Review of mental health crisis services in Northern Ireland

Review of mental health crisis services in Northern Ireland

Christine Bateson, Audrey Allen, Tory Cunningham, Gavin Davidson, Erin McFeely, Philip McGarry and Rory O'Connor

April 2021

Summary of the report

Introduction

In May 2020, the Department of Health published the Mental Health Action Plan for Northern Ireland. It identified the development of a new 10-year strategy as a key priority and one of the other objectives of the Action Plan was to "Consider and enhance the experience when a person is experiencing a mental health crisis, in particular in relation to emergency care." The aim of this Review was therefore to gather and evaluate the available evidence and perspectives in order to make recommendations for mental health crisis services. The Review Team, led by Christine Bateson, was identified and supported by the Department of Health but its members were independent of and external to the Department of Health.

Literature review

The literature review focused on policy developments in a number of countries where mental health services have recently been reviewed and on available existing reviews of research on crisis services. This was completed to ensure that the Review in Northern Ireland was informed by recent policy developments in other countries and the available research evidence. The literature review focuses initially on a discussion of definitions, an outline of the range of crisis service models and some examples of service users' perspectives on these services. It then provides a summary of recent policy developments in selected countries before providing an overview of existing reviews of the evidence of the effectiveness of crisis services. A summary of the policy and research context in Northern Ireland is also presented.

How the Review was conducted

In addition to the literature review, information was collected from a series of in-depth meetings including with all of the Health and Social Care Trusts, voluntary sector providers, the Police Service of Northern Ireland (PSNI), the Northern Ireland Ambulance Services (NIAS), the Public Health Agency (PHA), the Regional Emergency Social Work Service (RESWS), service users and carers. An online survey was also used to enable anyone to contribute to the review process.

Findings of the Review

The findings have been structured under the following headings: Crisis Resolution Home Treatment Services in Northern Ireland; Mental Health Crisis in General Hospitals; Mental Health Crisis and the Community and Voluntary Sector; Primary care; Interagency and collaborative working Partnerships; and the Online survey findings.

There were a number of key themes which were identified across the findings from the meetings and the online survey. These included:

- People in crisis should be able to access effective support when they need it
- Crisis services should be resourced to provide a range of evidence-based interventions to meet the needs of people in crisis
- A balance is needed between an equitable, consistent regional service model and supporting local needs/service development and innovation
- A clear priority is the need to develop safe, accessible alternatives to ED – perhaps on or beside general hospital sites including access or links to appropriate accommodation
- Liaison services in hospital settings are an important and necessary but separate function to mental health crisis services
- Need to further support other services – community and voluntary sector; recovery colleges; CMHTs to be able to further prevent and respond to crises

- Need to further develop multi-disciplinary/inter-agency training for crisis work
- Key issue is the integration of and communication between all the relevant people and organisations involved
- The Covid-19 context has highlighted the further potential of telephone/online services
- It is important to consider mental health crisis services in societal context - crisis services are a necessary component of addressing mental health needs but are only one aspect of what is needed
- Co-production should be a central aspect of the change process and there is great potential for the further employment of people with lived experience in crisis services
- Need to consider the management of change/implementation plan and the ongoing evaluation and development of crisis services.

Conclusion and recommendations

The Review Team have made 15 recommendations for the further development of mental health crisis services in Northern Ireland.

1. The Review Team recommends the establishment of an integrated Regional Mental Health Crisis Service that provides for everyone who presents in mental health crisis. This crisis model specification would have four key components that are essential to ensuring that there is a robust framework in place that responds to those in mental health crisis irrespective of the nature of the crisis.
2. The Review Team recommends the establishment of structures that will support the development of the Integrated Regional Mental Health Crisis Service. It is recommended that the structure should include:
   (i) A Regional Partnership Board that will have responsibility for agreeing and supporting the overall implementation of the model;
   (ii) Local implementation teams which will organise subgroup activity and, implement and monitor the new service in designated areas. They will report to the Regional Partnership Board;
   (iii) A phased implementation of the model initially in two test sites. All Trust areas will be invited via an open procurement process to be one of the test sites.
3. The Review recommends that the Distress Brief Intervention (DBI) response is introduced as part of the integrated model. Frontline staff including those in Primary Care, Emergency Departments, NIAS, RESWS, PSNI and Lifeline should be trained in DBI (Level 1) and can refer individuals for up to 14 days of support from Level 2 DBI practitioners based in community based crisis services.
4. The Review Team recommends that Crisis Resolution Home Treatment Teams will concentrate all their resources to provide effective and safe alternatives to inpatient care for those in mental health crisis.
5. The Review Team recommends that a Regional Subgroup (of the Regional Partnership Board) is established to work together to produce a high-fidelity regional approach to Home Treatment using evidence-based Fidelity Tools and Quality Standards such as the Home Treatment Accreditation Scheme (HTAS).
   The working group will also identify opportunities to standardise approaches to Home Treatment, in relation to criteria for acceptance, assessment protocols, safety plans and evidence-based outcome measures. The aim is to introduce a standardised approach that will reduce variability from Trust to Trust.
6. The Review Team recommends that all the main General Hospitals in Northern Ireland have a discrete onsite Mental Health Liaison Service.

An Enhanced 24 Model would ensure that there are staff available 24 hours a day to provide mental health assessments in line with NICE Guidelines. This will also reduce waiting times for assessment, allow for the cessation of Card Before You Leave and reduce the number of people who leave the Emergency Department without an assessment. Development of this multidisciplinary Liaison approach will deliver on enhanced care pathways with other Services such as CAMHS and Learning Disability Services to ensure that there is full equity of access. It will also allow for smooth transitions of care between partnership agencies such as the PSNI and NIAS to ensure that they have the capability to return to their other functions in a timely way.

7. The Review Team recommends that Mental Health practitioners from the Liaison Teams will work in partnership with proposed Acute Care Centres, (which will ideally be co-located with EDs) providing telephone support for those in mental health crisis and Mental Health Assessment in the Acute Care Centre for those not requiring the Emergency Department.
8. The Review Team recommends that a Regional subgroup (of the Regional Partnership Board) is established to develop an agreed specification for Mental Health Liaison Services based on an Enhanced 24 Model.
   The Subgroup should also agree on best evidence approaches in suicide prevention initiatives that can be regionally implemented.
9. The Review Team recommends that partnership proposals are submitted from each Trust area to tender for the integrated crisis service including pilot DBI community based crisis intervention services in two areas. Following evaluation, if deemed effective, this type of service should be extended across the whole of N. Ireland.
   The Review Team also recommends the piloting and evaluation of 'Crisis Cafés', as well as other innovative models of care including 'safe spaces' for all age groups.
10. The Review Team recommends that the rollout of Primary Care Multidisciplinary Teams is completed as a matter of urgency.
    Mental Health Practitioners within these Primary Care Multidisciplinary Teams can play a valuable role in the prevention of mental health crises.
    The Review Team recommends the development of shared interagency, multi-sectoral care pathways, processes and training programmes to ensure that people who present to Primary Care in Mental Health Crisis are directed in a compassionate way to where they will find help.
11. The Review Team recommends that the Regional Partnership Board oversees the piloting and evaluation of innovative, multi-disciplinary first response models so that anyone experiencing a mental health crisis is given an appropriate and compassionate frontline response from a Mental Health Practitioner. Effective models should become an integral part of a future Crisis Service Model, appropriate to the locality. For example, practitioners/frontline staff, trained in DBI, working in control centres within NIAS and PSNI, can play a vital part in providing a first line mental health response to mental health crises. The Multi Agency Triage Team has shown that mental health crisis response and assessment can be provided by Mental Health Practitioners in venues other than the Emergency Department.
12. The Review Team recommends that the Regional Emergency Social Work Service works in close partnership with the Regional Crisis Service. This will ensure that there is a range of crisis interventions that can be accessed in line with best practice, and that all available alternatives to compulsory intervention can be explored and, if compulsory intervention is the least restrictive option possible, then all the necessary safeguards are put in place.
13. The Review Team recommends that the Service Development Team will engage with Education and Training Providers at the earliest point in the design of the model to develop a regional training programme that will provide the skills required for the new functions of

the team and communicate the vision and ethos of the Regional Mental Health Crisis Service.

14. The Review Team recommends that all first responders receive appropriate mental health awareness and suicide prevention training. Mental health champions should also be identified within these agencies to support the effective provision of compassionate and appropriate response to people in mental health crisis.
15. The Review Team recommends that an independent evaluation, following realist evaluation principles, is commissioned to inform the implementation of the full model.

Contents

Introduction

Context of the Review

In May 2020, the Department of Health published the *Mental Health Action Plan* for Northern Ireland. It identified the development of a new 10-year strategy as a key priority and one of the other objectives of the Action Plan was to improve care and treatment in an emergency. Under this objective, the overall action (No. 8 in the Action Plan) was to "Consider and enhance the experience when a person is experiencing a mental health crisis, in particular in relation to emergency care." There were also two further specific and related actions. Action 8.1 was to "Consider the outcome of the RQIA [Regulation and Quality Improvement Authority] Review of Emergency Mental Health Service Provisions across Northern Ireland." The second specific action, 8.2, was to "Reconfigure mental health crisis services" and so this Review of mental health crisis services was established to directly inform the reconfiguration of mental health crisis services.

Aim of the Review

The aim of the Review was to gather and evaluate the available evidence and perspectives in order to make recommendations for mental health crisis services. The Action Plan highlighted a number of specific issues that should be included within the scope of the Review. They were:

- Evaluate alternatives to Emergency Department for people in mental health crisis.
- Evaluation and rollout of Multi Agency Triage Team [MATT].
- Consider interactions between different crisis responses such as MATT, Home Crisis Teams, ED [Emergency Departments], 999, police, primary care MDT [Multi-Disciplinary Teams] and similar.
- Further development of liaison mental health services across all Trusts.

The Action Plan also specified the intended outcomes that the Review will lead to which are:

- Reduction in people attending ED in a MH [Mental Health] crisis.
- Better MH crisis response.

In establishing the Review the Department of Health also specified that the recommendations of the Review should be designed to provide consistent services across Northern Ireland that are integrated across suicide prevention and early intervention, primary care, community and voluntary sector and statutory mental health services.

Scope of the Review

The Review therefore focused on four thematic areas:

- Mapping and evaluation of statutory Crisis and Liaison Services in Northern Ireland
- Mapping and evaluation of Voluntary and Community Services throughout the Region that provide Crisis Intervention to those in Mental Health Crises
- Examining the Regional Context and Involvement of Interagency initiatives to support those who present in Mental Health Crisis.
- Best Practice Initiatives including emerging evidence in Suicide Prevention.

A key aspect of the Review was to adopt an inclusive and open approach and so to seek the views of the range of relevant service users, carers and professionals, so the scope was across the life course and included the following service user groups:

- Those who currently are eligible for Adult Mental Health Services (18-65 years)

- Those who would be eligible for older people's services (over 65 years)
- Those who are eligible for Child and Adolescent Mental Health Service
- Those who are eligible for Learning Disability Services.

The initial target date for completion in the Action Plan was December 2020 but the Review Team was not established until October 2020 and additional time was requested to gather the views of as many people as possible so the completion date was revised to the end of April 2021.

Review Team

The Review Team was identified and supported by the Department of Health's Mental Health and Capacity Unit but its members were independent of and external to the Department of Health. The Review Team was made up of a Chair and six other members:

- Christine Bateson, Chair of the Review. Christine was the Head of Acute Psychiatric Services in Northern Health and Social Care Trust before her retirement
- Audrey Allen, Director of Operations, Action Mental Health
- Tory Cunningham, Senior Peer Support Worker, Belfast Health and Social Care Trust
- Gavin Davidson, Professor of Social Care, Queen's University Belfast
- Erin McFeely, Chief Executive of Developing Healthy Communities
- Philip McGarry, Consultant Psychiatrist. Dr McGarry worked with the Belfast Health and Social Care Trust's Home Treatment Team before his retirement
- Rory O'Connor, Professor of Health Psychology, Director of the Suicidal Behaviour Research Laboratory and Head of the Mental Health and Wellbeing Research Group, University of Glasgow. Rory has been involved in the development and implementation of the Distress Brief Intervention in Scotland.

Overview of the report

The next section presents a review of selected literature on international policy and service developments. The following section outlines how the Review was conducted. The findings of the Review are then presented which include: the mapping and evaluation of statutory Crisis and Liaison Services in Northern Ireland; the mapping and evaluation of Voluntary and Community Services throughout the Region that provide Crisis Intervention to those in Mental Health Crises; the examination of the Regional Context and Involvement of Interagency initiatives to support those who present in Mental Health Crisis; and any other best practice initiatives in Northern Ireland. The findings of the Review are then discussed. The final section provides the implications of the Review's findings for policy and services in Northern Ireland. This includes options for how services could develop and some indication of the associated resources needed.

There are a number of key issues that should be acknowledged from the start of this report.

The first is that the inclusive, systemic approach to the Review reflects the understanding that mental health is complex and that different perspectives, disciplines, interventions and services are needed to understand, assess and respond to the wide range of needs that people in crisis may have.

Mental health crisis services are an important component of mental health services but they are just one aspect of the services and wider societal context needed to effectively prevent and respond to mental health crises. Significant progress towards better mental health outcomes, including in the aftermath of a crisis, requires action across a range of social policy issues including education, employment and the economy, and cannot be achieved by health and social care alone.

Within health and social care, the effectiveness of crisis services is also dependent on non-crisis health and social care services being provided. If the balance between crisis and non-crisis services is not achieved it leads to the inefficient use of resources, such as an over-reliance on inpatient care, and/or inadequate support being provided potentially leading to increased needs and higher risks of harm.

Effective responses when people do experience a mental health crisis are also dependent on good coordination and cooperation across a wide range of people. This includes the Northern Ireland Ambulance Service, the Police Service of Northern Ireland, the Community and Voluntary Sector, people's families and friends and the Health and Social Care Trusts. There can be challenges in coordinating across agencies and sectors and some of these may be addressed by improved policy, practice and service models but some are the direct result of under-resourcing and it is important to try to distinguish these issues.

This Review was conducted in the context of COVID-19. It is hoped that by the time the recommendations of this Review are considered and implemented COVID-19 will no longer be such an immediate and dominant factor. Nonetheless, there have been some service developments in response to the COVID-19 context that may be important to continue and so, where relevant, these were included in the Review.

Finally, it is also important to acknowledge that people in a mental health crisis may often be feeling frightened, distressed and over-whelmed. How effectively we respond at that time is a key determinant in managing the immediate crisis and for the longer-term outcomes for that person, their family and our society.

Literature review

This literature review focused on policy developments in a number of countries where mental health services have recently been reviewed and on available existing reviews of research on crisis services. This was completed to ensure that the Review in Northern Ireland was informed by recent policy developments in other countries and the available research evidence. The literature review focuses initially on a discussion of definitions, an outline of the range of crisis service models and some examples of service users' perspectives on these services. It then provides a summary of recent policy developments in selected countries before providing an overview of existing reviews of the evidence of the effectiveness of crisis services.

Definitions

An important aspect of ensuring crisis services are accessible, available and protected for those who need them most is defining what constitutes a crisis. Boscarato et al. (2014, p. 287) provide a summary of how a mental health crisis has traditionally been conceptualised, "Mental health crises have been described in various ways. According to Caplan's (1964) crisis theory, 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. Disorganization and confusion might be subsequently experienced, leading to a 'breaking point', characterized by psychological decompensation and disturbed or destructive behaviour (Hobbs 1984)."

Newbigging et al. (2020, p. 33) suggest that "Traditional descriptions of a crisis emphasise the behavioural and symptomatic elements of a crisis, reflecting a biomedical framing based on clinical assessments of health and risk. These are widely contested for neglecting or negating the experiential aspects of a MH crisis and they potentially dismiss the agency of the individual and their family or carers in crisis management." Newbigging et al. (2020) also identified some of the common themes in the way the term is more generally used:

1. "a crisis is a time of heightened vulnerability,
2. a crisis is commonly conceptualised as an event, which poses a threat and leads to a sense of disequilibrium,
3. a crisis can be a negative or positive experience, such that a crisis is viewed as a 'turning point', with both risks and a constructive potential for change and personal transformation, and
4. the resources available to an individual, both their personal coping strategies and the availability and effectiveness of support, will influence their response to a crisis." (p. 33)

The Joint Commissioning Panel for Mental Health (2020, p.1) provide a good overview of the range of perspectives that may be involved in defining a mental health crisis:

- Self-definition: defined by the person or carer as a fundamental part of that person owning the experience and their recovery. Identifying potential crises is a skill that can be developed as part of self-management.
- Negotiated or flexible definition: defined as outside the manageable range for the individual, carer or society; to use the crisis service, a decision is reached between the user and the worker.
- Pragmatic, service orientated definition: defined by the service as a personal or social situation that has broken down where mental distress is a significant contributing factor. Crisis is a behavioural change that brings the user to the attention of crisis services and this for example might result from relapse of an existing mental illness. For the team, however,

the crisis is the impact of the change on the user and the disruption it causes to their life and social networks.

- Risk-focused definitions: viewed as a relatively sudden situation in which there is an imminent risk of harm to the self or others and judgement is impaired – a psychiatric emergency – the beginning, deterioration or relapse of a mental illness.
- Theoretical definitions: where crisis is viewed as a turning point towards health or illness, a self-limiting period of a few days to six weeks in which environmental stress leads to a state of psychological disequilibrium. Crisis is defined on the basis of the severity, not the type of problem facing the individual, and whether any acknowledged trigger factors for a crisis are present."

Mind (2020, p.1) provides a definition that includes some of the possible reasons why people may be experiencing a mental health crisis: "A mental health crisis is when you feel at breaking point, and you need urgent help. You might be: feeling extremely anxious and having panic attacks or flashbacks; feeling suicidal, or self-harming; having an episode of hypomania or mania, (feeling very high) or psychosis (maybe hearing voices, or feeling very paranoid). You might be dealing with bereavement, addiction, abuse, money problems, relationship breakdown, workplace stress, exam stress, or housing problems. You might be managing a mental health diagnosis. Or you might not know why you're feeling this way now."

The Mental Health Foundation's (2020, p. 1) definition highlights the subjective and individual nature of mental health crises, "A mental health crisis is an emergency that poses a direct and immediate threat to your physical or emotional wellbeing. There is no one set definition of what a crisis entails; it is highly personal to each individual case and can be escalated by service users, their carers, or family/friends according to what they consider normal/abnormal."

In general, a mental health crisis may be defined as arising when a person is unable to cope and urgently needs some form of support. There is a wide range of ways support can be provided and so an overview of some of the main approaches to providing mental health crisis services is outlined in the next section.

Service models

The *Mental Health Crisis Care Concordat* (Department of Health and Concordat signatories, 2014) was developed in England to set out what people experiencing a mental health crisis should be able to expect of services. It sets out four main components of the services that are needed:

1. Access to support before crisis point. These early intervention services aim to prevent distress from escalating into crisis and include working closely with service users and their families to identify when things are becoming difficult and promoting access to responsive, co-ordinated statutory and voluntary sector support.
2. Urgent and emergency access to crisis care. These services need to be available 24 hours a day and 7 days a week, and there should be equitable access for all.
3. Quality of treatment and care when in crisis. The Concordat highlights that responses to mental health crises should be equivalent to responses to physical health crises so safe, available when needed and provided with respect.
4. Recovery and staying well/preventing future crises. This includes the importance of working with people to develop crisis plans and to ensure transitions between services work well.

In the United States, the Substance Abuse and Mental Health Services Administration (2020, p. 3) have provided national guidelines for providing crisis services. They identify a number of core

services and essential qualities. “The following represent the *National Guidelines for Crisis Care* essential elements within a **no-wrong-door** integrated crisis system:

1. Regional Crisis Call Center: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer quality coordination of crisis care in real-time;
2. Crisis Mobile Team Response: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; and
3. Crisis Receiving and Stabilization Facilities: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

In addition to the essential structural or programmatic elements of a crisis system, the following list of essential qualities must be “baked into” comprehensive crisis systems:

1. Addressing recovery needs, significant use of peers, and trauma-informed care;
2. “Suicide safer” care;
3. Safety and security for staff and those in crisis; and
4. Law enforcement and emergency medical services collaboration.”

The International Mental Health Collaborating Network (2020, p. 1) have provided a list of the specific types of services that may be provided in a crisis. In addition to in-patient care, crisis services may include:

- “Crisis Resolution Teams (Home Treatment Teams). These should provide 24 hours, 7 day a week alternative home based treatment and support for intensive intervention as long as there is a need for the management of the crisis at home to prevent admission
- Crisis Houses. These have been developed as a more homely, small-scale residential alternative to hospital care. In some places these have been provided for specific groups, women, minority ethnic groups etc.
- Crisis Respite Service. These are informal non-residential short-term alternatives. They have been provided in hotels, guesthouses or supported accommodation. They are usually managed and supported by community mental health centre staff.
- User Run Crisis Houses. These are also referred to as peer – run crisis houses. They have a strong recovery and natural self-help ethos. They are managed and run mainly by service users. They provide many alternative coping strategies for self-determination, massage, counselling, skills training, meditation, reinforcing responsibility etc. They reach out to encompass the natural resources of the individual and their community.
- Host Families. These are based on the experience of adult fostering schemes but take this forward to provide a family support structure for individuals during their acute crisis. Sometimes they are also used to place people in order to prevent a crisis. Users record a very positive experience from these and they are highly valued by the host family and mental health professionals.
- 24 hour Community Mental Health Centres with acute beds. This model combines the functions of a Community Mental Health Centre/Home Treatment Service and acute/respite beds in one non-hospital setting. It has been found to be successful in providing continuity of care, ensuring responsibility to a specific community for the holistic care of individuals and

much preferred by users and carers as well as integrated with and highly regarded by local people.

