity across the system (rather than operating in silos to protect resources). (O_1) There is greater likelihood of cost effectiveness through more streamlined processes across the system and a reduced focus on resolving disputes. (O_2) Interagency systems that provide seamless crisis services are more likely to reduced distress and increase satisfaction with crisis services.	4, 10, 80, 97, 145, 151, 159	Minor methodological limitations. (Three studies minor limitations related to age of data and analysis.)	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Minor concerns about adequacy although most document provide rich data, one thin on data for this finding. Low number of studies.	Minor concerns about relevance.	Moderate confidence.	Minor methodological limitations, minor concerns about coherence, adequacy and relevance.
National standards and local implementation 39. (C) Crisis care operates to national standards with local implementation. (M_1)	27, 28, 30, 88, 91, 97, 144, 150, 155.	Serious methodological concerns. (Six studies report n o or limited method, two studies report	Minor concerns about coherence. (Concerns about the fit from the	Moderate concerns about adequacy. Three studies are thin on data.	Minor concerns about relevance.	Low confidence	Serious methodological limitations. Moderate concern about adequacy and minor concerns

Leaders engage with quality improvement, they set standards (nationally and locally) and lead the delivery of crisis services that meet these standards and expected outcomes. (M^2) Commissioners and leaders pay attention to local populations making service design responsive to local need. (O) Crisis services have potential for cost improvements through reduced use of the urgent care pathway.		minor limitations related to age of data and analysis).	studies and the review finding)				about coherence and relevance.
Interagency role clarity 40. (C) Staff understand how their role fits within an interagency system. (M) Staff across agencies have confidence (rather than concern) that the spectrum of care is available across the interagency system. (O) Suspicion and mistrust between different agencies are reduced and there is improved communication between staff and between agencies.	10, 15, 140, 147, 149, 159.	Minor methodological limitations. (One study reported no or limited method, two report minor limitations related to age of data and analysis).	Minor concerns about coherence. (Concerns about the fit from the studies and the review finding)	Minor concerns about adequacy although three documents provide rich data, low number of studies.	Minor concerns about relevance.	High confidence	Minor methodological limitations and minor concern about coherence, adequacy and relevance.