- Telephone helplines. Telephone help line have been shown to provide essential support to people who are experiencing a dramatic or traumatic experience in their lives. Some of these are provided by Non-Governmental Organisations and others are part of a Community Mental Health Centre service.
- Other interventions. Some places have developed initiatives that users have found useful, such as:
- Advance treatment/care directives. Users express and record their views and wishes on treatment they do not wish to receive when they are in a crisis
- User crisis card/joint crisis cards. These are on cards formally written and agreed wishes of a user themselves or between a user and professional. They can be kept on the person and presented to any service when necessary.
- Relapse signature. Using a person centred plan for the user and friends and family to recognise the unique circumstances of the triggers of a relapse and how to prevent it.
- Specific models. In some places in the world some models have been develop by individuals in counties. Some of these have been replicated in other countries.
- Soteria Recovery House. These were founded by Loren Mosher in the USA based on providing small scale therapeutic, humane, recovery support for people experiencing an acute psychosis. They have also been developed in Alaska. Switzerland, Germany, Sweden, Budapest and Denmark.
- Cedar House. This was established in Boulder, Colorado. It is an alternative to hospital care and runs as a therapeutic community giving responsibility to the "guests" whose stay is no longer than 10-15 days."

These examples of services are intended to provide an overview of the types of services that may make up a comprehensive response to people in crisis and the evidence for the effectiveness of these services, along with other inter-agency approaches, will be explored in the *International service developments and research evidence* section below.

Service user perspectives

In addition to defining what we mean by a mental health crisis and the types of services that have been developed, a central, perhaps the most important consideration is the perspectives of people who use those services.

As part of the Mental Health Concordat (2014, pp. 8-9) Mind gathered the views of service users and carers on what people who use services should expect:

- **"***Access to support before crisis point*
  When I need urgent help to avert a crisis I, and people close to me, know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who help me get better.

- *Urgent and emergency access to crisis care*
  If I need emergency help for my mental health, this is treated with as much urgency and respect as if it were a physical health emergency. If the problems cannot be resolved where I am, I am supported to travel safely, in suitable transport, to where the right help is available.

I am seen by a mental health professional quickly. If I have to wait, it is in a place where I feel safe. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me. Staff check any relevant information that services have about me and, as far as possible, they follow my wishes and any plan that I have voluntarily agreed to.

I feel safe and am treated kindly, with respect, and in accordance with my legal rights.

If I have to be held physically (restrained), this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing.

Those closest to me are informed about my whereabouts and anyone at school, college or work who needs to know is told that I am ill. I am able to see or talk to friends, family or other people who are important to me if I so wish. I am confident that timely arrangements are made to look after any people or animals that depend on me.

- *Quality of treatment and care when in crisis*
  I am treated with respect and care at all times.

  I get support and treatment from people who have the right skills and who focus on my recovery, in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service this is arranged without unnecessary assessments. If I need longer-term support, this is arranged.

  I have support to speak for myself and make decisions about my treatment and care. My rights are clearly explained to me and I am able to have an advocate or support from family and friends if I so wish. If I do not have capacity to make decisions about my treatment and care, any wishes or preferences I express will be respected and any advance statements or decisions that I have made are checked and respected. If my expressed wishes or previously agreed plan are not followed, the reasons for this are clearly explained to me.

- *Recovery and staying well / preventing future crises*
  I am given information about, and referrals to, services that will support my process of recovery and help me to stay well.

  I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future, that take account of other support I may need, around substance misuse or housing for example. I am supported to develop a plan for how I wish to be treated if I experience a crisis in the future and there is an agreed strategy for how this will be carried out.

  I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services for myself and others."

Boscarato et al. (2014) explored eleven people's experiences of contact with services, mental health and/or police, in a crisis. They found that people's experiences varied from "humane and compassionate treatment to over reactive and violent interventions." (p. 291) They identified five

main themes from people's experiences: "response speed; humane treatment; feeling threatened by personnel, over reactive police interventions exacerbating crisis situations, and disjointed responses and a lack of onsite collaboration." (p. 291) They also highlighted that the quality of communication appeared to be the main determinant of how people perceived the quality of the intervention that further reinforces the importance of involving people in these processes and responding to them with respect. They concluded that "While the preferred mode of crisis response was informal, when involving the provision of support from family members or friends, if a formal crisis response was needed, participants wanted this to be timely, consistent, respectful, humane, and nonthreatening, and if involving police and mental health clinicians, they wanted this to occur in a coordinated manner." (p. 294)

Chris White (2021, pp. 92-93), who works for the Mental Health Foundation in Scotland, also provides a lived experienced perspective on emergency responses to mental health crises. He writes "Mental health crisis care pathways feel very different from what I have come to expect from emergency services responding to a physical health crisis. Whilst there are examples of quality care and support, this can be highly variable, even within services. Too often it felt that I was treated from the perspective that somehow, I was in control or responsible for my psychiatric distress. To complain or speak out is difficult and in the past has been be viewed as manipulative or symptomatic in order to dismiss or discredit my views and opinions.

But there are opportunities to explore alternative responses to crisis. As patients we should expect this as our right to the best possible health care, and I believe that the majority of staff within services want to respond compassionately, treating patients with respect, but they too often find systematic barriers to finding or accessing appropriate pathways to crisis care such as restrictive referral criteria, underfunding of mental health services, high caseloads of staff, and lack of availability of hours services…

There is a need to reassess what emergency mental health care should look and feel like. There are too few crisis services based in the community, and other non-crisis community-based supports rarely exist outside of Monday to Friday, nine to five business hours. Where services do exist care pathways may be blocked for people in cyclically crisis or are seen to have challenging symptoms and behaviours.

We all know that things could and need to be done differently. The Scottish Government has created the National Suicide Prevention Leadership Group and the National Distress Intervention Group to explore alternative approaches. This includes funding a new Distress Brief Intervention Pilot aiming to offer a compassionate alternative to an ER presentation, through community-based support within 24 hr for people in distress to help people seek positive solutions to their stressors.

We can offer better services, improved care pathways and develop new community-based pre-crisis responses to people who try to seek help before distress escalates into crisis. Not only does this require a will for change, it requires commitment to learn from best and emerging practice evidence, innovative thinking and above all investing in and listening to the voices of experience; however, difficult or challenging some personal narratives may be."

International policy context

In this section, a number of new or recently reviewed mental health policies from selected countries are presented. The included countries are Australia (State of Victoria), England, Finland, Republic of Ireland, New Zealand, Scotland and Wales. The focus in this section is on what the policies include in relation to crisis services but a more general summary of most of these policies is available from the

Mental Health Foundation in their publication *International learnings on mental health plans, policies and implementation* (McDaid et al., 2020).

Australia (State of Victoria)

In Australia, in the State of Victoria, the Royal Commission into Victoria's Mental Health System published its final report in March 2021. It published an interim report in November 2019 and highlighted some of the key issues relevant to crisis services. The interim report stated:

"Systemic complexity, navigation difficulties and a lack of accessible, appropriate services can mean that people are unable to obtain the right support when it would make the most positive difference. This can result in missed opportunities to intervene early and increase the likelihood that poor mental health will lead to a crisis (for example, intentional or accidental self-harm) or escalation of symptoms.

Professional groups told the Commission that the lack of appropriate community-based mental health services has led to disproportionate growth in mental health presentations to emergency departments, with public hospital emergency departments becoming the default entry point for accessing treatment and care when people are experiencing poor mental health.

Related to this, the Commission heard that police and ambulance services are increasingly responding to mental health crises." (p. 197)

Evidence to the Commission also highlighted the issues of stigma, discrimination and equitable and timely access to support. In relation to suicide prevention, it was reported that:

"With limited options in the community, many people who are in suicidal distress or who have attempted suicide present to emergency departments. However, evidence before the Commission indicates that emergency departments are not optimal environments for supporting people experiencing a mental health crisis, and the experience can be traumatic or distressing for some people…

Crisis helplines form an important part of the suicide prevention system in Australia. Several organisations operate mental health helplines staffed by trained professionals and volunteers who provide crisis support…

The Commission was told about the increasing use of and potential for using digital technologies to help prevent suicide, particularly among younger people. Technology and online platforms are increasingly providing support for and advice to people who are unable to get help from mental health services…

There is a need to build workforce skills in suicide prevention so more people are trained and feel confident in providing support to people affected by suicidal behaviour." (pp. 342-349)

One of the key recommendations of the Commission is that a Victorian Collaborative Centre for Mental Health and Wellbeing should be established to "bring people with lived experience together with researchers and experts in multidisciplinary clinical and non-clinical care to develop and provide adult mental health services, conduct research and disseminate knowledge with the aim of delivering the best possible outcomes for people living with mental illness." (p. 391)

The Royal Commission's (2021) final report included four specific recommendations on crisis services:

“Recommendation 8:

Responding to mental health crises

The Royal Commission recommends that the Victorian Government:

1. ensure each Adult and Older Adult Area Mental Health and Wellbeing Service delivers a centrally coordinated 24-hours-a-day telephone/telehealth crisis response service accessible to both service providers and to members of the community of all ages that provides:

a. crisis assessment and immediate support;

b. mobilisation of a crisis outreach team or emergency service response where necessary; and

c. referral for follow-up by mental health and wellbeing services and/or other appropriate services.

2. expand crisis outreach services in each Adult and Older Adult Area Mental Health and Wellbeing Service to provide treatment, care and support from a clinician and non-clinical worker such as a peer worker.

3. improve emergency departments’ ability to respond to mental health crises by:

a. establishing a classification framework for all emergency departments and urgent care centres, based on their capability to respond to people experiencing mental health crises;

b. using the classification framework to ensure that health services are appropriately resourced to perform their role in a regional network of emergency departments and urgent care centres; and

c. ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in each region.

Recommendation 9:

Developing ‘safe spaces’ and crisis respite facilities

The Royal Commission recommends that the Victorian Government:

1. invest in diverse and innovative ‘safe spaces’ and crisis respite facilities for the resolution of mental health and suicidal crises which are consumer led and, where appropriate, delivered in partnership with non-government organisations.

2. in collaboration with the new agency led by people with lived experience of mental illness or psychological distress (refer to recommendation 29) and non-government organisations that deliver wellbeing supports, establish:

a. one drop-in or crisis respite facility for adults and older Victorians per region (refer to recommendation 3(3)); and

b. four safe space facilities across the state, comprising a mix of drop-in spaces and crisis response services, co-designed with and for young people.

3. establish a crisis stabilisation facility, in consultation with people with lived experience, led by a public health service or public hospital in partnership with a non-government organisation that delivers wellbeing supports.

Recommendation 10:

Supporting responses from emergency services to mental health crises

The Royal Commission recommends that the Victorian Government:

1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.

2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe:

a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and

b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).

3. ensure that mental health clinical assistance is available to ambulance and police via:

a. 24-hours-a-day telehealth consultation systems for officers responding to mental health crises;

b. in-person co-responders in high-volume areas and time periods; and

c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.

Recommendation 11:

New models of care for bed-based services

The Royal Commission recommends that the Victorian Government:

1. review, reform and implement new models of multidisciplinary care for bed-based services that are delivered in a range of settings, including in a person's home and in fit-for-purpose community and hospital environments.

2. deliver a broad range of bed-based services, including as a matter of immediate priority:

a. expanding Hospital in the Home services as an alternative to acute hospital-based treatment, care and support where appropriate;

b. investing in a wide range of time-limited and flexible residential respite services informed by local priorities, including establishing a peer-led residential respite service at a demonstration site; and

c. developing new bed-based rehabilitation services (refer to recommendation 12).

3. build on the interim report's recommendation 2 about the need for the expansion of acute mental health services and deliver at least 100 additional beds in settings that reflect optimal allocation and distribution across Victoria.

4. periodically review the allocation of new beds as part of the statewide and regional planning processes recommended by the Royal Commission (refer to recommendation 47) and audit the outcomes." (pp. 46-49)

England

In England, the Department of Health's (1999) National Service Framework for Mental Health and its Policy Implementation Guide in 2001 provided clear guidance on the establishment of crisis resolution/home treatment teams, which are one important component of crisis services. The Policy Implementation Guide specified that:

"People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care. The majority of service

users and carers prefer community-based treatment, and research in the UK and elsewhere has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital. A crisis resolution/home treatment service should be able to:

- Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible
- Remain involved with the client until the crisis has resolved and the service user is linked into on-going care
- If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge
- Reduce service users' vulnerability to crisis and maximise their resilience.

Experience indicates that the following principles of care are important:

- A 24 hour, 7 day a week service
- Rapid response following referral
- Intensive intervention and support in the early stages of the crisis
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs
- Learning from the crisis". (pp. 11-12)

The Implementation Guide also provided helpful, clear and specific guidance on the multidisciplinary composition and operation of the Teams.

In 2014 the *Mental Health Crisis Care Conduct* (HM Government and Concordat signatories, 2014) provided guidance on improving outcomes for people experiencing mental health crisis. It stated:

"Every day, people in mental health crisis situations find that our public services are there when they need them – the police officers who respond quickly to protect people and keep them safe; the paramedics who provide initial assessment and care; the mental health nurses and doctors who assess them and arrange for appropriate care; and the Approved Mental Health Professionals, such as social workers, who coordinate assessments and make contact with families.

These services save lives. There is much to be proud of. But we must also recognise that in too many cases people find that the same services do not respond so well. There have long been concerns about the way in which health services, social care services and police forces work together in response to mental health crises." (p. 6)

It provided a useful structure for considering the range of mental health crisis services that are needed:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis

- Recovery and staying well, and preventing future crises

More recently the *Five Year Forward View for Mental Health* (Department of Health, 2016) acknowledged some of the challenges:

"In its recent review of crisis care, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police. The inquiry found that while adults were seen promptly where liaison mental health services were available in an A&E department and there were clear pathways through to community services, those aged under 16 were referred directly to children and young people's services but seen only when services were open during office hours. This could involve waiting a full weekend and lead to a significant variation in the quality of care on the basis of someone's age." (p. 9)

It specified that "People facing a crisis should have access to mental health care 7 days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work. Early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs… Good liaison mental health care is also needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a minority of A&E departments have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am." (p. 12)

It recommended that "By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme." (p. 34)

Finland

In Finland the *National Mental Health Strategy and Programme for Suicide Prevention 2020–2030* (Ministry of Social Affairs and Health, 2020) specified that "in addition to preventive work, brief interventions should be available for people in difficult life situations or crisis" (p. 25) The programme for suicide prevention includes plans for:

- "General awareness-raising…
- Restricting access to common means of suicide…
- Low-threshold crisis support must be available in all areas of country. Information about these services should be adequately provided so all residents are aware of where to find services in their local area, and how to access them.
- Access to treatment will be enhanced by prioritising treatment for people at risk of suicide, and providing increased support for bereaved friends and family. Early intervention for people in crises or difficult life circumstances may prevent further suicides.

- Suicide risk related to substance abuse will be prioritised on the same level as other population groups at increased risk of suicide.
- Improvements in responsible coverage of suicide by the media…
- Developing EU legislation in order to limit destructive social media content…
- Up-to-date data is needed for different age groups and risk groups in relation to suicide mortality, suicide attempts, access to treatment, quality of care, and early intervention." (p.48)

Republic of Ireland

In Ireland, the new mental health strategy *Sharing the Vision* (Department of Health (Ireland), 2020) recommended that, as part of the continuum of services, (which includes in-patient care, day hospitals, crisis houses, the Community and Voluntary Sector, Community Mental Health Teams, peer networks and Recovery Colleges):

"Out-of-hours crisis cafés should be piloted and operated based on identified good practice. Such cafés should function as a partnership between the HSE and other providers/organisations…[and]

Sufficient resourcing of home-based crisis resolution teams should be provided to offer an alternative response to inpatient admission, when appropriate…

New Zealand

In New Zealand the 2018 Report of the Government Inquiry into Mental Health and Addiction *He Ara Oranga* [Pathways to Wellness] stated that:

"Mental distress, at all points, will be viewed as a recoverable social, psychological, traumatic, spiritual or health disruption. Underpinning all services will be early, easily accessible support for people in crisis, maintaining their connections to family and whānau, homes, schools, workplaces, friends and communities.

When people are seriously distressed and need immediate support, they will receive an immediate response from services led by caring, competent and skilled health, peer and cultural workers. All emergency departments will have access to skilled mental health workers who can provide immediate support and advice. Appropriate physical spaces will mean people can have their immediate needs addressed safely and privately.

The immediate response service will be able to effectively de-escalate situations and support people into appropriate assessment and respite services, community hubs or inpatient services. Community hubs, assessment and immediate support centres that provide calming and safe environments will provide an alternative to police cells. Peers will be present in these services. Where people come to the attention of police and are in custody, they will have access to trained mental health workers who can assess their immediate needs and make referrals as appropriate. Police will be well trained and supported to provide trauma-informed backup and support to mental health immediate response teams." (p. 93)

Scotland

The Scottish Government's (2020) *Mental Health – Scotland's Transition and Recovery* plan focuses on the mental health impact of Covid-19 and it has identified a number of key actions including:

- "The expansion of the NHS 24 Mental Health Hub so that it is available to the public 24 hours a day, 7 days a week.

- The establishment of Mental Health Assessment Centres. These Centres provide the assessment of unscheduled mental health needs for anyone presenting in mental health crisis or distress, in a separate location to emergency departments. The establishment of these Centres has allowed quicker access to specialist services for those that need them, and access to other interventions such as Distress Brief Intervention where appropriate. This has had a positive impact for people presenting with mental health needs, ensuring they receive the right support at the right time while also alleviating pressure on Emergency Departments.
- The expansion of digital services. As with all health services, mental health services had to adapt quickly to delivering support and care in different ways. Many NHS Health Boards have moved parts of their services online, and have provided less urgent care digitally using Near-Me. [They] will further build on this…with the roll-out of Computerised Cognitive Behavioural Therapy, which will support a minimum of a further 10,000 people.
- The roll out of the Distress Brief Intervention (DBI) programme on a national basis. DBI gives people over 16 who present in emotional distress the opportunity to be referred for further dedicated support." (p. 8)

Distress Brief Intervention (DBI) is an innovative way of supporting people in distress. The DBI approach emerged from the Scottish Government's work on the Suicide Prevention and Mental Health strategies. The need to improve the response to people presenting in distress has been strongly advocated by people who have experience of distress - and by front line service providers and was supported through a review of available literature.

The overarching aim of the DBI Programme is to provide a framework for improved inter-agency co-ordination, collaboration and co-operation across a wide range of care settings, interventions and community supports, towards the shared goal of providing a compassionate and effective response to people in distress, making it more likely that people in distress will engage with and stay connected to services or support that may benefit them over time.

A Distress Brief Intervention is a time limited and supportive problem-solving contact with an individual in distress. It is a two-level approach. DBI level 1 is provided by front line staff and involves a compassionate response, signposting and offer of referral to a DBI level 2 service. DBI level 2 is provided by commissioned and trained third sector staff who would contact the person within 24-hours of referral and provide compassionate community-based problem-solving support, wellness and distress management planning, supported connections and signposting for a period of up to 14 days.

What does DBI involve?

DBI Level 1.

- Initial empathetic assessment, risk assessment and signposting as necessary with a further decision whether to refer onto the next day community DBI local service.

DBI Level 2. (up to 14 days)

- Empathetic problem focused assessment – physical, psychological and social.
- Identification of existing supports and assets.
- Recognition of past trauma and attachment in the person's life and how these affect the present.
- Risk assessment and self-management.

- Exploration of strategies to help resolve problems.
- Information and supported signposting to specialist services and other community resources.
- Creation of a Distress Management plan (D-Map) – how to identify and avoid triggers, what to do to manage distress in the future.

Who is DBI for? Distress is defined as 'An emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response'. The initial test period focused on people aged 18 and over in 4 pilot areas of Scotland and it has recently been extended (as an extension of the pilot) to those under 18s (14-17 years). DBI does not replace existing arrangements for anyone in distress who requires further medical treatment, it is an additional option for frontline staff. For the purposes of the pilot, the DBI approach has been tested primarily in relation to people presenting in distress to A&E, Police Scotland, Scottish Ambulance Services and primary care, including out of hours, although there is flexibility at each partnership site.

In addition, in 2020 in light of COVID-19, DBI was rolled out nationally across Scotland, giving people over the age of 16 who are in emotional distress due to COVID-19 the opportunity to speak to specially trained staff. This roll-out was via NHS24. Anyone in distress who telephoned NHS24, staffed by the NHS24 Mental Health Hub could be referred into DBI over the phone.

Provision of DBI level 1 is by front line staff, in the above settings. Provision of level 2 is by third sector mental health services, providing a welcome additional option to which level 1 staff can refer people to.

An interim report on the evaluation of the Distress Brief Intervention Programme (Duncan et al., 2020) had reported that:

"The Distress Brief Intervention (DBI) programme emerged through direct engagement with people who have experienced distress, with front-line service providers and from a literature review, all of which highlighted the need to improve the response to people in distress in Scotland. The Scottish Government established the DBI pilot, which is being conducted from November 2016 to March 2021 in Aberdeen, Inverness, Lanarkshire and Scottish Borders. It represents a national and regional distress collaboration between health and social care, emergency services (Primary Care, Police Scotland, Scottish Ambulance Service and Emergency Departments) and the third sector. Within the DBI Programme, distress is defined as:

"An emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response."

Preliminary evaluation findings are positive. Our interim impact analysis indicates that people who receive a DBI intervention generally find it compassionate and effective at reducing their distress. The DBI programme is providing support for individuals to learn how to understand, manage and seek help effectively for their distress, who otherwise report they would turn to primary care, medication, unhealthy coping skills or suicidal behaviour. A key strength of DBI implementation has been the gradual and reflective approach to its rollout within and across services in the pilot sites." (pp. 7-8)

Wales

In Wales, the *Review of the Together for Mental Health Delivery Plan 2019-2020 in response to Covid 19* (Welsh Government, 2020) included some key actions for crisis services:

"Mental Health Crisis Care Concordat (MHCCC) and Regional Mental Health Criminal Justice Groups to implement the new National Crisis Concordat Action Plan across health boards, police forces, local authorities, the Welsh Ambulance Service NHS Trust (WAST) and the third sector…

National Collaborative Commissioning Unit (NCCU) to complete a rapid urgent mental health access and conveyance review across health boards, police forces, local authorities, WAST and the third sector to make recommendations for improvement…

Welsh Government (Health and Social Services) investment to support health boards to extend and standardise the delivery of crisis and out of hours services to provide 24/7 access across all ages, including delivering on the priority areas in the National Crisis Care Concordat Action Plan…

Welsh Government (Health and Social Services) and partners to support a range of pilots, including street triage, hub models, et cetera to inform evidence based practice and the MHCCC to identify the good practice and models for roll out." (pp. 30-31)

International service developments and research evidence

There are a number of existing reviews of the research evidence relevant to crisis services. Perhaps the most directly relevant and useful was completed by Paton et al. (2016). It provided a rapid synthesis of the evidence for available models of crisis and organised its findings into the four main areas identified if the Mental Health Crisis Care Concordat:

"*Access to support before crisis point*

Studies across a range of disorders suggest telephone support and triage appear to result in quick access, acceptable referral decisions and minimal harm. However, at present there are very few data in relation to the use of telephone support and triage for providing support to people before the point of mental health crisis.

In addition, studies that have assessed the benefits of training and supporting primary care and community-based staff have not identified any models that clearly benefit service user outcomes.

Recommendations by NICE on access to support before crisis point are derived mainly from expert consensus and overlap largely with recommendations from the Crisis Concordat and the London Strategic Network commissioning guide. These include the importance of receiving care with a minimum of delay, the importance of quick referral (either through self-referral or building links between mental health services, primary care and third-sector organisations) and equality of access.

Urgent and emergency access to crisis care

There is limited quantitative evidence on the clinical effectiveness of interventions to improve urgent and emergency access to crisis care. Most studies were on liaison psychiatry models that were associated with reduced readmission rates, reduced waiting times (in most studies) and improved service user satisfaction. However, there was a lack of high-quality well-controlled trials and, for most studies, it was not possible to rule out the potential for confounding. There was less evidence on the benefits of providing mental health training to emergency department staff.

The evidence was even more limited regarding the provision of support from mental health professionals to police officers, either through training programmes, street triage or telephone triage. Street triage and training of police officers both appeared to reduce police time at the scene of mental health-related incidents. Street triage may also potentially improve service user engagement with outpatient treatment services. Police officers with mental health training were

more likely to transport people to a health-care setting and less likely to arrest people with potential mental health problems. However, there was no evidence that either street triage or mental health training reduced level of force used by police officers in mental health-related calls.

Quality treatment and care in crisis

Crisis resolution and home treatment teams were found to be both clinically effective and cost-effective with benefits including substantial reductions in the probability of hospital admission and greater service user satisfaction compared with inpatient treatment. However, the quality of evidence was rated low because of the small number of studies, a high risk of bias in included studies and high heterogeneity. Reviews of factors affecting clinical effectiveness and cost-effectiveness of CRHTTs found a great deal of variability when implementing these interventions. Although there were examples of good practice in the UK regarding various elements of CRHTT care it appears that few teams were exhibiting good practice across a comprehensive range of criteria.

Crisis houses and acute day hospitals were not found to be more clinically effective than inpatient treatment. However, it should be noted that there is no evidence that crisis houses and acute day hospitals are associated with greater readmissions and are recommended by NICE as viable alternatives to inpatient treatment. In addition, there is evidence that crisis houses are associated with greater service user satisfaction in both quantitative and qualitative studies.

In terms of conflict and containment in inpatient mental health services, the evidence was largely based on descriptive studies with few controlled trials. The Safewards model has been suggested as a foundation for future research on inpatient treatment. They propose six factors that influence conflict and containment: (1) staff team; (2) physical environment; (3) outside hospital; (4) patient community; (5) patient characteristics; and (6) regulatory framework. A recent cluster randomised trial has been completed based on the Safewards model and found reductions in conflict and containment versus controls.

Promoting recovery/preventing future crises

Promoting recovery and staying well covers a large and diverse literature. We have sought to review this literature primarily by drawing on systematic reviews of interventions recommended by NICE mental health guidelines.

For all other stages of the care pathway we only included service models. However, we also included individual-level interventions on promoting recovery to reflect the emphasis of these interventions in the Crisis Care Concordat and also feedback provided by service user members of the advisory group.

There are a large number of effective interventions for promoting recovery and preventing relapse recommended by NICE. These include service models [e.g. early intervention services (EISs)], pharmacological interventions (e.g. antidepressants for people with depression and antipsychotics for

people with psychosis), individual-level interventions to prevent relapse of mental health conditions [e.g. cognitive–behavioural therapy (CBT) for people with psychosis, family intervention for people with psychosis, dialectical behaviour therapy (DBT) for people with borderline personality disorder (BPD)] and strengths-based interventions to promote recovery (e.g. self-management and supported employment).” (pp. xxi-xxii)

Paton et al. (2016) also provided a summary of the implications for practice:

"*Access to support before crisis point*

- Services should ensure that people at risk of mental health crisis receive care with minimum delay, receive quick referral (either through self-referral or building links between services) and that there is equality of access to such care.

Urgent and emergency access to crisis care

- Although there is evidence of benefits for liaison psychiatry teams in improving waiting times and reducing readmission this is largely based on uncontrolled studies and a lack of data from the UK.

Quality treatment and care in crisis

- Crisis resolution teams (CRTs) are more effective than inpatient care for a range of outcomes, although implementation of this model of care varies across the UK with few teams meeting all evidence-based criteria for good practice.
- Crisis houses and acute day hospitals appear as clinically effective as inpatient treatment but are associated with greater service user satisfaction.

Promoting recovery

- Effective service models include EISs for people with psychosis and other serious mental illnesses, and collaborative care for depression (particularly for people with chronic physical health problems).
- Effective pharmacological interventions include antidepressants for people with depression, lithium for people with bipolar disorder and antipsychotics for people with psychosis.
- Effective individual-level strengths-based interventions include self-management and supported employment. There is also some evidence for benefit for peer support (but this needs further high-quality research to validate these findings).
- Individual-level interventions with evidence of benefit include for people:
    - with psychosis – CBT, family interventions
    - with bipolar disorder – psychological interventions
    - who self-harm – psychological interventions
    - with BPD – DBT and mentalisation-based therapy
    - with depression – CBT (particularly mindfulness-based cognitive therapy).
- Crisis planning is currently recommended by NICE, although more recent research has raised questions regarding the clinical effectiveness of this intervention; therefore, further research is needed on whether or not this is an effective approach to promoting recovery." (pp. xxii-xxiii)

There are also systematic reviews of the evidence for more specific aspects of crisis services.

Murphy et al. (2015) conducted a Cochrane Systematic Review on *Crisis intervention for people with severe mental illnesses*. They concluded that "Care based on crisis-intervention principles, with or without an ongoing homecare package, appears to be a viable and acceptable way of treating people with serious mental illnesses. However only eight small studies with unclear blinding, reporting and attrition bias could be included and evidence for the main outcomes of interest is low to moderate quality. If this approach is to be widely implemented it would seem that more evaluative studies are still needed." (p. 2)

Shepperd et al.'s (2009) earlier Cochrane Review had focused on *Alternatives to inpatient mental health care for children and young people*. They "included seven randomised controlled trials (recruiting a total of 799 participants) evaluating four distinct models of care: multisystemic therapy (MST) at home, specialist outpatient service, intensive home treatment and intensive home-based crisis intervention ('Homebuilders' model for crisis intervention). Young people receiving home-based MST experienced some improved functioning in terms of externalising symptoms and they spent fewer days out of school and out-of-home placement. At short term follow up the control group had a greater improvement in terms of adaptability and cohesion; this was not sustained at four months follow up. There were small, significant patient improvements reported in both groups in the trial evaluating the intensive home-based crisis intervention using the 'Homebuilders' model. No differences at follow up were reported in the two trials evaluating intensive home treatment, or in the trials evaluating specialist outpatient services." (p. 2)

Another systematic review by Molyneaux et al. (2019) provided a meta-analysis of the available evidence on crisis-planning interventions. They included 5 randomised controlled trials and found that crisis planning interventions substantially reduced the risk of compulsory admissions among people diagnosed with psychotic illness or bipolar disorder.

Newbigging et al. (2020) conducted a mixed-methods study, which included a coping literature review, service mapping and stakeholder interviews, to explore the contribution of the voluntary sector to mental health crisis care. They reported that "A mental health crisis is considered a biographical disruption. Voluntary sector organisations can make an important contribution, characterised by a socially oriented and relational approach. Five types of relevant voluntary sector organisations were identified: (1) crisis-specific, (2) general mental health, (3) population-focused, (4) life-event-focused and (5) general social and community voluntary sector organisations. These voluntary sector organisations provide a range of support and have specific expertise. The availability and access to voluntary sector organisations varies and inequalities were evident for rural communities; black, Asian and minority ethnic communities; people who use substances; and people who identified as having a personality disorder. There was little evidence of well-developed crisis systems, with an underdeveloped approach to prevention and a lack of ongoing support." (pp. v-vi) They emphasised the need for a whole-system, inter-agency approach to mental health crisis services.

Although not reviews of the available evidence some further studies have been included below to highlight specific important and emerging aspects of mental health crisis services.

Johnson et al. (2018) conducted a randomised controlled trail of a peer-supported self-management intervention for people discharged from a mental health crisis team. The intervention consisted of up to ten sessions with a peer support worker who worked with the service user on completing a personal recovery workbook which included personal recovery goals and crisis plans. The control group also received the recovery workbook but it was just sent to them by post. The intervention did appear to reduce readmissions and serious adverse events. In general, the role of peer-support in crisis services does appear to be a positive and important component to develop.

Another important component is the role of families. Griffiths et al. (2020) explored the impact of training to develop professionals' skills in working with families in crisis. This was in response to some concerns identified in the literature that, at times, carers reported negative experiences of crisis services including feeling overlooked or excluded. The training was developed based on feedback from families and focused on how families may be affected by mental health crises, the benefits of a systemic, inclusive approach, and some principles, skills and strategies for working with

families. The evaluation was positive and suggested ongoing training to promote engagement with families could be worthwhile.

Goldsmith et al. (2020) are examining the impact of the introduction of psychiatric or mental health decision units on mental health crisis care pathways in England. These are specialist short-stay (24-72) units in psychiatric hospitals which offer assessment, support and care planning for people with complex needs who would otherwise experience long delays in emergency departments and/or frequently use other services including the police and ambulance services. This ongoing study is using an interrupted time series design to consider the impact on outcomes including the number of admissions, length of stay and the use of compulsion.

Three further studies focus on the implementation of crisis services. Wheeler et al. (2015) conducted a systematic review to try to identify the key characteristics of effective crisis teams. They found that there was variation in the composition and activities of services and so it was difficult to be confident about what the critical components of these services are. Lamb et al. (2020) conducted a survey of 75 crisis teams to assess their fidelity using a scale focused on good practice for crisis teams. They found that no teams had high fidelity, 65% were assessed as having moderate fidelity and the rest low fidelity. They concluded that there is a need to promote fidelity, consistency and service improvement. Lloyd-Evans et al. (2020) conducted a cluster-randomised trial to assess the impact of a service improvement programme for crisis teams. They found that the programme did not have a significant impact on service user satisfaction but did seem to improve model fidelity and reduce inpatient admissions.

There are also useful findings from the research literature on interagency approaches to crisis services. Parker et al. (2017) conducted a systematic scoping review of interagency collaboration models for people with mental health problems who were in contact with the police. They reviewed 125 studies and identified 13 different interagency collaboration models which tended to focus on pre-arrest diversion, co-response, post-arrest diversion, information sharing (such as Multi-Agency Public Protection Arrangements), court diversion, co-location, comprehensive systems approaches, consultation, service integration, special protective measures (adult protection and access to justice), joint investigation training, rehabilitation programmes, and integrated models. They highlighted the need for the Ambulance Service and Alcohol and Drug services to be better integrated into these approaches. Puntis et al. (2018) completed a systematic review of the evidence on co-responder models of police mental health 'street' triage. They included 26 studies which did suggest that street triage could reduce the need for the use of compulsory powers and/or police custody but that there was considerable variation in the implementation and operation of co-response approaches. Park et al. (2019) conducted a scoping review of the models of mental health triage for people who are in contact with the police who may be experiencing a mental health crisis. They identified 33 studies which reported on 47 schemes and again highlighted the diversity of the services and the need for a more standardised, consistent approach. Sloper (2015) reported positive outcomes from an innovative service development led by the London Ambulance Service which involved the introduction of a Mental Health Clinical Advisory Service in their Emergency Operations Centre. They provide a hear-and-treat service; warm transfers (assisting with more difficult calls); and staff advice to ambulance crews. In their first year they responded to 5,961 calls with 15.9% (948) managed with a hear-and-treat response. Cook (2019) highlights that in 2014 the Birmingham and Solihull Mental Health Foundation Trust, introduced a collaborative approach which involves a police officer, paramedic and mental health nurse working together to respond to those experiencing a mental health crisis. Initial evidence suggests that in the first year, over 1000 patients were diverted from the Emergency Department and there was a 50% reduction in the use of police

powers under mental health law. A similar approach has now been adopted by the South Western Ambulance Service Foundation Trust (SWASFT) and Avon and Wiltshire Mental Health Partnership (AWP). The Birmingham and Solihull Mental Health Foundation Trust service has also informed the development of services in Northern Ireland but these will be explored in more depth in the Review's findings section.

Northern Ireland policy context

The Health Services Act in 1948 led to the establishment of a structure for mental health care in Northern Ireland through the NI General Health Services Board and the NI Hospitals Authority. The main mental health policy direction until 1961 was to increase the number of in-patient beds, which peaked at 6,486 in 1961 (Prior, 1993). Although the policy direction then changed to focusing on the development of community care, the Minister of Health at the time, Enoch Powell, acknowledged, in what has become known as the Water-Tower Speech that "This is a colossal undertaking, not so much in the new physical provision which it involves, as in the sheer inertia of mind and matter which it requires to be overcome. There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside - the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault" (Health Foundation, 2021, p. 1).

The transition from an institutional/hospital focused approach to providing crisis care and support to a more community focused approach has been relatively cautious in Northern Ireland. As elsewhere, it was driven by a combination of factors including: the research on the impact of institutionalisation; developments in care and treatment; concerns about people's rights and new mental health law (the Mental Health Act (NI) 1961); and concerns about the cost and effectiveness of in-patient care (Killaspy, 2006). The transition was facilitated by a number of service developments in the 1960s which included: the increased use of out-patient care and day hospitals; the development of psychiatric units in general hospitals; and the development of non-hospital accommodation and support but the development of comprehensive community services was very slow. As Prior (1993) highlights, it's difficult to estimate the relative impact of all the factors involved, including the context of political violence, on mental health policy developments in the following decades.

The Health and Personal Social Services (NI) Order 1972, which integrated health and social care and established the Health and Social Services Boards, and the reintroduction of direct rule in 1972, may also have had an impact on the nature and speed of change. The first Regional Strategy (1975-82) included two key mental health objectives, "the development of community health and social care for the mentally ill" and "the relief of overcrowding in psychiatric hospitals" (Prior, 2012). The next Strategy (1983-88) included the need for the development of adolescent psychiatry and a medium secure unit. The following Strategy (1987-92) included as a key objective the need to move from institutional to community care and a specific objective to reduce the number of beds in psychiatric hospitals by 20%. This period also saw the introduction the comprehensive community care policy *People First: community care in Northern Ireland in the 1990s* (Department of Health and Social Services, 1990) and the restructuring of health and social care into Health and Social Services Trusts. The transition to community care was reinforced in the 1992-97 Regional Strategy which included the objective to reduce the number of psychiatric in-patient beds to 1500 (Prior, 1998). The focus on community care enabled the development of community services in the 1990s and the 1997-2002 Regional Strategy stated "By 1998 Boards should assess the needs of their population and determine the future requirements for specialist hospital services for people with a mental illness. The strategic goal should be that long-term, institutional care should no longer be provided in traditional psychiatric hospital environments." (Department of Health and Social Services, 1997, p. 29). The development of community services, to prevent crises and the need for hospital admission, was further enabled by the introduction of the *Supporting People* programme in 2003.

In England, the White Paper *Better Services for the Mentally Ill* had identified that "A vital function for the therapeutic team is the provision of a 24 hour emergency service which can be provided in the patient's home when necessary. This crisis service should be planned in consultation with the primary care services and is essential if families in particular and the community in general are to be able to cope with a higher proportion of the mentally ill being oared for outside hospital. Where such a "crisis intervention' service is available it can often help to avoid admission to hospital." (Department of Health and Social Security, 1975, p. 3). Crisis services were slow to develop however until 2001 when the Department of Health for England set out a specific specification for Crisis Resolution/Home Treatment Teams in the *Mental Health Policy Implementation Guide*. It stated that:

"People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care. The majority of service users and carers prefer community-based treatment, and research in the UK and elsewhere has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital. A crisis resolution/home treatment service should be able to:

- Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible
- Remain involved with the client until the crisis has resolved and the service user is linked into on-going care
- If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge
- Reduce service users' vulnerability to crisis and maximise their resilience.

Experience indicates that the following principles of care are important:

- A 24 hour, 7 day a week service
- Rapid response following referral
- Intensive intervention and support in the early stages of the crisis
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs
- Learning from the crisis" (pp. 11-12).

Although this guidance did not apply to Northern Ireland it directly informed the development of the first statutory mental health crisis services in Northern Ireland in 2003.

The Bamford Review of Mental Health and Learning Disability, which began in 2002, made a number of recommendations relevant to mental health crisis services. In its first report in 2005, which focused on adult mental health services, the User Reference Group Statement included "When the cause of the 'crisis' is commonly social and emotional, clinical responses are often inappropriate and ineffective. What is needed are respect, understanding, and the provision of a safe and welcoming environment. Hospitals do not often provide these responses. Home or respite service responses should be the norm. As Experts by Experience we recommend crisis responses from a variety of sources that include service user and carer initiatives and participation. The person in crisis must have a choice of care." (p. 7) The Report also included a number of recommendations to promote effective crisis services:

- "Comprehensive provision of 24/7 appropriately resourced Home Treatment Services
- A single system of acute and crisis provision including Home Treatment, Day Hospital, Step-up, Step-down and Inpatient services
- All services of high quality providing a range of therapeutic interventions, sensitive to gender and cultural needs
- A lead clinician or manager with overall responsibility for inpatient services." (p. 17)

The *Mental health and wellbeing improvement* report, in 2006, included as an action to consider: "Provide crisis care, offering services where people live and work, preventing deterioration or hospital admission whenever possible, and only admitting people with very severe needs or those who are a risk to themselves or others." (p. 117).

In 2006 *Protect Life - A Shared Vision*, the Northern Ireland Suicide Prevention Strategy and Action Plan (2006-2011) (DHSSPS, 2006) was also launched and included the need for: community led suicide prevention and bereavement support services; local research into suicide; GP Depression Awareness Training; enhanced crisis intervention services; all-island public information campaigns; Lifeline 24/7 Crisis Referral Helpline; the establishment of the Deliberate Self-Harm Registry; and the development of local suicide cluster emergency response plans.

The first Bamford Action Plan 2009-11 (DHSSPS, 2009) highlighted that "Under *Protect Life* a number of initiatives have been developed including "Lifeline" the regional 24/7 crisis response telephone line and support services, community-led prevention services, deliberate self harm pilot projects, guidelines for media reporting and research projects." (p. 24) It also included the action to: "Improve and harmonise model for crisis intervention services…[and] to issue regional principles for provision of crisis mental health services. Trusts to ensure regional principles are complied with and that services are harmonised across Northern Ireland" (p. 82).

Protect Life was updated in 2012 and Objective 2 focused on *Improved services for people who are in emotional crisis and those people with pre-existing mental health problems*. The indicators for that objective were

- "Assertive outreach in place for patients who miss mental health service appointments.
- Availability of "Places of Safety/ Quiet Rooms".
- Level of repeat A&E attendance by individuals in emotional distress.

- Level of complaints about services.
- Inclusion of these recommendations as actions within the Bamford Action Plan 2012/15.
- Implementation of recommendations of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in Northern Ireland (2011)." (DHSSPS, 2012a, p. 36)

The next Bamford Action Plan (2012-15) (DHSSPS, 2012b) also included the action to "Improve and harmonise model for crisis response and home treatment services…[and] Implement agreed regional model for crisis response and home treatment" (p. 58).

In 2011, *Transforming Your Care*, the independent review of the provision of health and social care service, it was suggested that "Virtual wards will also be developed. Under this model, individuals are admitted into the care of specialist teams, and provided with similar care as would be available in a hospital ward, but remain in their own home. Mental health treatment services will also be available at home, provided by Crisis Response and Home Treatment teams. This will result in reductions in inpatient care…An urgent care model will be implemented in every area to provide 24/7 access to urgent care services. These services will be planned in accordance with local need. Whilst the model will take account of local circumstances, the outcomes will be consistent. The system of urgent care will ensure each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers." (Compton, 2011, p. 46-47).

In 2013, the *Transforming Your Care Strategic Implementation Plan* (Health and Social Care Board, 2013) included plans for Crisis Resolution and Intensive Treatment Teams as part of Child and Adolescent Mental Health Service provision and:

- "6 Admissions units – one in each of the 5 local areas plus one more unit in the Western area.
- Significant reduction in institutional care and the number of inpatient beds across the region by 2015.
- Improved focus on community-based treatment" (p. 7)

In 2014, the Regional Mental Health Care Pathway set out a comprehensive stepped care model for mental health services which include "Acute Mental Health Services. This generally involves care provided by Crisis Resolution and Home Treatment Teams and/or specialist hospital care teams. These services provide support at a time of crisis and can provide intensive home support and/or admission to hospital when someone is temporarily unable to manage independently." (Health and Social Care Board, 2014, p. 25) and the importance of Personal Safety and Crisis Management Plans.

The Department of Health, in 2016, launched its 10-year approach to transforming health and social care, *Health and Wellbeing 2026: Delivering Together*. It included acknowledgement of the social determinants of mental health and the importance of co-production, and the need to:

"Provide more support in primary care to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems;" (p. 12)

There is also the *Regional Interagency Protocol on the Operation of Place of Safety & Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986* (Social Care Commissioning Lead for Adult Mental Health, 2019) which is a framework for joint working between the Police Service Northern Ireland, the Northern Ireland Ambulance Service and the Health and Social Care Trusts to

inform the inter-agency cooperation needed in some mental health crisis. The most recent version was published in December 2019.

In 2019, *Protect Life 2* was also published which include a number of specific actions under the objective to enhance the initial response to, and care and recovery of people who are suicidal. These were:

- "Provide timely, accessible de-escalation services for those in emotional crisis or despair
- Develop and implement a regional training framework which will include suicide awareness and suicide intervention for HSC staff with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services, & mental health/addiction services) by 2022
- Encourage health and social care professionals, & others, who provide services to people at risk of suicide to (as a matter of course) seek patient/client permission to engage trusted family or friends in their safety planning for that person
- Embed suicide prevention in drug and alcohol policy and services" (p. 56).

As mentioned in the Introduction, one of the key objectives of the current *Mental Health Action Plan* (Department of Health, 2020a) is to improve care and treatment in an emergency which led to the establishment of this Review of Mental Health Crisis Services in Northern Ireland. The consultation on the draft *Mental Health Strategy 2021-2031* opened in December 2020. The draft Strategy included a specific section on crisis services:

"Crisis services

137. Outcome:

- A regional mental health crisis service.
- Effective help and support for people in crisis, through a regional crisis service, with a resultant reduction in Emergency Department attendance for mental health patients.

138. A recent report by the Royal College of Psychiatrists found that 40% of mental health patients have been forced to resort to emergency or crisis services and one in ten people in distress end up in Emergency Departments. People in crisis require help and support and no-one should have to wait for that help.

139. Crisis services exist to provide support to some of the most vulnerable patients in a very difficult time of their lives. Over recent years a number of pilots of new crisis services have been tried in Northern Ireland, including cooperation between the PSNI, the ambulance service and HSC Trusts (Multi Agency Triage Team), community crisis intervention service in Derry/Londonderry and others. Other improvements to crisis and urgent care services include the creation of mental health liaison in Emergency Departments.

140. While the pilots have been providing good results, it is important that the development of crisis response services are an integrated part of the wider mental health system.

141. Effective crisis services will mean fewer people with mental health problems attending Emergency Departments. It will also mean that people with existing mental illness who find themselves in crisis have clear contact pathways and access to the right service when they need it.

142. We need to improve the mental health crisis response. An expert review is currently ongoing and will inform the policy direction and a way forward.

ACTION 19. Create a regional crisis service to provide help and support for persons in mental health or suicidal crisis. The crisis service must be fully integrated in mental health services and be regional in nature." (Department of Health, 2020b, pp. 41-42).

Northern Ireland research context

The development of mental health crisis services in Northern Ireland has also been informed by some audit, evaluation and research studies. This section does not provide a comprehensive summary of all of the relevant studies but highlights some of the key findings and themes from some of this work. It is also important to emphasise the importance of building in, from the start, a process of ongoing monitoring and evaluation for the further development of these services to ensure there is useful and accessible data about what these services are providing and, crucially, how effectively they are meeting the needs of people experiencing mental health crises. There are five recent overviews which provide helpful accounts of the complex issues involved: the Regulation and Quality Improvement Authority's (2019) *Review of Emergency Mental Health Service Provision across Northern Ireland*; the Northern Ireland Commission for Children and Young People's (2018) report *Still Waiting – A rights based review of mental health services and support for children and young people in Northern Ireland*; Donnelly's (2019) report on *Zero Suicide*; O'Neill and O'Connor's (2020) identification of the key challenges and opportunities for suicide prevention in Northern Ireland; and the Mental Health Crisis Support debate in the Northern Ireland Assembly in 2020. There are also a series of reports on specific aspects of crisis services including: the Card before you leave scheme (Health and Social Care Board and Public Health Agency, 2013); Lifeline (Public Health Agency, 2014); home-based treatment (McGarry, 2019); the importance and complexities of inter-agency working (Davidson et al., 2021); the Community Crisis Intervention Service (Ennis and Walker, 2020); the Crisis De-escalation Service (Social Market Research, 2020); and the Multi Agency Triage Team (Gossrau-Breen and Mallon, 2021).

The Regulation and Quality Improvement Authority's (2019) Review of Emergency Mental Health Service Provision across Northern Ireland used the principles of the Regional Mental Health Care Pathway to assess a range of emergency mental health services in the 5 HSC Trusts which included:

- "Adult Mental Health Services (for patients aged 18-65 years);
- Older People's Services (for patients aged 65 years and over);
- Child and Adolescent Mental Health Services (CAMHS) (for patients aged 0-18 years);
- Learning Disability Services (for children and young people and adults with a learning disability); and
- Emergency Departments." (p. 5)

It reported that "Within working hours (Monday to Friday 9:00am to 5:00pm) all 5 HSC Trusts have systems and processes in place to provide emergency mental health services for patients of all ages. Outside normal working hours, all 5 HSC Trusts find it a challenge to provide dedicated specialised services for their local population during out-of-hours periods. This was particularly evident in relation to CAMHS, learning disability and older people's services." (p. 5)

It also highlighted the importance of communication within and between Trusts: "Communication systems between mental health teams in each Trust and across the region have not been fully developed and there is a potential risk of information loss when patients transfer in an emergency context." (p. 6)

The report concluded with nine recommendations to improve services:

“1. (i) The Health and Social Care Board should convene a short life working group, to include appropriate representation from each Health and Social Care Trust, in order to develop a regional information transfer protocol.

(ii) Implementation of this protocol should ensure patient information is transferred securely and in a timely manner when patients transfer between Health and Social Care Trusts in an emergency mental health context.

(iii) The Health and Social Care Board should ensure information transfer between Health and Social Care Trusts in an emergency mental health context is considered as part of the Encompass programme for Northern Ireland.

2. The Health and Social Care Board should work collaboratively with each Health and Social Care Trust to help reduce the length of inpatient stays in those HSC Trusts where there is significant variation in relation to their peers, allowing for differing demographics and profile of patients. Learning should be shared across the region to ensure patients receive care appropriate to their assessed needs in the most appropriate location, delivered by the most appropriate professional(s).

3. The Health and Social Care Board, together with the Health and Social Care Trusts, should review the current provision of core community mental health services (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to:

(i) Ensure adult patients are cared for in the most appropriate setting; and

(ii) Alleviate pressures currently experienced within acute mental health services.

4. Each Health and Social Care Trust should provide the same emergency mental health service during the out-of-hours period to their over 65 population as is currently provided to their adult (patients aged 18-65 years) population.

5. Each Health and Social Care Trust must ensure a robust system is in place 7 days a week, 24 hours a day, to provide an emergency mental health assessment and treatment service for all children and young people, in line with the Child and Adolescent Mental Health Services stepped care model (Child and Adolescent Mental Health Services; A Service Model, July 2012, Department of Health, Social Services and Public Safety, Northern Ireland).

6. The Health and Social Care Board, together with each Health and Social Care Trust, should review the current model and provision of core community learning disability services for adults (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to:

(i) Ensure adult patients with a learning disability are cared for in the most appropriate setting; and

(ii) Alleviate pressures currently experienced within acute learning disability services for adult patients.

7. The Health and Social Care Board, together with each Health and Social Care Trust, should review the current model and provision of core community learning disability services for children (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to:

(i) Ensure children and young people with a learning disability are cared for in the most appropriate

setting; and

(ii) Alleviate pressures currently experienced within acute learning disability services for children and young people.

8. Each Health and Social Care Trust must ensure that an appropriate physical space to undertake mental health assessments is available 24 hours a day, 7 days a week within the Emergency Department setting.

9. The Regional Crisis Resolution Home Treatment (CRHT) Forum should:

(i) Establish formal governance arrangements to ensure there are defined terms of reference, clear roles and responsibilities, and effective operating processes underpinning its work; and

(ii) Consider widening its remit to include Child and Adolescent Mental Health Services, Learning Disability Services and Older People Services." (pp. 40-42).

Oscar Donnelly (2019) has been a key advocate for bringing the Zero Suicide approach to Northern Ireland and his report on Zero Suicide also contained a number of recommendations:

"1. The Northern Ireland's Towards Zero Suicide Collaborative (the Collaborative) should development a Suicide Prevention Pathway (SPP) for Northern Ireland.

2. Inpatient admissions should be reviewed as an element of the SPP so that where an admission is assessed as being required this should be aimed at a brief intervention informed by therapeutic models of suicide prevention work.

3. Staff training in skills and in developing a positive suicide prevention culture are essential to the SPP. The Towards Zero Suicide Collaborative should consider and develop a training model similar to that used in Gold Coast to support the implementation of a SPP in Northern Ireland.

4. It is recommended that a skills and competencies framework linked to evidence based suicide prevention practise be developed and a subsequent training needs analysis of mental health practitioners be completed to ensure that mental health service users are receiving high quality evidence based interventions.

5. In developing a SPP for N Ireland the TZS Lived Experience group should be involved through, in particular, the development of lived experience led key performance indicators and outcomes for the delivery of Zero Suicide

6. The SPP requires evidence based interventions delivered in a timely and integrated way across providers. The local SSP should include the identification and incorporation of relevant local independent sector provider partners on a common evidence based pathway.

7. The implementation of a SPP needs to be in the context of a supportive Just Culture. Health & Social Care in N Ireland incorporates the NHS Just Culture model. It is recommended that the Collaborative should undertake a review of staff beliefs and experience of SAI investigations and how staff feel they are supported and how this could be improved. This should inform the development of a staff support framework

8. It is recommended that the Collaborative along with PHA/HSCB should look to identify a range of common patient safety metrics for the mental health system in N Ireland which would help inform practice and guide service improvement.

9. A contrast between the services visited and N Ireland mental health services is the complexity of our local mental health system. Handovers between clinicians and teams heightens risks, leads to

delays, provides a poorer patient experience and can lead to poorer outcomes. It is recommended that mental health services in N Ireland should review their structures with the aim of reducing complexity and patient handovers and improving continuity of patient care.

10. It is recommended that a collaborative care approach to meeting mental health needs on a population basis co-designed across primary and secondary care and incorporating the independent sector and local community services be implemented and evaluated within a GP federation area in N Ireland."

The Northern Ireland Commission for Children and Young People's (2018) report *Still Waiting – A rights based review of mental health services and support for children and young people in Northern Ireland* included a number of recommendations relevant to crisis services (the numbers listed refer to the order in which they are listed in the report):

"Crisis Support

21. Implement RCPCH 'Minimum Care Standards for Children and Young People in Emergency Care Settings who present with Mental Health Problems' (RCPCH, 2018).

22. The DoH should enhance the statutory framework, requiring RQIA to routinely inspect A&E Departments against the 'Minimum Care Standards for Children and Young People in Emergency Care Settings who present with Mental Health Problems' (RCPCH, 2018). This should include appropriate, robust enforcement powers and the provision of sufficient resources to carry out this role.

23. Crisis intervention support for children and young people should be available 24 hours a day, all year round, in all HSCTs.

24. Include a Clinical Decision Unit, or equivalent service model, as part of every A&E Department in Northern Ireland. This would be useful for young people who may require a period of observation, further investigation or other interventions which cannot be completed within the four hour timeframe within A&E Departments.

25. An evaluation of the compliance with, and effectiveness of, the Card Before You Leave scheme (CBYL) for children and young people in A&E should be carried out.

4. Progress the development, implementation and monitoring of service specific integrated care pathways, such as those involving A&E, CAIT and SHIP. These must be informed by the staff and professionals working across the agencies involved.

Drug and Alcohol Services

There is also a correlation between crisis mental health and alcohol and drug use, however services are not integrated or sufficiently resourced. NICCY made the following recommendations in its 'Still Waiting' Review.

41. Statutory CAMHS should adopt a 'harm reduction approach' to ensure that young people can access mental health support whilst withdrawing from substances.

Appropriate levels of supervision and support for young people withdrawing from substances should be provided.

42. Universal and timely access to Drug and Mental Health Services (DAMHS) should be available across Northern Ireland. DAMHS should be closely aligned to CAMHS, and closely linked to Step 2 commissioned drugs and alcohol services.

43. Step 4 specialist intensive community based support and interventions for young people with drug and/or alcohol and mental health problems should be expediently developed, and provided across Northern Ireland. This should include day treatment programmes and age-appropriate interventions.

44. Inpatient care and treatment should be provided for young people with co-occurring drug and/or alcohol and mental health problems, who cannot be safely and effectively supported within the community. This provision should take a holistic approach to need, provide a range of interventions and be fully integrated into the Stepped Care CAMHS service model.

Care Planning and Treatment

14. The administration of prescription medication for young people must comply with NICE guidelines. Where medication is prescribed to a young person with a history of alcohol and/or drug problems this should be risk assessed and appropriately supervised. HSCB must monitor prescribing data to ensure compliance with NICE guidelines."

O'Neill and O'Connor (2020) provided a helpful overview of the key wider issues relevant to suicide in Northern Ireland including epidemiology, risk factors and prevention. They highlighted some key challenges and opportunities for intervention:

- "Improve the accessibility of psychological therapies and fully implement the Northern Ireland psychological therapies strategy
- Enhance the response to self-harm in emergency departments through the assessment of suicidal thoughts and delivery of suicide-specific interventions
- Develop and test interventions that take account of transgenerational trauma and community divisions, and the role of alcohol in coping
- Involve people with lived experience in the design and delivery of suicide interventions" (p. 6)

They conclude: "interventions should be trauma-informed, in recognition of the transgenerational effect of the conflict. Suicide-specific interventions and psychosocial interventions should be delivered alongside crisis intervention services and treatments for mental illness." (p. 7)

In September 2020 there was a debate in the Business Committee of the NI Assembly on Mental Health Crisis Support. The motion was presented by MLA Alex Easton, and following speeches by a number of MLAs, was agreed:

"That this Assembly recognises the importance of collaborative and well-resourced services that support those in mental health crisis across Northern Ireland; notes with concern a COVID-19 survey conducted by the stress, trauma and related conditions (STARC) laboratory at Queen's University Belfast, which found that one third of people locally met the criteria for depression; highlights the success of the multi-agency triage team (MATT) partnership between the health and social care sector, the PSNI and the Northern Ireland Ambulance Service in providing on-the-spot mental health support to people in emotional crisis; and calls on the Minister of Health to commit urgently to the expansion and funding of this project to all health and social care trusts."

One of the speeches was by Health Minister, Robin Swann, who stated “In my Department's mental health action plan I have included an action that specifically looks at the configuration of crisis services. Specifically, action 8.2 is included to provide a "Better MH [Mental Health] crisis response" and aims to reduce the number of people who attend emergency departments in a mental health crisis. The action specifically seeks to evaluate alternatives to the emergency department for people in mental health crisis, to evaluate the roll-out of the multi-agency triage team, to consider the interactions between different crisis response services such as MATT, the home crisis teams, emergency departments, 999, the police, primary care multidisciplinary teams and similar. It also seeks to further develop the liaison between mental health services across all our trusts. Through that, I am committed to a further roll-out of the multi-agency triage teams, but it has to be done in an integrated way as part of the wider development of our mental health crisis response. The MATT cannot exist in isolation and must be supported by effective integration with emergency departments, statutory mental health services, primary care, the police and the community and voluntary sector.”

There have also been a number of reports on specific aspects of mental health crisis services which further inform the future development of services.

In 2013, the Health and Social Care Board and Public Health Agency produced an evaluation of the Card before you leave scheme. It reported that “The scheme provides an important gateway into services for those who engage with next day follow-up appointments, with almost half of patients who attend receiving further follow-up by the mental health service. Non-attendance at next day appointments remains an issue that requires attention and recommendations are made to address this issue.” (p. 5) It also recommended that “For some patients, consideration should be given to making mental health assessments available in an alternative location to the ED. This would have the dual impact of improving the environment for carrying out the assessment process and reducing unnecessary pressure on the ED. Ensuring that patients are seen and assessed in the most appropriate environment should be a focus for future development of services and this may involve a more significant role for the voluntary and community sector.” (pp. 5-6). It concluded that “the scheme appears to be effective for some patients, namely those that choose to attend the next day appointment and subsequent mental health care, if needed. The challenge lies in engaging more of these patients to attend next day appointments and also ensuring that appropriate assessment and support services are in place for those presenting to ED with alcohol and /or drug problems.” (p. 7)

In 2014, the Public Health Agency published a summary of the feedback it had received to its public consultation on the Lifeline Crisis Response Service. The service had originally been piloted in 2007 and expanded to cover the whole of Northern Ireland in 2008 with the aims of providing additional support to all people in crisis. There was a range of responses across different issues covered in the report. The consultation had specifically asked people to prioritise the services that could be provided in the context of limited resources and the responses suggested:

- “The main lifeline helpline service - 24/7 free-phone crisis helpline, de-escalation of immediate crisis and suicide risk;
- Comprehensive assessment of callers risk of self-harm or suicide;
- Referral to specialist mental health services;
- Face to face Psychological Therapies i.e. counselling;
- Client check-in service via; telephone, text and/ or online;
- Telephone Psychological Therapies such as counselling via telephone and mobile crisis response.” (p. 41)

In relation to developments in home-based treatment, McGarry (2019) reported that "In Northern Ireland, the first Crisis Response Team was set up in the Homefirst Trust in 2005. With the reorganisation to five Trusts in April 2007, each Trust was mandated to provide Home Treatment. As has been the case elsewhere, different models of care have been set up across the five Trusts, although they do appear to be broadly similar…

In Belfast, Home Treatment was set up in 2006. It has always worked on a 24/7 basis. In the year after, it took over responsibility for gatekeeping all admissions in 2009, the number of admissions dropped by 27%. Belfast has achieved a reduction of over 40% in acute psychiatric beds since 2009. The team has four consultants, including an old age psychiatrist. Belfast also has a self-harm/personality disorder team, and an unscheduled care team which assesses patients presenting to the EDs and many of the crisis patients referred by general practitioner's (GP), thus allowing Home Treatment to focus on the most severely ill patients…

Critics of Home Treatment have expressed concerns about a fragmentation in care, with patients moving between a number of consultants during acute episodes of illness…

Over recent years, the evidence for the cost-effectiveness of Home Treatment has been somewhat more mixed than in earlier studies...

Murphy et al. (2015) concluded for the Cochrane collaboration that while the research evidence was very limited: 'Home Treatment appears to be a viable and acceptable way of treating people with serious mental illness'. The review also noted that Home Treatment was more acceptable to patients and 'is less burdensome to relatives', while there was evidence that it can reduce the number of repeat admissions and lead to improvement in patients' mental health." (p. 4).

Davidson et al. (2021) conducted a regional audit of assessments under mental health law in Northern Ireland which had been prompted by concerns about the impact of possible delays in these complex, inter-agency and, at times, high risk processes. The audit concluded that "despite the level of need and risk involved, and the complexity of coordinating all the professionals involved, there were no issues or concerns identified in the majority of assessments considered in the audit. Although there were delays identified due to the difficulties in coordinating professionals and in securing a bed, in only 3/189 (2%) of the cases delay was identified as contributing to increased distress and risk. Nonetheless, although these are very small numbers, the potential outcomes of delay that may increase risk still makes this concerning." (p. 5). It reinforced the need for ongoing inter-agency collaboration, guidance and agreement to facilitate this aspect of crisis services.

The report of the evaluation of the Community Crisis Intervention Service was published in January 2020 (Ennis and Walker, 2020). This Service provided in Derry/Londonderry by Extern was opened in January 2019 to provide an intervention service to support individuals in crisis. The evaluation has a range of findings including:

- "Service user reports of what works well about the CCIS were categorised into two themes, which were the advantages of a non-clinical intervention and the perception of the CCIS services as an impactful and individualised intervention to prevent the escalation of suicidal thoughts and behaviour.
- Referral partner reports of what works well about the CCIS were categorised into two themes, which were the advantages of a non-clinical intervention and how the CCIS the CCIS services were perceived as impactful for overall service provision.

- Service user suggestions as to how the CCIS service could be improved were categorised into two themes, which were the need for extended opening hours and the need for greater awareness of the service.
- Referral partner suggestions as to how the CCIS service could be improved were categorised into two themes, which were the need for information sharing and the need for more collaborative working." (p. 4)

The evaluation provides a number of recommendations including:

- "…Relevant bodies need to progress partnerships among referral agencies to allow provide follow-up care for service users as recommended in NICE (National Institute of Clinical Excellence) guidelines…
- Across all relevant service providers, strategies need to be developed regarding management of individuals who experience frequent crisis situations and present to services (CCIS or any other service)." (p. 4)

The evaluation also highlights the need for more research in this area including "Further study of the experiences of individuals prior to a crisis situation is needed. This should include the use of measures of mental health, well-being and family outcomes as well as qualitative studies to better understand the impact of this [going into crisis] on all family members." (p. 5)

An Evaluation of the Crisis De-escalation Service completed by Social Market Research in June 2020. This service was started in March 2019 for the Belfast area, by INSPIRE and the Belfast HSC Trust, to provide an intervention for people in psychosocial crisis. After initial demand being lower than expected the service was redesigned with the aim of making it more integrated with the Unscheduled Care Team. The evaluation identified a range of ongoing complex issues but that "Feedback from CDS staff and UCT staff suggests that the latest hospital-based model (the "Fairview" model") is effective in:

- De-escalating emotional crisis, and
- Reducing adverse outcomes for clients.

The CDS is now having positive impacts on patients. CDS staff report that they are having positive impacts and UCT interviewees supported this.

However, the CDS has not been effective in:

- Reducing the burden on the Emergency Department
- Reducing the need for the allocation of Card Before You Leave
- Reducing the burden among the C&V sector and OOH drop ins/calls, or
- Significantly reducing the burden for the Unscheduled Care Team.

Finally, the impact on families is less clear. There are different views amongst CDS staff as to their role with families. In some cases, families are welcomed as part of the solution to the patients' presenting issues. In other cases, families can disrupt the de-escalation process and, in such circumstances, are an unwelcome barrier to successful outcome. Furthermore, some CDS staff did not see it as their role to go beyond the patient that was referred to them and did not make any contact with families." (p. 3)

Most recently, an evaluation of the Multi Agency Triage Team has been conducted (Gossrau-Breen and Mallon, 2021). That service is "a crisis de-escalation service available for those experiencing an acute mental health (MH) crisis (aged 18 and older) and who are in contact with emergency services

by phoning 999 or 101. The team comprises mental health professionals (MHP) working alongside dedicated police officers and paramedics in a mobile community unit (ie ambulance). MATT has been operating in the Lisburn, Castlereagh, and North Down/Ards area since 6 July 2018 and has expanded into Belfast HSCT area since 3 August 2019. The service operates between 7pm and 7am on a Friday and Saturday night (ie 24 hours each weekend)." (p. 5)

The draft summary report of the evaluation which was produced in March 2021 and made available to the Review Team so it could be included in this Review. It concluded that:

"Both service users and staff considered MATT to be working well. MATT was viewed to be a positive alternative to the usual and previous way of responding to individuals experiencing a mental health crisis. The success of the service has been due to good collaboration between the HSC Trusts, NIAS and PSNI. The transition into the BHSCT area, 13 months after the initial set-up between SEHSCT, NIAS, and PSNI, was relatively smooth." (p. 25)

"Overall, the evaluation findings are in line with the wider evidence on street triage/co-responder models as noted in a recent rapid evidence synthesis by NIHR (Rodger et al., 2019) and other reviews (eg Puntis et al., 2018). The evaluation was unable to address some gaps in the evidence (eg limited outcome data for service users to undertake cost-effectiveness analysis) and experienced some difficulties with the quality of monitoring data." (p. 26)

The complex issues involved in these, and other aspects of mental health crisis services, are further explored in the findings section of this report.

How the Review was conducted

The Review was designed to involve a comprehensive and inclusive approach to gathering information, evidence and perspectives from a wide range of sources.

Review Team composition and meetings

As outlined in the Introduction, the Review Team was identified and supported by the Department of Health's Mental Health and Capacity Unit but its members were independent of and external to the Department of Health. The Review Team was made up of a Chair and six other members:

- Christine Bateson, Chair of the Review. Christine was the Head of Acute Psychiatric Services in Northern Health and Social Care Trust before her retirement
- Audrey Allen, Director of Operations, Action Mental Health
- Tory Cunningham, Senior Peer Support Worker, Belfast Health and Social Care Trust
- Gavin Davidson, Professor of Social Care, Queen's University Belfast
- Erin McFeely, Chief Executive of Developing Healthy Communities
- Philip McGarry, Consultant Psychiatrist. Dr McGarry worked with the Belfast Health and Social Care Trust's Home Treatment Team before his retirement
- Rory O'Connor, Professor of Health Psychology, Director of the Suicidal Behaviour Research Laboratory and Head of the Mental Health and Wellbeing Research Group, University of Glasgow.

The Review Team was appointed in October 2020 and began the review process in November 2020. Throughout the review process the Team met regularly via Zoom, to discuss progress, the next steps and then to consider the drafts of the report. The review process was completed on 22nd April 2021 with the submission of this report to the Department of Health.

Literature review

The literature review was a narrative review of the literature to provide an overview of policy, service and research developments on crisis services. As explained in the literature review section, it focused on policy developments in a number of countries where mental health services have recently been reviewed and on available existing reviews of research on crisis services. This was completed to ensure that the Review in Northern Ireland was informed by recent policy developments in other countries and the available research evidence. The literature review covered a discussion of definitions, an outline of the range of crisis service models and some examples of service users' perspectives on these services. It then provided a summary of recent policy developments in selected countries and an overview of existing reviews of the evidence of the effectiveness of crisis services. The Northern Ireland policy and research contexts were also explored to highlight some of the key relevant developments and issues.

Meetings with service providers, service users and carers

The main focus of the Review was a series of meetings with service providers, service users and carers. This enabled in-depth qualitative data to be collected from a wide range of people. The meetings were conducted via Zoom (due to COVID-19) and used a semi-structured interview format to provide:

1. Information on the role of the group or person attending the meeting

2. Their experiences of mental health crises and/or mental health crisis services
3. What works well currently and what could be improved.

The interview participants were informed about the Review and invited to participate through several routes:

- Communication from the Department of Health
- Communication by the Review Team via email
- Individual invitation.

The meetings were organised to ensure representation of the following key groups:

1. Policy Leads for Mental Health Services
2. Service Providers
3. Service Users and carers.
4. Interagency Partners and others.

A list of those involved is included in the tables below.

Policy Leads for Mental Health Engagement Events

Name of the Person/ Organisation	**Date of the Meeting**	
Public Health Agency Dr D O Hagan	21/01/21	NI Deliberate Self Harm Registry.
Public Health Agency Fiona Teague	Initial meeting 21/12/20 subsequent meetings	Protect Life 2 Strategy Fiona also facilitated PLIG meetings and Lifeline Meeting
PHA Nursing Team	22/1/21	
Dept of Health Mental Health Improvement Board	4/2/21	
Oscar Donnelly/ Phil Hughes	11/11/20	Mental Health Strategy
Oscar Donnelly/ Dr G Lynch	4/12/20	Towards Zero Suicide Initiative
Siobhan O Neill Mental Health Champion	11/12/20	Mental Health Champion
Windsor Murdock and Roger Kennedy	7/4/21	Multidisciplinary Teams Primary Care and No More Silos Work

Service Providers (Trust) Engagement Events

Name of the Person/ Organisation	**Date of the Meeting**	
Northern Trust	8/02/21	**Trust Engagement Events.** Trusts were invited to contribute through their Director and Assistant Director of Mental Health. Meetings were arranged by an identified link person within the Trust who invited a range of people
Western Trust	21/01/21	
South Eastern Trust	13/01/21	
Southern Trust	4/2/21	

Director/ Ass Dir South Trust requested following initial trust meeting	22/02/21	within the Trust to represent Adult Mental Health Older peoples Services CAMHs, Learning Disability, Emergency Department Service User Representative.
Meeting with Southern Trust Medical Team	22/02/21	

Community and Voluntary Organisation Engagement Events

Name of the Person/ Organisation	**Date of the Meeting**	
Belfast Trust Protect Life 2 Implementation Group	10/03/21	Meetings were arranged by the Protect Life Leads in each of the Trust Areas. An open invitation was extended to community and voluntary groups working within each area. Organisations were also given a link for the online survey to share with those that use services and/or work in them
Northern Trust Protect life 2 Implementation Group	16/03/21	
Southern Trust Protect Life 2 Implementation Group	23/03/21	
South Eastern Protect Life 2 Group	22/03/21	
Western Trust Protect Life 2 Group	23/03/21	
Cause	22/03/21	
PIPS Hope and Support - Crisis Café	4/03/21	
SHIP -Zest	24/2/21	
Lifeline	29/03/21	
Community Crisis Intervention Service Extern	29/03/21	

Service User Engagement Events

Name of the Person/ organisation	**Date of Meeting**	
Service User Consultant Northern Trust	5/03/21	The meeting was arranged to engage with Service User Consultants to determine the best ways to ensure service user participation in the Review. Service user Consultants met with Review Team and they also circulated the online survey through social media links
Service User Consultant Western Trust	5/03/21	
Service User Consultant Belfast Trust	10/02/21	
Service User Consultant South Eastern Trust	24/02/21	
Service User Consultant Southern Trust	12/03/21	
Family Voices Forum	8/12/20 27/1/21	
MyStoryYourStory	31/03/21	

Partnership and other engagement Meetings

Name of the Person/ Organisation	**Date of the Meetings**	
PSNI Mark Cavanagh	15/12/20	MATT
Una Williamson	19/03/21	PSNI
Northern Ireland Ambulance Service	7/12/20	Mental Health Initiatives within NIAS
Dr Aisling Diamond	30/03/21	ED Consultant
Dr P Ryan (DOH)	10/03/21	Primary Care and Mental Health Crisis
Royal College of GPs	13/04/21	Primary Care and Mental Health Crisis
Dr Windsor Murdock and Roger Kennedy	7/04/21	Multidisciplinary Teams in Primary Care
Kerry McVeigh and Des Flannagan	19/04/21	Approved Social Work and Regional Emergency Social Work Service, BHSCT

The meetings were recorded on Zoom, transcribed verbatim and anonymised and then the recordings were deleted. All participants were offered a follow up meeting or individual meeting if they preferred. Outcomes were analysed and the themes identified which are presented in the findings section of this report.

Survey of service users, carers and professionals

As it was not possible to meet individually with everyone involved in crisis services, an online survey was co-produced by the Review Team to enable anyone who wanted to contribute to the Review to do so. The survey was designed to be accessible but also used mainly open questions so people were able to respond in as much depth as they wished to. The survey questionnaire had seven main questions:

1. Thinking about your interest in mental health crisis services, which of the following groups best describes you and/or your job role? (please select all that apply)
2. What services are you aware of in Northern Ireland specifically for people experiencing a mental health crisis?
3. What's working well in these services?
4. What's not working well in these services? Any gaps?
5. Are there any examples of best practice, nationally or internationally, that you are aware of?
6. What would make crisis services better in Northern Ireland?
7. Do you have any further comments?

Limitations of the Review

Whilst there was a systematic and inclusive approach to engagement, the Review Team acknowledges that there are limitations to the range and number of those who could be included in the Review based on the scope and the time-frames for completing the Review. It is anticipated that the ongoing process of developing mental health crisis services will continue to be an inclusive process and so there should be further opportunities for people to engage in the development, delivery and evaluation of these services.

Findings of the Review

The findings of the Review have been structured under the following headings:

- Crisis Resolution Home Treatment Services in Northern Ireland.
- Mental Health Crisis in General Hospitals
- Mental Health Crisis and the Community and Voluntary Sector
- Primary care
- Interagency and collaborative working Partnerships
- Online survey findings

Crisis Resolution Home Treatment Services

It is important to understand how the public conceptualises mental health crises and how this influences their expectations of the current and future provision of Mental Health Crisis Intervention Services.

Crisis Resolution Home Treatment Services are one important component of a Mental Health Crisis Service and were established with clear outcomes in mind. A significant investment has been made in this area and it is a commonly held belief within the general public and many stakeholders that these services provide the main source of Mental Health Crisis Response regionally.

Crisis Resolution Home Treatment Services in Northern Ireland were introduced in 2004. They were commissioned to provide intensive support at home for individuals (McCallion & O'Hare, 2014) experiencing an acute Mental Health Crisis. The primary aim of such teams was to reduce both the number and length of mental health Hospital admissions and ease the pressure on inpatient beds.

The concept was not a new one and was initially outlined in in the NHS Plan for England in 2002, which set the target to provide 335 CRHT teams across England

In Northern Ireland, 'The Bamford Review', 'Transforming your care', and more recently Wellbeing 2026 have supported the shift in Acute Mental Health Services from an inpatient to a Community based model.

The Mental Health Policy Guide (2001) for England provided clear guidance on the size, construct, principles and practices of CRHT Teams.

As outlined in the Policy Implementation Guide, the size of CRHT teams was dependent on:

- The population and size of the catchment area to be served.
- The level of need in a specific catchment area.
- The number of inpatient admissions in the Trust Area prior to the introduction of the CRHTT and the reasons for admission
- Resources required to deliver a 24-hour rota-based service.

This approach has contributed to services being developed in quite different ways within each of the five Trust areas in Northern Ireland.

These Services were not commissioned or developed simultaneously.

Whilst the design and make up of Teams reflect the diversity of need within each Trust, the population they serve and the experience of admissions to inpatient units prior to the establishment of the Crisis Resolution Home Treatment Service, this approach has also created challenges.

Service Users can find it difficult to navigate the different systems from Trust to Trust. There are communication issues that have made inter Trust transitions difficult for those who move from one Trust to another. Differing thresholds have contributed to perceived inconsistencies in service provision across the region. There is a need to reduce the current variations and provide a more standardised approach across the region.

Table 1: Trust configuration of Crisis Resolution Home Treatment Services

Name of the Trust	Population	Urban/ rural	Type of Crisis Service	Hours of operation	Inclusion Criteria
Northern Trust	470,000	Mixed	Crisis Resolution Home Treatment Service Integrated crisis and Home Treatment Functions	9pm-10pm On call 10pm-9am (*Provides assessment function to Causeway hospital on Call Out of Hours*)	Adult Service 18 years inclusive of functional over 65years
Southern Trust	387,612	Mixed	Integrated Crisis Resolution Home Treatment Services with Liaison functions to General Hospitals in the Trust Area	24 hour (Out of hours includes cover provided to the ED)	Adult Service 18 years and over inclusive of functional over 65 years. (It *has assessed those with LD but not included in operational policy.)*
Belfast Trust	359,845	Urban	Unscheduled Care Team based in RVH and Mater and two Community facilities for GP referrals (Home *Treatment Team offers Acute Mental Health Care at home as alternative to Hospital Admission as a separate Team)*	1 Practitioner RVH 1 HT Practitioner available throughout the might	Adult Service 18 years and over inclusive of functional over 65 years.
South Eastern Trust	345,000	Mixed	Assessment Centre, ED based Service and provides Home Treatment services	24 hour (Out of hours includes cover provided to the ED)	Adult Service 18 years and over inclusive of functional over 65 years.
Western Trust	300,000	Mixed (2 large Urban Centres)	Integrated Crisis, Liaison, Home Treatment, with bed management	24 hours per day with OOH Service based in Omagh and	Adult Service does not accept referrals for under 18 years and those with an

			responsibilities out of hours	Grangewood to fulfil all service functions	intellectual disability.

The efficacy of Crisis Resolution Home Treatment Teams is linked to their fidelity to a specific model specification that has been evaluated to achieve the desired outcomes. There have been several model fidelity measures developed including Core Crisis Resolution Fidelity Scale V2, to assist Teams to measure their performance against 20 agreed principles, some of which are outlined below:

- Rapid Mobile Response following referrals
- Gatekeeping of inpatient beds and early discharge
- 24-hour availability and 7 days per week Service
- Clearly defined target population
- Ease of access
- Multidisciplinary approach
- Intensive intervention and support in the early stages of the crisis
- Facilitate early discharge
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs.

The Royal College of Psychiatrists has developed The Home Treatment Team Accreditation Scheme (HTAS) which works with Home Treatment Teams to assure and improve the quality of Crisis Resolution and Home Treatment Services for people with Acute Mental illness and their carers.

The National Institute of Mental Health England identified that the group that would most benefit from this service was the adult population, primarily 16-65 years, and would primarily be those with a diagnosis of Severe and Enduring Mental Illness or with an acuity level that would warrant admission to a Mental Health Hospital bed. They also provided guidance for those for whom the Service would not usually be appropriate, highlighting the following diagnoses:

- Mild anxiety disorders.
- Brain damage or organic brain disease including dementia
- Primary diagnosis of alcohol or other substances
- Learning Disability
- Recent history of self- harm but not suffering from a psychotic or severe illness
- A crisis solely related to relationship issues.

These criteria were adopted by the majority of CRHT Teams that were developed in the early 2000s. A major goal was to treat at home those with severe mental illness who would otherwise have had to be admitted to hospital, and indeed the funding for the new teams was largely provided by savings made from closing wards.

However, the focus on severe mental illness has contributed to a perception of exclusion in a changing mental health environment with an emerging culture of inclusivity and equality, particularly for those under 18 years, those with a learning disability and those over 65 years with a functional illness. It is interesting to note that NICE stressed that they did not wish to set rigid exclusion criteria, but to assist in making sure that CRHTT Services were targeted to the group that most benefited from their input.

Most referrals to Crisis Resolution Home Treatment Teams are from Primary Care.

There can be uncertainty about thresholds for referral to Crisis Resolution Home Treatment Teams within Primary Care at present.

There is also a high level of concern about the safety and wellbeing of individuals who present to General Practice in Mental Health Crisis in a region that has high rates of suicide. There are limited alternatives for specialist Mental Health advice or support other than referral to the CRHTT or Emergency Department.

New Service models such as the GP Federations have employed mental health practitioners and there may be opportunities in the future to have interventions at the primary care level to assist individuals earlier to prevent mental health crises escalating.

The benefits for Primary Care of the current system is that there is a single point of referral, and assessments are generally completed within four hours or on the same day. The expediency of this approach is preferable to considering other Mental Health Referral pathways.

On examining referral data to CRHTT from Primary Care across the 5 Trusts, many referrals do not meet the threshold for inpatient care or home treatment. Thus a significant number of those who are referred to and assessed by Crisis Response Home Treatment Teams are not offered further intervention following assessment.

This has contributed to some people feeling dissatisfied with Trust Crisis Services and a belief among User groups that these Services are not meeting the needs of the population.

It should be noted that the majority of those who are accepted by Crisis Resolution Home Treatment Teams for further care and intervention appear to be generally happy with the Service, and outcomes have been broadly positive

Carers of those in Mental Health Crisis who are not taken on for active treatment have reported disappointment and frustration at what they perceive as an inadequate response.

Trusts that adhere strictly to the original Crisis Resolution Home Treatment criteria often find that there are significant numbers of people who do not meet the threshold for their service accessing General Hospital Emergency Departments in the absence of any other alternative.

Community Mental Health Teams play a valuable role in providing urgent interventions for patients currently known to the service.

There are Duty systems in place within each Trust area that respond to urgent calls from those under their.

Individuals who require mental health services have stressed the importance of continuity of care and the importance of being able to contact someone who knows them well when in crisis.

The current 9-5 Monday to Friday Service has inevitable limitations. An extended service providing some input over weekends and bank holidays could prevent people from requiring to be referred for Acute Care or for Crisis Resolution.

The current Crisis Resolution Home Treatment Model has provided good quality care, and has led to a significant reduction in in-patient beds.

People who are experiencing severe acute mental illness can be treated safely in the least restrictive environment with minimum disruption to their lives with input from these teams.

Crisis Resolution Home Treatment Teams continue to offer a safe alternative to inpatient care.

Many Service Users prefer Home Based Treatment, and research in the UK has shown that the outcomes achieved by community-based treatment are at least as good as those achieved in hospital.

The maximum benefits from Crisis Resolution Home Treatment Services are for a targeted population. They are an essential, but only one component of Mental Health Crisis Services.

A more comprehensive Mental Health Crisis Model is required to provide intervention and support for those in crisis, but without severe mental illness.

Many of the concerns about 'deficiencies' in current Trust Crisis Resolution Home Treatment Services have arisen because they are perceived by some Stakeholders and others that they are the main provider for Mental Health Crisis Services across the region, which they were not in fact set up to be.

Mental Health Crisis Care in General Hospital facilities

Protect Life 2 (2019) identified that in Northern Ireland a significant number of patients who experienced a mental Health Crisis will attend an Emergency Department to access the treatment they need.

The Northern Ireland Registry of Self Harm annual report 2017/18 identified that attendances to Emergency Departments continue to rise. They identified 13,911 attendances to Emergency Departments in the one-year period 2017/18, a rise of 2% from the previous 3-year period.

There are several key policy drivers that make an overwhelming case for improving Urgent and Emergency Health Care Services.

In England, The Independent Mental Health Task Force Five Year Forward View (Feb 2016) set out its commitment to improving access to high quality Mental Health Care through prompt access to evidence based NICE recommended Care that has equal parity with care provided for physical health care needs.

Mental Health Liaison Services operate as a specialised Service within Acute Care which support people in crisis as well as those who have mental health problems in General Hospital wards settings.

Table 2: Current Provision of Mental Health Liaison Services in Northern Ireland

Trust	Service Providing Liaison Function	Service Characteristics
Belfast	Unscheduled Care Team/	The ED Liaison Service in BHSCT is offered to both the Mater Hospital and Royal Victoria Hospital Emergency Departments.

	Home Treatment Team	There are staff available 24 hours per day. 2 staff members available at night. They also use the Card before you leave. They assess all patients aged 18 and over. (There is a 9am-5pm inpatient liaison service for those over the age of 65).
South Eastern Trust	Home Treatment Liaison Service	The Liaison Service is available 9am -8pm from an Assessment Centre base. There is a staff member based in The Ulster Hospital from 8pm – 7am, who also provides a service to OOH GP. There is a separate substance misuse Liaison Service that operate seven days per week but not 24 hours per day. Older people's team provides a liaison response for those over 65 years to five sites, but do not offer a service to the Emergency Department. Psychosocial assessment is provided to this age group in the ED by Crisis Resolution Home Treatment Service.
Southern Trust	Crisis Resolution Home Treatment Service	Ward based assessments are completed Mon- Fri 9-5pm. ED and CDU have access to assessments 7 days per week and on call by CRHTT and Junior doctors. They fulfil this role alongside their CRHTT role and bed management responsibilities.
Northern Trust	Mental Health Liaison Service and CRHTT	MHLS based in Antrim Area Hospital 24 hours per day 7 days per week, available to provide assessment and support to both ED and Wards. Care pathways agreed with LD and CAMHS to support care pathways for those who present in crisis. Causeway MHLS operates until 10pm and urgent referrals are picked up by the CRHTT overnight. Out of hours cover provided by CRHTT on call alongside Crisis and Home Treatment functions.
Western Trust		Crisis Resolution Home Treatment Team (CRHTT) in the Southern Sector of WHSCT have 2 sites; Tyrone and Fermanagh (T&F) Hospital, Omagh and South West Acute Hospital (SWAH), Enniskillen. • 8am -8pm; 1 band 6 nurse practitioner and 1 band 5 nurse practitioner on each site covering crisis, home treatment and bed management for the T&F Hospital, this includes crisis assessments in ED • 8pm –8am; 1 band 6 nurse practitioner covers both sites in Tyrone and Fermanagh including crisis assessments in ED and GP out-of-hours and bed manager for the Tyrone and Fermanagh Hospital. • In the Northern Sector there are 3 x Band 6 CRHTT staff, available for assessments and bed management, including ED. This reduces to 1 member of staff overnight. Card-before-you-leave assessments have recently been taken on by this team also.

		Older People • Older Persons staff potentially could be called for an ED assessment, although most input is at the ward level, Monday to Friday 9-5.

There is a wide variation in the degree of provision of Liaison Mental Health Services across the Region. Lack of a strategic regional approach contributes to inconsistencies in provision which impedes the ability of Liaison Services to deliver optimal care.

The Northern Ireland Registry of Self Harm identified that people with suicidal ideation and/or Self-harm attended the ED more often between 10pm and 7am. In order to provide accessible and timely care for all, services need to be available all day, every day.

Just as it is essential to ensure the provision of 24/7 care for people with urgent and emergency physical health needs, people experiencing a mental health crisis should also be able to receive 24/7 care that meets their needs.

As Table 2 (above) illustrates, several Trusts provide in-reach to General Hospitals by Crisis Resolution Home Treatment Teams.

However, there are implications in this approach for both Mental Health Liaison and Crisis Resolution Home Treatment Teams.

As part of the Review the Team engaged with a wide number of stakeholders. One of the most common concerns expressed by people who have attended or accompanied someone to the Emergency Department is the waiting time to be assessed by Mental Health Practitioners.

The current target outlined in the NICE Guidance is that people who need mental health assessment should be seen preferably within one hour of presentation to the Emergency Department. It is unlikely that these targets can be met unless Mental Health Teams are an onsite distinct Service that can respond immediately to referrals

When Crisis Resolution Home Treatment Teams provide psychosocial assessment in the Emergency Department this reduces the time available to deliver their core function of community based urgent mental health response, providing intensive Home Treatment as an alternative to inpatient care. A guidance statement on Fidelity and Best Practice for Crisis Services (2007) highlights that “diversion of Out of Hours Work to Emergency Department is not felt to be good Practice”.

This is illustrated in the Northern Trust where there is a distinct Mental Health Liaison Service working 24 hours per day which is able to complete assessments within 2 hours of presentation to the Emergency Department over the 24-hour period. However, in a second General Hospital within the Trust there are no overnight Mental Health staff on site and emergency assessments are completed by On Call Crisis Resolution Home Treatment Team. Those who are referred for assessment can have extended waits. Travel distances and competing risk priorities can contribute to this problem.

Service Users can be offered “Card Before You Leave”. This offers an appointment the next day for those who wish to go home before being fully assessed. However, there are often difficulties in establishing contact with these individuals and the proportion who do attend for follow up is low. It

is clearly important that services should be arranged to provide a full assessment prior to the person leaving the facility.

All Trusts regionally strive to provide a 24-hour Mental Health response to their General Hospitals and have also tried to address the needs of those under 18 years and those with an intellectual disability. However, Services that are commissioned as a hybrid model do not meet the minimum core 24 service model as set out by NICE` (section 3.31) in their document 'Achieving Better Access to 24/7 Urgent and Emergency Care'.

There are several Liaison Model specifications available as illustrated in Table 3.

Table 3: Mental Health Liaison Models

Type of Services	Characteristics
CORE	These have the minimum specification suggested by the literature. They are for General Hospitals where there is limited demand and it would be deemed uneconomical to provide a full 24-hour Service. This model can provide a service for an Acute Health Care System with or without an ED facility, but has Limits to its response times, particularly out of hours.
CORE 24	These Services have benefits where there is sufficient demand across 24 hours. They are of most benefit to urban or suburban Acute Hospitals with busy ED's. They do not have capacity to attend inpatient or provide enhanced functions of the Enhanced 24 model.
Enhanced 24	They have a specification that can fill gaps in existing pathways such as Learning Disability and CAMHS. They also have a range of additional expertise in substance misuse and addictions either through care pathways developed or integrated within the Team. They have an extended role in providing input to inpatient units and outpatients and are able to meet all CORE 24/7 standards.
Comprehensive Service	Comprehensive services are required at large secondary care centres with regional and supra-regional services. These services include Core24 level services but will have additional specialist consultant liaison psychiatry, senior psychological therapists, specialist liaison mental health nursing, occupational and physiotherapists. They support inpatient and outpatient areas such as diabetes, neurology, gastroenterology, bariatric surgery, plastic and reconstructive surgery, pain management and cancer services. They may include other condition specific elements such as chronic fatigue and psychosexual medicine teams. Some may include specialist liaison psychiatry inpatient beds. Comprehensive services run over office and extended hours supported by the core service running twenty-four hours, seven days a week.

NHS England has set out in the Five Year Forward View for Mental Health, its commitment by 20/21 to invest to ensure that no Acute Hospital in England is without all-age mental health liaison Services in Emergency Departments and Inpatient Wards. It specifies that least 50 percent of all Acute Hospitals should meet the CORE 24 Service Standard as a minimum.

In identifying which Liaison model is preferable as a Regional Model it is helpful to consider which one can assist in addressing current deficits within our crisis provision.

Child and Adolescent Mental Health

Child and Adolescent Mental Health Services throughout the five Trusts have arrangements in place to respond to crisis presentations from 9am -5pm who are already receiving care from CAMHS Services. This is delivered as part of their core stepped care service provision.

They also have in place arrangements to respond to urgent referrals from GPs for young people who are in the process of being referred.

Out of Hours the arrangements differ from Trust to Trust. The Belfast Trust and South Eastern Trust provide a joint out of hours response via the Crisis Assessment and Intervention Team (CAIT) which operates within core CAMHS to deal with crises. The team works up until 9pm and then operates an on-call system throughout the night.

The majority of crisis presentations in under 18s present to the Emergency Departments and in many instances are signposted there by Out of Hours GPs.

It is not safe for young people and children to leave the Emergency Departments without assessment to wait for assessment the next day.

To provide parity of access over the 24-hour period consideration needs to be given to whether Crisis Intervention should be provided by CAMHS as a standalone model, or with CAMHS expertise being integrated with Adult Mental Health Services. There is scope within the Enhanced 24-hour Liaison Model specification to allow for collaborative pathways to be developed to support the latter option.

Many crises in the under 18-years are not driven by primary mental illness, but by social and related factors, but it is also the case that the prevalence of more severe mental health problems increases in mid to later adolescence.

Assessments need to be age and developmentally appropriate and conducted in a safe and pleasant space.

Staff who are undertaking assessments should have expertise in Child and Adolescent Mental Health and Safeguarding procedures.

The Northern Trust operates such a model in Antrim through their Mental Health Liaison Service, which is an Enhanced 24-hour Liaison Service.

Mental Health Liaison staff provide an initial assessment of young people who attend the Emergency Department. There are specific collaborative care pathways with CAMHS that facilitate specialist assessment at the earliest point the next day. CAMHS provide training and provide shadowing opportunities to the Mental Health Liaison Team to support learning opportunities.

It is vitally important that whatever model is deployed there should be consistency across the region to prevent perceived inequalities based on postcode.

CAMHS may also benefit from a uniform regional standard for the provision of crisis care for those under 18 years which clearly defines the regional arrangements which would include:

- The overall care provisions
- Access to Crisis Care for those under 18 based on a regionally consistent model
- Day time Urgent access
- Out of hours Urgent Access
- Management of Self Harm
- Use of recreational substances.

The BHSCT told the Review Team that a Regional Managed Care Network has been established which would ensure that Services are responsive and consistent, through collaborative learning and coordination.

Many of those we spoke to also identified the need for appropriate safe spaces for young people who present, particularly out of hours, who cannot go home in the short term.

This model also provides opportunities for other groups.

Crisis assessment for those with Intellectual Disability

The majority of people who have an Intellectual Disability now live in a community setting. Each of the Trusts has a range of services in place to meet their needs.

They access mainstream health services in the same way as all other groups through mainstream generic health services.

Intellectual disability encompasses a wide spectrum of need from very mild to severe and it is often difficult to know on presentation if someone has an intellectual disability unless they wish to disclose this.

Core Learning Disability Services offer a range of services and work in collaboration with Carers and Care settings to understand individuals and engage with them to prevent crises occurring.

However, individuals with an intellectual disability do attend Emergency Departments and in some cases are admitted to acute medical or surgical units.

In line with the Equality Act (2010), Health Care Services have a duty to address health inequalities and ensure reasonable adjustments are in place so as not to disadvantage people with a learning disability.

Standards for those who present with a mental health crisis to the Emergency Department are also applicable to those with an intellectual disability.

The Enhanced 24 model allows for the development of care pathways with Learning Disability Services to provide an initial assessment of the person's mental health needs and timely and supported transitions to Core Services for specialist input. Access to information systems, shared crisis plans, and 'passports' are important in ensuring that there is information available that will assist the person in the immediate crisis.

The main aim of an initial assessment is to support the safety of the individual and to help them modulate their feelings and behaviour. This can be achieved through timely access to a practitioner who is able to adapt their approach to the individual's level of functioning.

Development of care pathways for those who require initial assessment in the Emergency Department can be achieved through full collaboration of the Liaison Service and Learning Disability Teams. Training and expertise require to be developed to help practitioners to attain skills in communication and behaviour.

The Western Trust have recently employed two Learning Disability Liaison Nurses to assist with this.

New models of Liaison can also recruit staff from this speciality to work within teams as a resource for learning as well as providing critical clinical expertise.

A good example of this collaborative approach is in the Northern Trust which has implemented a robust care pathway for those who present in Crisis with a learning disability.

As well as providing training for the staff and timely specialist assessment following initial assessment by Mental Health Liaison staff, they also share care plans to prevent crises and an alert system over weekends and holiday periods.

What people told us

These statements were provided following service user and carer engagement meetings with the Review Team. They have been worded from the perspective of the person experiencing a mental health crisis and or their family member or Carer to highlight the need to develop urgent and emergency mental health services with the person at the centre.

We want to treated with compassion and understanding

I find ED very frightening and it makes me feel that I don't deserve help

I had to wait a long time for the mental health nurse to come I couldn't wait I needed to go home to bed.

Need to acknowledge the role of families and carers who wouldn't be carers if other supports existed.

There is a lack of privacy I had to tell my story which was very painful behind a very thin screen I knew everyone could hear me

As someone who has attended the ED with my husband I felt terrible I was not spoken to and did not feel that I was heard even though I had to take him home and keep him safe

There needs to be a meaningful conversation about consent between carers and the person in crisis

I need to feel safe

What people told us would improve services

To be able to see someone who understands my problems

An area near to the ED that is quieter and more private would be better for assessments

Speak to relatives/carers

If I am to be involved in a Crisis Plan for my loved one. I need to know what I am dealing with and need to be supported in carrying out what am required to do

I think mental health staff working in the ED would mean that there would be no waits for them coming to see me

Don't make me repeat my story it is painful

My Crisis happens when my keyworker is off and I have nowhere else to go. If I was able to see my keyworker more flexibly it would stop me needing to go to the ED

More access to mental health assessment for those under 18 who go to the ED

Alternatives to Emergency Department for those who present in mental health crisis

It is widely recognised that the Emergency Departments in General Hospitals are not always the best place for those in Mental Health Crisis to access help.

The principle underpinning any alternatives must ensure that people who are accessing help are directed to the 'best door'.

The Northern Ireland Registry of Deliberate Self Harm in 2017/18 Report recorded that for the period from 1st April 2017 to 31st March 2018, there were 9,217 self-harm attendances to emergency departments (EDs) in Northern Ireland. The Registry also identified that in addition to those who self-harmed there were 4,784 presentations with suicidal ideation recorded during the same period.

This is a 50% increase in the number of ideation presentations between 2012/13 and 2017/18.

These 4,784 ideation presentations were made by 3,310 individuals.

Almost half (46%) of all ideation presentations involved alcohol, slightly more so for males (48% vs. 43%).

The highest recorded number of suicidal ideation presentations was to the Mater Hospital, accounting for 19% (n=918) of total presentations and the Antrim and Craigavon Hospitals with a 14% share each (n=684 and 680 respectively) of presentations.

The largest number of ideation presentations was recorded in the Belfast HSCT area (n=1,551), accounting for 32% of all ideation presentations made during this period.

An average of 13 presentations involving suicidal ideation was recorded per day and, as in self-harm presentations, was highest at weekends.

One in ten presentations due to ideation resulted in the patient leaving the ED without being seen or before a care recommendation could be made.

It is reasonable to assume that there is an opportunity to provide an alternative access to mental health crisis assessment and intervention for these people.

Some of these people are brought to the Emergency Department by the Northern Ireland Ambulance Service and the Police Service of Northern Ireland.

The development of locality based Mental Health Crisis Centres in places that are easily accessible and that can provide assessment intervention and have care pathways into other services to assist the person in crisis would be beneficial.

The Department of Health Covid and Emergency Care Action Plan 2020, has created potential opportunities to provide an alternative to the Emergency Department for those who have no emergency medical or surgical needs.

The Phone First Initiative outlined in No More Silos would allow for those in mental health crisis out of hours who do not have urgent medical needs to be offered an appointment for assessment by Mental Health Staff. This could be offered in a facility separate from (but probably co-located with) the ED. This would be dependent on an onsite mental health team to provide the assessments. This would also mean that if there were emerging medical needs they could be addressed immediately.

We have consistently been told by users, carers and staff that the lack of privacy and overall environment in Emergency Departments is not conducive to biopsychosocial mental health assessment. A facility located near to an Emergency Department but separate would be much more suitable. The provision of an appointment time would also remove the sometimes long waits for assessment as the Mental Health Practitioner would be available and waiting for the person to attend.

For those who require surgical or medical care in the ED, people continue to be frustrated with long waiting periods. Any service development in the future must aim to ensure that people are seen within the guidance set down by NICE. It is also important that the mental health and medical care pathways run in parallel with Mental Health Assessments commencing at the earliest opportunity.

People are often brought or accompanied by a family member or friend to the Emergency Department. They have told us that at this point they may not recognise themselves as carers, but are frequently cited in safety plans. They say they often feel unsupported and even at times disregarded.

The Belfast Trust has an independent Peer Advocate who provides support and a voice for those who are supporting someone in Crisis. Families and Carers have found this beneficial.

CAUSE has also told us about training that they provide to medical and nursing staff on the needs of carers. They also provide a vital ongoing support for carers. It is important that services recognise the role of carers and that staff are trained in engagement strategies as outlined in the Triangle of Care.

Mental Health Crisis and the Community and Voluntary sector

Mental Health Crisis is complex in its aetiology and its presentation. Social and psychological factors can contribute adversely to a person's wellbeing, causing acute distress.

In some this can be further compounded by the use of alcohol and drugs.

Statutory Mental Health Services are primarily designed to assist and support people who present with acute presentations as a result of an underlying Mental Health Disorder.

However, no matter what has precipitated a mental health crisis, if that crisis contributes to the person feeling high levels of distress or hopelessness or if they have no resilience or capacity to deal with their issues, their risk of suicide can be very significant indeed.

A Mental Health Crisis is often the precursor for suicidal thoughts or behaviour. Therefore, access to timely appropriate Community based Crisis Intervention Services can influence and change a potentially catastrophic outcome for the individual.

The Northern Ireland Protect Life 2 Suicide Protection Strategy 2019-24 outlines the long-term strategy for reducing suicide and the incidence of Self Harm. It emphasises the importance of services, communities, families and society working together to prevent suicide.

It recognises that no single organisation or service can deliver what is needed to serve the whole population and that there needs to be a range of services provided to support those in Crisis.

As part of the Protect Life 2 Strategy all Trusts areas have commissioned Services to meet the needs of their population.

N. Ireland is fortunate that there are many Community and Voluntary Care Sector Organisations that provide services which promote mental health and wellbeing and support recovery. These are key elements in the prevention of mental health crisis, a sentiment that is upheld by the Mental Health Concordat (Feb 2014) as an essential element in Mental Health Crisis Services.

Whilst many Community and Voluntary Sector Organisations provide a response to those in Crisis, there are only a small number of services specifically commissioned to fulfil that role

Lifeline is a 24-hour regional Mental Health Crisis Service is currently managed by the Belfast Trust.

There is a single telephone number that the general public can use, and it also accepts referrals from other agencies.

As well as providing a telephone help line, it also offers face to face assessment and up to 6 sessions of counselling. The aim of the service is to support the safety of the individual by the formulation of safety plans, deescalate the crisis and promote self-regulation of the individual. It also signposts the person to other community and voluntary organisations to assist with other needs which may be negatively affecting the individual's mental health.

Community Crisis Services

The Crisis Intervention Service, provided by Extern in Derry, has been in operation for 2 years and continues to operate as a pilot. It is a Drop-In facility based in the Community. People can self-refer. It is open Thursday, Friday, Saturday and Sunday from 4pm – midnight.

All of the five Trusts described referral pathways with SHIP. SHIP provides an appointment time within 24 hours of referral with a trained counsellor. SHIP aims to offer a compassionate and empathetic approach for those who are struggling with their mental health. They offer up to 6 face to face sessions of counselling to assist the individual develop a toolkit to deal with their issues.

PIPs Hope and Support, in the Southern Trust Area, has recently launched the first Crisis Café in Northern Ireland.

Crisis Café or Crisis Haven is a concept that has been developed in England and forms part of the NHS Long Term Plan to fund a range of services to meet crisis mental health needs.

The concept supports community connectedness and brings crisis support to a local community level. The PIPs crisis café in Newry is new and will require evaluation but the concept is innovative and offers the potential to support a complementary and alternative model of crisis care in the community.

One of the biggest challenges in providing services presently is the lack of integration and cohesion between the Third Sector and the Statutory Services.

There is a perception that each has separate and discrete functions that do not require integration, and too often they operate side by side with a very limited interface.

This has led to people who use services feeling that they are passed round a system with no overall clear aim or agreed purpose.

In some instances, there is the ability for someone who has been referred to the Community and Voluntary Sector to be able to be referred back to the Statutory Service if the person's mental health needs change.

However, this is not common practice and many who require further input from Statutory Services must seek a further referral by the GP. This is an unnecessary hurdle that could be resolved by agreed processes and protocols.

Any future developments in Mental Health Crisis Care must support a more integrated system for Mental Health Crisis Response, in order to provide a continuum of care, including – where appropriate- the GP, the Statutory sector and the Community and Voluntary sector. This would lead to a more consistent approach and would provide a more seamless system for those in Crisis to navigate.

Scottish Model

NHS Scotland in partnership with the Scottish Government has developed the innovative Distress Brief Intervention (DBI) Model.

Distress is defined as emotional pain for which the person has sought or was referred for help and does not require an emergency service response.

The overarching aim of the initiative is to provide a framework for improved interagency coordination and collaboration across a wide spectrum of care settings, interventions and community supports, to provide a compassionate and effective response to people in distress.

The Distress Brief Intervention is a time limited and supportive problem solving contact with an individual in distress. It is a two level approach.

DBI level 1 is provided by front level staff such as emergency services, GPs, EDs and mental health practitioners who offer a compassionate response, signposting and an offer of referral to DBI level 2.

DBI level 2 is provided by commissioned and trained third sector staff who contact the person within 24 hours and provide community based problem solving support, wellness and distress management planning, supported connections and signposting for a period of up to 14 days.

Training has been developed and provided through the University of Glasgow's Institute of Health and Wellbeing.

There are positive outcomes emerging from this work and it provides a useful perspective on how local crisis services can be delivered. Some of the functions within the DBI approach are similar to what services in N. Ireland sometimes offer. However, what the DBI programme does in Scotland is provide a clear, consistent and comprehensive service for those in distress, but without severe mental illness.

Primary Care

Primary Care is often the first point of contact for people who are experiencing a mental health problem.

A study completed by MIND (June 2018) of more than 1000 GPs found that two in five appointments involved mental health, while two in three GPs said the proportion of patients needing help with mental health had increased in the previous 12months.

In Northern Ireland people who require statutory crisis services must present to the GP to have a referral made to CRHT or go to the Emergency Department.

However many of those referred for mental health assessment are not taken on for treatment as they are deemed (correctly) not to have significant mental illness but rather to be experiencing mental distress.

There is a clear gap in the system for people in this category, and this understandably causes frustration and anxiety among GPs and patients.

The recent introduction of Primary Care Mental Health Teams provides the opportunity for mental health staff to be part of the Primary Care Team. This is an innovative best Practice approach to support a holistic approach to care. There is potential within these initiatives to enhance the options for those who present seeking help for their emotional distress.

Primary Care also has a part to play in preventing crises emerging by identifying issues and intervening earlier, using NICE approved psychological therapies to help improve health outcomes.

Interagency Mental Health Crisis Care

People in mental health crisis often seek help from places that they recognise as providing an emergency response to distress, and for many 999 or 101 is the first number they call.

The PSNI and NIAS provide front line support to individuals in response to those calls.

Responding to mental health crises can be resource intensive for these services, particularly if the issues presented are complex.

Very often the only way that PSNI and NIAS can respond is to bring the person to the Emergency Department.

Conveyance delays and waits in the Emergency Department for both NIAS and PSNI can be lengthy and can adversely affect their ability to carry out other responsibilities.

The PSNI database for October 2019 recorded that of PSNI crews bringing people to hospital 61% remained for five hours with 25% remaining more than 6 hours.

There are several best practice interagency initiatives regionally that work collaboratively to ensure that the person in crisis gets the service they need after the initial call.

The Multiagency Triage Team

The Multi Agency Triage Team (MATT) is a crisis de-escalation service available for those (aged 18 and over) experiencing an acute mental health crisis and who are in contact with emergency services. In MATT, mental health professionals work alongside dedicated police officers and paramedics in a mobile community unit on Friday and Saturday nights in the BHSCT and SEHSCT area.

The project was initially introduced in the South Eastern Trust area operating in Lisburn, Castlereagh and North Down and Ards area in July 2018. It was extended to the Belfast Trust Area in August 2019.

The Service operates from 7pm – 7am on Friday and Saturday nights.

The aim of the service is early intervention to prevent a further deterioration in mental health that would warrant further input from secondary care services.

It provides an alternative to emergency Departments for those with no medical needs who are in mental health crisis.

It also means that those who require a mental health assessment can have this completed in the community, potentially reducing the number of people who require follow-up appointments for the 'card before you leave' initiative.

An evaluation of the MATT has just been concluded in 2021 by Health and Social Care Board and it has shown the service to have been very beneficial.

Over the evaluation period, 6 July 2018 to 23 February 2020, MATT received 439 referrals. Of this number only 96 required attendance to the Emergency Department.

Service users who took part in the evaluation viewed MATT as a positive alternative to the previous way of responding to individuals experiencing a mental health crisis.

Staff and PSNI officers benefited from the innovative and interagency approach with access to joint training and shared information.

One of the areas that was particularly useful was the availability of Mental Health Staff to provide telephone advice and support to crews, the person in crisis and or their family or carers.

The evaluation identified that of the 428 MH crisis referrals, over half (52%) could be resolved by phone advice only, provided to the attending crew, the individual in crisis, and/or their carer/family.

This role is also recognised as a vital component in the DBI Service in Scotland where DBI trained practitioners work in partnership with Police and Ambulance services, and facilitate appointments to the DBI community services for further input if required.

The evaluation also showed that The MATT Team provided callouts to 45% of the referrals with three quarters (84%) of them being seen within one hour. For seven in ten (71%) callouts a MH assessment was undertaken.

The predominant reason for referral to the MATT was Suicidal ideation and thoughts of life not worth living.

In 68% of referrals, alcohol/drugs were involved, particularly in suicidal behaviour (80%; excluding OD), suicidal ideation/TLNWL (79%), and self-harm (74%). Nearly half of referrals (43%) were already open to a programme of care.

The evaluation also indicated that 72 cases were referred for further mental health and substance misuse services and over half of the referrals required no new services.

The sustainability of this service is dependent on recurrent funding.

Whilst the model appears to offer benefits particularly to an urban population, the experience of expanding the service to Belfast has also uncovered challenges, which include potential increase in demand, complex substance misuse issues, a transient homeless population, and cultural and legacy issues from the Troubles.

Despite this, other areas regionally could potentially benefit from this approach. A question to be considered in any new model is perhaps whether this service could be provided in another way, as part of a specification of a commissioned integrated community crisis service delivering a DBI type model.

Regional Emergency Social Work Service (RESWS)

The Regional Emergency Social Work Service has been operational since May 2013.

The service is available from 5pm to 9am next morning. It aims to provide a regional emergency social work response.

The Regional Emergency Social Work Service provides an emergency service to people with mental health issues. This is only one aspect of the work they do as they provide assistance for children and young people as well as Older people and those with emergency homelessness needs. They are responsible for emergency financial issues outside working hours.

The main principle of mental health crisis care is the ability for it to be delivered with the cooperation of those who are in crisis and their families in the least restrictive way.

For some this cannot be achieved, and they may need admission to a mental health hospital for a period of assessment. This should only be the case when all other therapeutic options have been considered.

The Regional Emergency Social Work Service accepts referrals where compulsory admission to hospital under the Mental Health Order NI (1986) is being considered. Most of the referrals that they receive are from Primary Care or existing statutory Mental Health Services. They work in collaboration with PSNI and Northern Ireland Ambulance Service in fulfilling their role.

The Regional Interagency Protocol outlines the necessity for all agencies to work together with clear collaborative processes and strong communication links to ensure that Mental Health Order Assessments are carried out in a timely and coordinated way that does not contribute to distress and wellbeing of the person and their family.

One of the challenges for a regional service that is recommending admission to inpatient facilities is the availability of inpatient mental health beds and at present Mental Health Inpatient Services are experiences severe bed pressures.

This can contribute to long waits for confirmation of the location of the available bed, which can lead to delays in conveyance to the hospital.

In some instances, people are admitted to a mental health hospital that is far from their home. This can be very difficult for the person and their family, often adding to the distress.

Whilst the Regional Emergency Social Work Service has access to all the different patient information systems, they would benefit from a more simplified approach regionally rather than navigating multiple systems.

Any recommendations made in respect to Regional Developments must include this service as it fulfils another important function in the provision of Mental Health Crisis Care.

Online survey results

The online survey questionnaire had seven main questions:

1. Thinking about your interest in mental health crisis services, which of the following groups best describes you and/or your job role?
2. What services are you aware of in Northern Ireland specifically for people experiencing a mental health crisis?

3. What's working well in these services?
4. What's not working well in these services? Any gaps?
5. Are there any examples of best practice, nationally or internationally, that you are aware of?
6. What would make crisis services better in Northern Ireland?
7. Do you have any further comments?

The findings are presented by question and, where appropriate, organised thematically. There were 282 responses to the survey and so it has not been possible to include everyone's responses but the aim was to highlight the key issues and illustrate these with some selected quotations from the survey responses (which are included in italics).

1. Thinking about your interest in mental health crisis services, which of the following groups best describes you and/or your job role?

Of the 282 respondents there were: 36 service users/experts by experience; 24 carers; 29 family members/friends; 24 Community and Voluntary Sector workers; 22 Community and Voluntary Sector managers; 68 Health and Social Care Trust workers; 27 Health and Social Care Trust managers; 2 Criminal Justice workers; 4 Criminal Justice managers; 2 Policy-makers; 4 Researchers; and 40 in the Other category. Respondents were asked to select as many of these roles that applied and then, if they did so, to identify the main one for the purposes of the survey. 56 respondents identified more than one role and some suggested that it was difficult to identify just one of those for the purpose of the survey and so they were included in the Other category. It was also highlighted that there was often overlap between the carer and the family member/friend categories.

2. What services are you aware of in Northern Ireland specifically for people experiencing a mental health crisis?

There was a wide range of services identified. The list below may not be exhaustive but it does reflect the range, and possibly the complexity, of the current approaches to providing services for people experiencing a mental health crisis.

PIPS Suicide Prevention Ireland; Action Mental Health; Aware NI; Bridge of Hope; Lighthouse; A&E; Street triage; Lifeline; Samaritans; Home Treatment and Crisis Resolution Services; Liaison Services; Self-Harm Intervention Programme SHIP; SEHSCT's provision of mental health services for the prisons; GPs, including out-of-hours; primary care Liaison services; inpatient services; crisis teams for CAMHS; Inspire; Colin Community Counselling; Mental Health Hubs; Lenadoon Community Counselling; Crisis De-escalation service in Belfast (Inspire) and Community Crisis Intervention Service (CCIS) in Derry/Strabane (Extern); Unscheduled Care Teams; Phoning 999; Community Counselling; Police Service of Northern Ireland; Community rescue service; Northern Ireland Ambulance Service; Turning Point NI; Rapid, Assessment, Interface and Discharge; DalDoc; CMHTs; Mencap; Action Mental Health Helpline; Aware NI Helpline; Mindwise; Extern Helpline; Together for You; Rainbow Project; Niamh Louise Foundation; Start 360; St. Peters Immaculata Youth Centre; mentoring and personal coaching; Drug and Alcohol Mental Health Service; Suicide awareness support group; Wellbeing NI; Minding Your Head; Office of the Mental Health Champion; Cruse Bereavement Care; Lagan Valley Hospital; Muckamore Abbey Hospital; Belfast City Hospital Acute inpatient ward; social services; Regional Emergency Social Work Service; Multi Agency Triage Team (MATT); Self harm intervention program; CBT; motivational interviewing; Relate NI; Gransha; Lissan House, Omagh; Men's Action Network; Hurt; CAMHS Crisis Assessment and Intervention Team (CAIT); Pastoral support and counselling in schools; Service, Treatment, Education and Prevention

Team; PAPYRUS; New Life Counselling; LINKS Counselling; Barnardo's; the Right Key; Trasna House; Bluestone - Craigavon Area Hospital; Mental Health Assessment Centres; Extern Crisis Service; Childline; Mind Your Mate and Yourself; Zest; Northlands; Clinical Psychology; Crisis Café NI; Community Addictions Services; Dunlewey Addictions Service; West Belfast Suicide Partnership; Holy Trinity Counselling; Oakview House; Early Intervention Team; Pure Mental NI; Young People's Centre (CAMHS); Mental health liaison services; acute day treatment; Approved Social Work assessments; Mourne Matters; Domestic abuse helpline; Rape Crisis NI; Grangewood; Mental Health nurse at GP surgery; Praxis; Rapid Action Team; Blues Programme and Choices Programme by Action for Children; Psychiatrist; Supported accommodation; Card before you leave scheme; Mental health worker at GP surgery; Men's Shed; Aurora counselling; Life coaches; Close family or friend who can help; Women's Aid; Police custody Nurses; Forensic Medical Officers; Recovery network services; Old See H; Woodstock Lodge; Aisling Centre; Nexus; Local support groups; Community Associations; Recovery Mental Health Teams; Care Management; Support workers; Psychological Therapy Services; Recovery Colleges; Social Prescribing; Social care teams; Crisis Response Service; Survivors of Suicide; West Belfast Suicide Awareness; Tyrone and Fermanagh Hospital; Trusts' Gateway Service; Jigsaw.

3. What's working well in these services?

The strengths that were identified about current services can be organised into five broad themes: access, interventions, communication, structures and resources.

Access

PIPS - open door policy where can walk in without appointment

24/7 access in Belfast and SET areas for under 18yrs

Life Line - accessibility via telephone, they can provide you with immediate support and refer to their own counselling service and others.

Colin Community Counselling and Lenadoon Community Counselling can accept self-referrals, no need for a GP or medical services referrals.

Samaritans can provide immediate help in relation to speaking to those in distress immediately

They are 24 hour services

During the current pandemic services have continued and prompt although remote

I feel that community lead counselling and mental health services works best. Accessing services in your local area is important to many suffering mental health problems as going somewhere unbeknown to them can be daunting

The creation of multiple places of safety presents a far better proposition - all community based mental health provision should provide an out of hours service both telephone and walk-in.

No cost for service (funded).

Community based walk-in crisis intervention resource within local communities for people.

Services might need to come to where the young people feel most comfortable. There are youth services in most communities that can host these sessions and might enable young people to commit to the sessions more.

Immediate help to talk to someone

Someone initially to speak to for urgent assistance

Swift access with most of the supports

Mindwise - great drop in centres

Patients seem to have access when needed

Immediate pickup of service users experiencing a crisis in their mental health

People can receive their initial contact with services in a timely manner. For people with severe and enduring mental distress, the pathway can be quite clear: home treatment team or hospital treatment if necessary.

Telephone and text contacts are excellent. Some innovative thinking in the C&V sector

Free family counselling offered via Dunlewey

They are well advertised

Belfast HTT is 24 hr and has no upper age limit

Helplines and GP can be accessed quickly

There's always someone available to help

24/7 listening ear

Community / voluntary sector orgs are more approachable

You can text Samaritans if needed/if not comfortable with phone

You can usually speak to the OOH GP quite quickly. Lifeline is accessible to everyone

Interventions

PIPS - more than 6 sessions client focussed

Are responsive and staffed by caring and compassionate individuals

Someone who will listen to them

Check in service

Face to face services provided.

Anonymity on occasions.

Community based Suicide Prevention work as a means of Intervention/Postvention.

MDT working between medical staff, social work and CPNs, quality of acute psychiatric inpatient provision – BCH

The counselling places are not suitable for a mental health crisis but they are good for helping with managing and working through any issues you may have before they spiral out of control.

24 hour availability, attempts to provide stabilisation in the community, not rushed to place people in hospital

Designated person assigned in MH team to 1 individual

Lifeline and Extern both offer a timely response & provide a flexible approach to patient needs

There is a wealth of good work taking place in the community and voluntary sector which generally sits in the stepped 2-3 part of the stepped care model. There are over 40 Art Psychotherapists working in the community sector in Northern Ireland providing trauma informed work with children, young people and adults and their families.

HTT model works fairly well

Links Counselling

The Right Key

MATT is very flexible and convenient for users. Has potential to be further refined

They are local community anchors, well established and known, provide excellent social value, cost effective, deliver specialist services at a minimum cost of that of statutory services, provide direct help, giving and sharing of information, raising awareness of an issue, work outside the normal 9-5 working hours, better understanding on local culture.

Presentations to Crisis Service will have a thorough assessment and appropriate plan put in place where needed to support the person.

One to one work, project, programme work, some mental health in schools work, some counselling services

Home treatment can prevent admission to hospital, in Belfast a person is seen medically on second day, mon to fri, Belfast trust ensure 7 day follow up after discharge from HTT, being able to be titrated without inpatient admission, the Availability of occupational therapy in many of the services

CBT Therapy and counselling can work well for short term issues

Local provision of outdoor alpaca therapy to deliver real, tangible reduction in anxiety, isolation, stress, depression and confidence issues

The specialist ambulance that responds and de-escalates situations is great and exactly what needs scaled up. If you don't know what to do having a service that comes to you is invaluable

CAMHS works brilliantly for those accepted, giving them someone to talk to and someone to help them. Re-evaluate their choices and responses to negative feelings

Blues Programme is brilliant in that it's evidence based, providing help for those already suffering with mental health issues but has also been developed recently as a resilience training programme too, making it preventative. Evidence has shown that children's mental health is positively impacted after completing the programme

MATT is a good emergency service for week end crisis

Paramedics and front line staff working in hospitals often go above and beyond to provide care for our loved ones. Particularly nurses who work in Acute Inpatient Care wards. Recent first hand experience with staff at Tobernaveen was excellent. A credit to the NHS.

Unscheduled Care service plays a vital role in triaging and signposting service users that present to ED in mental health crisis.

Communication

Good Information sharing

Interface between GP and primary care Liaison services

Interface between Primary care Liaison services and the community and voluntary services

Follow-up with other professional services

Partnership working with CV sector and Public/HSC sector to take referrals.

Partnership working with CV sector to refer for community based activities etc.

Engagement/ case conferences to discuss issues arising with other interested agencies

There is better information sharing and collaboration between statutory and voluntary sectors to a degree.

There is increasing inter service communication which is beneficial in giving the patient / client a rounded support package at time of crisis

Structures

Good links between Stat and C&V sector

Mental health teams are on site in each prison and there is a mix of availability of psychiatry, mental health nurses, OTs and limited clinical psychology services

Schools dependent on compassionate and caring teaching and support staff, and they contain MH issues until they can be addressed professionally.

MATT provides a collaborative approach to mental health crisis in the community each weekend in SEHSCT and BHSCT

DE/DOH emotional well-being framework has potential to be further enhanced and make a significant long term impact at all levels of need

The combination of both voluntary and statutory works well and each situation needs different approaches. With crisis presentations the use of voluntary sector services such as SHIP and lifeline has proved very effective although sometimes individuals require short term statutory services. With those presenting with SMI's they require the consistent approach and support from statutory services

The implementation of a Managed Care Network (MCN) is still in early development stages and will require ongoing evaluation as it is rolled out, however, it aims to improve the co-ordination of statutory services and simplifying pathways for children and young people. It remains unclear how voluntary and community services will be connected into this MCN, however, it is critical that this happens.

Resources

Lifeline - well resourced in Belfast Trust, it was under-resourced with Contact NI. Well-known brand and good initial response service.

I believe they are under-funded, under-staffed. The staff still work well to the best of their abilities.

Amazing community-based projects operating on minimal funding and led by the voices of young people. Fighting for every penny to keep going.

All but lack of money

Women's centres and charities associated with these should get more funding because they are fantastic

4. What's not working well in these services? Any gaps?

The limitations that were identified about current services can also be organised into the five broad themes of: access, interventions, communication, structures and resources.

Access

Visiting my GP surgery always feels very impersonal

Often those in crisis don't know what to say or how to engage in conversation, feeling afraid or possibly need immediate intervention and it is missed. For those engaging there is often no follow up and can leave family members/carer feeling fearful, anxious and/or lonely/isolated not knowing how to support family member, friend or colleague

Difficult to access these services.

Access for SEN community to these services is limited.

Access for BAME community to these services is limited - especially CV sector services

Possibly reaching young men

Unavailability 24 hours. Lack of resources to deal with the number of people suffering mental health issues and the constant deflecting of health care to other organisations, the police in particular.

Delays in admissions when police bring individuals to A&E - which sometimes seems to be because police are there to keep things calm. One occasion where hospital staff demanded police remain with individuals ready for admission but refuse to admit them if police leave.

Access to assessment not always possible due to referral. Criteria barriers.

People who are in crisis for whatever reason should be able to access crisis services for triage assessment and then following assessment be offered a service or signposted to appropriate services to meet their needs.

Access to these services and the setting of expectations of the limits of each service, a lack of communicating fundamentals in basic psychology and explaining key terms

People suffering with mental health that have consumed alcohol and or drugs - difficulty in assessing their condition but in the interim too frequently these are required to be managed by police resources which is not sustainable.

Acute MH services difficult to access, when young people are at high risk of suicide

Substance misuse is an issue as individuals who are under the influence and/or present with drug/alcohol induced mental illness cannot be assessed and have to remain in A&E or on hospital wards where they are abusive, distressed or cause distress to others

Very lengthy waiting times in (way beyond 4 hours) for police officer with person removed to place of safety - waiting for crisis team and Dr to arrive. Police resources are limited and often feels an unnecessarily long wait

Children and young people - there is a gap between what happens to the children and young people who DO NOT meet the criteria for CAMHs services. For those who are waiting for an assessment and then those who get assessed and are told that they do not meet the CAMHs criteria and therefore need to then find support somewhere else.

I have to drive my loved one quite a distance to access services

Delays

Waiting times

Long waits between referral and being seen - 4 hours is too long for family/other services to keep someone safe.

No safe space to wait for assessment

Less available out of hours for under 18 and LD

Could do with better facilities outside of healthcare as not all crisis are primarily mental health problems, as such could medicalise distress and ordinary experience

It's much too difficult for someone in crisis to access help via the trust, they have to go through at least 2 services before getting help. If its day time they have to be seen by GP, Mental Health Team and then Crisis service, often that takes hours and the crisis service insist they come to them for assessment are not willing to go to the person. If it's after 5pm or out of hours again really long wait often in casualty or a and e departments which is totally unsuitable for people experiencing a crisis in their mental health

Long waiting lists to be seen

Long referrals to appropriate services

Long wait for diagnosis

I found it exceptionally difficult to access crisis response for elderly relative with undiagnosed dementia back in 2013. They fell between the cracks and this severely impacted their and my family's mental health struggling to care for them

CAMHS - Waiting lists, systems, processes. Initial phone appointment cancelled with no notice or explanation.

People with learning disability are underserved

There is at least a 9 week waiting list for first appointment with CAMHS. Disgraceful!

There are simply not enough spaces in CAMHS etc for everyone who needs help to get it. People are on waiting lists for up to 1 year and in that time they have gotten worse or taken their own lives.

A&E is not an appropriate 'place of safety' for someone experiencing a mental health crisis. Wards are often busy, noisy and crowded. An initial assessment by unscheduled care can take anywhere between 12-24 hours. This is too long. Patients who are in crisis are free to discharge themselves

BEFORE being assessed by the mental health team. Assessments are not carried out quick enough, especially during out of hours and through the night in hospitals.

Interventions

Not enough time allocated to each GP appointment

When talking to various mental health professionals over the years, I have always felt that people are reading and working off a script rather than listening to what I am actually telling them. Instead of working with people's needs, there seems to be a one-size-fits-all approach to mental health

Statutory services are too medical model driven and also not person centred. Staff attitudes have a blaming approach. Not enough support for dual diagnosis. Not enough team capacity.

There is a major lack of youth counselling and mental health services available in Belfast particularly in West Belfast.

There are people contacting LifeLine regularly. They may not be in immediate crisis but they are certainly vulnerable. LifeLine has been known to stop taking calls from these people. I appreciate they are a crisis response service, but there is an obvious need here that is not being addressed.

Card before you leave - how do we know this works - no follow up to see if people actually reach out to these cards

No dual-diagnoses support - so if you become suicidal because you have been drinking too much or other substance misuse you are referred to addiction services but its more often than not you are drinking or other substances but of past trauma etc - so referral is the wrong door

Youth facing crisis services - targeted youth crisis services and awareness campaigns

Lack of social media presence for youth regarding services available.

Lack of social media monitoring for people in crisis, particularly youth.

Lack of crisis intervention service in criminal justice context.

no follow up in many of the services, hub short term fixes for people - 6 weeks only offered and then they have to waiting another year for another referral. sporadic services depending on the area. you can be on medication for 20 years but only get 6 hours of counselling

CAMHS appointment system not working. Many children do not have the support needed to make it to appointments so the 3 strikes & you're out system is failing them.

Lack of supports for schools - not enough counselling, no other MH support apart from that one hour a week.

Lack of training for teachers and support staff in MH crises. Children who are suffering are regularly punished for their 'blow ups', lack of co-operation or apathy re learning

the value and work of Art Therapists in Northern Ireland is not considered as there are currently ONLY 2 employed Art Therapists in the HSC and they are in the Western Trust. This skill set should be acknowledged and employment opportunities given with the HSC as these professionals can offer a trauma informed, intervention that works well for all presenting issues. It can be especially effective for early intervention work, for client with ASD, LAC children and brain injury to name a few.

if service user isn't ready to engage, there is rarely an alternative to offer

Dismissive attitudes

The services in educational setting are stretched beyond capacity. Waiting lists are enormous and the initial allocated of sessions is barely enough to establish a working relationship with a young person, let alone make progress.

Trust led CRHTT service provision can be ad hoc, unstandardised and limited access for those in crisis.

No assertive approach to engaging person - often sent back to referrer with 'the person didn't want to engage' or 'we were unable to contact them'.

Staff in CRHTT can be 'burned out' and lacking in compassion.

Patients report feeling that they aren't being taken seriously and that advice is poor

Simple befriending role model services for young people and elderly would be beneficial

Poor attitudes of staff in general hospital setting

Crisis team or HTT can be very dismissive, I've went to them many times in crisis to be told I'm not in crisis according to them and they can't help me. I get an assessment and sent home with no plan or follow-up and even less trust in mental health services.

'Crisis teams' can have dismissive, even callous, attitude.

Unrealistic expectations of service from patients/ families Esp in relation to expectations to get patients to stop using illicit drugs and to remain on an acute ward for months due to substance use

Understaffed and not utilising all available resources - the creative arts therapies; namely dramatherapy, music therapy and art therapy are barely employed in any of the NHS Trusts in Northern Ireland. This means that there are gaps in both staffing in terms of numbers and also in types of therapeutic intervention available. Many service users may not respond particularly well to talking therapies/interventions for a wide variety of reasons, and this means service-users are not receiving access to the fullest potential of person-centred care.

Greater facilitation of Early Discharge from hospital across all areas

Communication

Having to answer the same questions over and over. A&E can be a long wait.

We need to talk more to family or next of kin - they are the people living with them 24/7 and can give you more of the picture of what is going on. How many deaths have occurred and no one told families their person was suicidal or had been to A&E with having made attempts on their life or families or loved ones are saying they are suicidal but the client says there are not sure families or loved ones are not given a voice - massive gap here

Continued awareness raising in communities about services available and how to access them. Continued awareness of the process to be referred to CAMHs and the service they provide.

The notes should be available to all involved, patients' lives are at risk as a result of this failure to communicate.

Not always joined up, some body assessed but not taken on by crisis teams but needs signposted to services which should be part of wrap around services for people in crisis

Crisis response often do not provide effective communication to community mental health team - families often left in limbo

Poor communication

Communication is generally poor & carers/family excluded.

Long standing interface issues between CMHT and CRHTT. There has been interface meetings but no positive changes made. No follow-ups

Poor communication by crisis service within CRHTT when discharging service users - telephone/Epex etc. Not always up to date. CRHTT awkwardness towards CMHT when asked for paper documentation of their assessment, risk screening tools, dc letter etc plus this paperwork can be slow in reaching CMHT

Community / voluntary sector has no easy contact / link with statutory MH services that can be approached for advice

Feedback from users is that services are not easy to navigate, high staff turnover means dealing with several professionals - no consistency, and support is limited in terms of contact.

There is a lot of talk about inter-agency communication, but it isn't happening.

Structures

Inclusion of Carers in policy making, planning and decision making still not as inclusive as it needs to be. Carers often experience their own mental health issues as a result of the demands and stresses of 24 hour caring which are often not addressed

Joined up thinking and service. Services have sometimes focussed on Trust areas rather than patient/client care and I have had experience as a service user of having to make multiple calls taking upwards of an hour to access any support. As a person in crisis that would be too overwhelming.

Gap for more local crisis centres within communities of higher need and vulnerability

We need to partner with youth services to better provide the support for young people. They have ready-made audiences and can provide children and young people spaces where they feel safe and secure, nurtured and supported.

Lack of adequate psychology service

Lack of adequate ASD service

Lack of adequate personality disorder training and pathways/interventions for mainstream CMHTs - specialism exists however this has not trickled down into mainstream services

No real crisis support between community teams to HTT to hospital admission

These services all need to be linked closer to together, working with each other, easier pathways to each service.

GP/ ASW - reliance on GP for referral can delay/ prevent person being assessed /detained when MHS clearly can see the person requires treatment but GP does not cooperate.

Crisis may be related to their use of substances. When people are referred to Addictions teams, they may believe they are not getting help for their mental health. But the Trusts' addictions services are

also mental health services, with psychiatrists, nurses and social workers. So they are being referred to a mental health team. Work could be done on publicising this. But more joint-up working between mental health and addictions services would be helpful. A dual diagnosis service might help.

People may present repeatedly with self-harming, substance misuse and suicide attempts. These people are the hardest to support as mental health or personality disorders team may not accept a referral for someone misusing substances. Addictions service may not be set up to provide the support and crisis intervention they need. These are the service users for whom it is most difficult to provide appropriate support.

Lack of beds for addiction recovery in NI means that patients have ""nowhere"" to go if they are rock bottom with addiction issues

Lack of operational policy shared with stakeholders

It needs to be one joined up service and governed by DOH

Not all trusts have Home treatment houses,

MATT isn't in every trust, referral criteria differs, lack of access for people with addictions in crisis

Delays in being seen when referred, not all patients care seen medically

Lack of beds in area, or in region for those who need it

Some HTT services aren't 24hr

Some HTT services are not for older adults aged over 65

All teams are under pressure. Community teams are understaffed and cannot always respond to a crisis which can escalate the level of service that patients require. Some people are being admitted to sofas in acute inpatients due to bed pressures. Voluntary services are slow to provide accommodation in the community delaying discharge and creating more pressure in the system

Personally from a mother's view, the two mental health/addiction services I believe should now be run alongside each other, without been discharged from mental health units and been put on a waiting list for addiction services by the time appointments are available people are back to their addiction and their mental health has deteriorated again needing help again. These two issues are at the forefront of our lives now and need changed.

Combinations of addiction and mental health are extremely challenging for everyone as no one service deals with both issues at the same time.

Resources

No government funding at all and dramatically increased numbers of clients

Stat services could be better resourced to meet the increasing demand for service

Clinical psychology services are very limited

Completely under resourced

Local counselling services not receiving long term funding which results in long waiting times

Crisis Services - are in crisis themselves, due to funding as with Lifeline when it was in 3rd sector

People may present in crisis which may be situational in nature, and they are very distressed, but hospitalisation, or referral to a mental health team may not be the appropriate. Often the need is social, housing-related, financial etc, and there may not be time for the assessing practitioner to deal with that need. People can be signposted or referred on for the appropriate support, but there is often a time lag in their being picked up. Better resourcing of community and voluntary services would speed up their support. A 'whole person approach' would be helpful.

lack of long-term funding, funders need to recognise the potential and the strengths that local charities can provide in delivering and supporting public services

Community Addictions: limited resources or explanation of the options available

Insufficient resources

Specialist services need more funding and development

There is an obvious lack of resources

Referral into CAMHS is way too long, minimum of 12 weeks, young people are not being seen and services are not there to support them. Much more money is needed for the children and young people's mental health budget in relation to the overall health budget, the disproportionate gap between the two is unthinkable!

Over reliance upon crisis service to shore up vastly underfunded & under-resourced MH services in post-conflict society often results in revolving door effects.

No follow up, lack of resource in rural areas

There needs to be greater value placed on the role of the VCS in providing mental health support. This value can be shown by formalisation of the relationship between Statutory CAMHS and the Voluntary and Community Sector (VCS), through the development and implementation of clear strategic policy direction and a 'funding and practice partnership model', which takes account of the investment required across all key services and sectors included in the Stepped Care Model.

5. **Are there any examples of best practice, nationally or internationally, that you are aware of?**

Card before you leave - when administered with fidelity to the evidence base.

Involving community workers with lived experience to support those in crisis especially if attending ED's as quite often a person in crisis feeling vulnerable doesn't need a busy ED but a safe space for someone to listen who can also identify with them.

What has been missing is adequate resourcing. We have these extensive consultations with many well made points being made time and again. This only leads to apathy, frustration and does not create the climate for progressive problem solving. We have asked people in crisis. They have told us what they need. We have excellent practice across many of our mental health services, but they are under-resourced and piece meal. Most best practice gets adequate funding. This is where the change needs to come and quickly.

Mersey Care NHS has some excellent best practice with evidence based practice happening

Some of the crisis de-escalation services across the UK have some really good best practice

When Trust, Lifeline, Community services communicate it's amazing the outcomes

MATT service in South Eastern Trust and Belfast trust should be rolled out across NI

The Herbert Street project in USA is a combination youth work and health centre. This system works really effectively with the children and young people.

Yes Cuba - investing in preventative health care from birth to old age, mental health is treated differently than physical health less investment, alternative to medication needs to be invested in eg. counselling, EFT, rewind technique,

NICE Guidelines

Perinatal service - NI

Recovery network - Scotland

If trying to aspire to "zero suicide" this will never occur when bodies all involved in the care of the same patient do not communicate either between the different bodies or even within the same body. How difficult can this be?

The service should be 24 hour, 7 days per week and general public as well as GPs and community mental health teams should be able to access the service without any major referral barriers.

Prevention better than cure

Yes, a lot of countries throughout Europe have Crisis Centres open from 6pm until 9am. They have fantastic teams of mental health professionals and specialists on duty to treat and access anyone who may need it.

Countries also have safety nets under and along the decks of bridges. These are there to catch anyone jumping. A lot have had a 100% success rate in the prevention of suicides from the bridge"

Accredited Autism Training for all front line health workers.

Assist training is amazing - should be mandatory for everyone who works with children and young people.

CAIT are known as the Belfast model and it has been praised in England.

The clinical governance in place in agencies like AMH New Life Counselling, Barnardo's NI, Relate NI and LINKs are good examples of best practice due to systems/ procedures/outcome measures and data recording.

Crisis houses, safe spaces, sanctuaries and havens are interesting

Edinburgh crisis centre offers 24/7 crisis support, has a helpline and also 4 beds for people in crisis, for short stays of up to a week.

Maytree house in London allows short stays for people in crisis.

Linden House in Cardiff has a therapeutic alternative to hospital.

Several English Health Trusts have 'crisis cafés' for people in distress: these exist in Leeds, Lambeth, Surrey.

In Birmingham there is a crisis café run by the Mind charity: and it is open both to people known to statutory services and to anyone else.

In Hertfordshire there is a host family scheme, similar to fostering, in a way, for people in mental distress, as an alternative to hospital.

The CAMHS CRHTT and AMH MHL agreement is a superb example

Super-sized CMHT -locality based with Crisis and HT function built in with medical continuity of car

MDT teams in surgeries although this is putting pressure on community/voluntary sector

I am aware of the strategy recently published for South Australia mental health services and think it sounds impressive

LIFEMAPS programme for young people used in the voluntary sector to promote positive mental health

Excellent services in Johns Hopkins in Baltimore, Maryland

Open Dialogue, currently on trial in the south of England promotes a team approach and favours psychotherapy over medication led psychiatry.

Access to OT ties in with nice guidelines for various mental health conditions

PIPS preventive courses and services including education. Easy to access services. Group bereavement supports.

PHA & Gov should approach Suicide and mental ill health like Covid 19 was approached. Expect everyone to get it community response announcement every week by H Minister.

Finland use to have a huge issue with suicide and they addressed it.

Australia are light years ahead in terms if care services and support for mental health as are Canada so look at their models which address the issues of trauma rather than patch them up and kick them down the road.

Action for children's Blues Programme has been working successfully for schools over the past number of years, with evidence there to prove the incredible impact. The funding has run out but the department of health could invest money here where the programme has already been researched, tried and tested rather than spending extra money starting from scratch

The community crisis intervention service, run by Extern in Derry

I think services like pieta house or crisis houses that are available in other parts of the UK are something we are seriously lacking here. When you go to statutory services and are turned away there are very little options here compared to other parts of the UK and I think we need to move with the times and provide services that meet the needs of people in crisis. A&E is not the place for someone in crisis, especially when they can be sat for hours waiting for a mental health assessment

Dance group held in Coleraine covered all dance. Walking group. One to one CPN assessment weekly. Other therapy should be offered like American therapies. They are more advanced I believe.

There is a crisis house in Leeds where people experiencing a mental health crisis can self refer. The house provides crash beds and counselling services (Dial House). This can reduce the stigma of presenting to mental health services, and relieves pressure on acute beds. It would be a good addition to services here

Crisis Now Services in USA which through use of technology link mental health, ambulance, police and community and voluntary services together in networks to provide mental health care/support at the point of crisis and speedy access to a range of MH and/or community resources.

Crisis Houses in NHS England operating as an alternative to inpatient admissions (also examples of Crisis Cafes - Aldershot?)

Gold Coast Health Care Australia towards Zero Suicide model as published.

There are numerous examples of the use of peer support workers within in crisis services to provide support to people in crisis alongside care from clinicians.

Distress Brief Intervention in Scotland is an excellent model and has now been evaluated with positive outcomes. It focuses on crisis intervention but also includes onward support.

Improved follow-up for anyone who is suicidal at key points post crisis to support through to de-escalation and onwards support.

Assertive Outreach services for those who find it difficult to access services.

Every Trust in the rest of the UK has mandated early Intervention in Psychosis services. This is evidence based practice which is more reliable and objective that 'best practice'

There is a reasonable evidence base for well developed psychiatric liaison services

In Cardiff the custody suite piloted a referral system, where they made a referral to mental health support as a way out of custody rather than bailing to court they can release to a mental health support team and advise the CPS that the person case is pending the outcome of working with the team. Who prepare a report to CPS if they person is making progress their case may not come to court, if they fail to engage then it's handed back for normal prosecution process.

I worked in a trust in England that had an out of hours helpline service. this worked very well as the staff running this had access to the patients records- risk assessments, care plans, safety plans etc. If they called the out of hours helpline it took some pressure or CRHTT and then this would be documented on the patients notes and a request from the patients keyworker to follow up was made.

There are many examples, but citing one in the UK - In England, the NHS uses dramatherapy as an official intervention in treating early intervention psychosis with great outcomes, as per NICE guidelines.

ARC Fitness is a non-profit social enterprise in Derry, Northern Ireland, to support individuals and their loved ones in recovery from alcohol and drug addiction through learning, coaching, physical activity and community support.

The crisis intervention team based in Derry/Londonderry works very well but is restricted in terms of access to rural areas. We are working closely with them aiming to develop such a service in the rural communities.

First Steps women's centre is an excellent centre to provide respite and therapies for those recovering from mental health illnesses. Aware NI's living life to the full classes are also solid courses to introduce people to group therapies

Social prescribing has definitely had an impact in our area. We can see the change and the confidence emerge with our many participants

Narrative therapy used in New Zealand: https://www.stuff.co.nz/national/102115864/in-narrative-therapy-mori-creation-stories-are-being-used-to-heal

RAID/LIAISON is a great service if it were funded properly

An Example of Best practice for me, was when I found the South Eastern Trust Recovery College.

For older people it is vital to have Old Age Psychiatry within CRHTTs

Scotland has National Standards for MH Crisis services

The "Support Hub" model works very well for enduring or persistent vulnerability, where the individual is engaging with multiple services (in and out of crisis) -both scheduled and unscheduled services- as long as the individual is actually engaging with services."

Towards zero suicide has also been effective in the use of safety planning which really empowers an individual in taking responsibility for their own safety and information/support to those who support an individual in knowing how they can help."

National Core Fidelity Scale University College London (UCL) ;(Lloyd et al, 2016) Core Fidelity principles are met well within the NHSCT and an audit of this was completed 2018 comparing national data.

The WHSCT has introduced a Clinical Decision Unit as part of the A&E department at Altnagelvin Hospital. The unit is for patients who may require a short period of observation, further investigations, or other interventions that cannot be completed within the four hour timeframe within the Emergency Department. It can accommodate patients for up to 24 hours. Young people that present to A&E, who have taken alcohol and drugs, are being fast tracked to this Unit as soon as they are identified by staff. Young people are therefore not having to sit for long periods of time in the A&E reception.

The WHSCT also have emergency accommodation, referred to as the 'crash pad', which provides a supervised safe place for young people to de-escalate. There is also access to on-call social work teams.

NHSCT uses a model where Crisis Response Home Treatment (CRHT) has a joint protocol with Rapid Assessment Interface Discharge (RAID) professionals based in the A&E, to ensure there is 24/7 cover and that children are seen within 2 hours. The protocol's intention is that a young person would be seen by a mental health practitioner based in A&E who would link them on to appropriate support e.g. medication, counselling and GP service.

A&E Services in England are already working to the RCPCH 'Minimum Care Standards for Children and Young People in Emergency Care Settings who present with Mental Health Problems'.

The concept of Crisis Houses would definitely be useful. These offer intensive, short term support to help you manage a mental health crisis in a mental health setting (rather than in a hospital).

6. **What would make crisis services better in Northern Ireland?**

No waiting lists

More funding for mental health specialists based in A&E

More training in crisis response for all NHS staff

Appropriate resourcing

Shared communication / records system

Regional approach

Clear information on how to access services and consistency of service across NI (as opposed to different Trusts having different arrangements)

Better communication between teams, more respect for each other's professional judgement and clinical decision making and keeping the patient central

accessibility: 24/7 cover regionally, not having to attend a local emergency department to access service

A dedicated, well funded and specialist team of mental health experts that triage, treat and support people in mental health crisis. Dedicated crisis centres

Having services easily accessible with appropriate resources and additional opening hours.

Not needing to have a referral from medics.

Opening it up to local communities, creating safe spaces locally where people feel safe in their own towns, not needing further anxieties of travelling distances to get help or support. Somewhere to go to in their own town that they can just BE and feel safe.

Statutory crisis support but outside of general medical settings. So like a crisis cafe or a place people can specifically go for help, rather than a&e.

Better staff training around trauma and assessments to be more holistic and person centred.

Early intervention and actually listening to carers concerns to assess patients so they don't get extremely unwell.

Facilities that take patients in ASAP not to A&E!!!

Having an increase in services as demand is growing rapidly and wait times are costing lives

Carers/Families being involved in decisions of what the client needs

Better Dual-diagnoses supports

70% of people who die by suicide have not be in contact with any services - how do we advertise Lifeline, MH services, Community services better - how do we reach those 70% - how do we remove the stigma of talking.

Bespoke training for all levels - MH training from Hair dressers, factory, taxis to A&E staff including the doctors right up to staff working in MH

Additional funding for evidence based crisis services.

Patients' treatment teams should automatically liaise with families at intake in order to gain a better understanding of the patient's needs and history. Patient discharge should be subject to rigorous risk assessments and patients should be kept in hospital until it can be determined that they are able to be discharged in a manner that does not place them at risk of harm.

FASA had a great idea (before it collapsed) with Nightingale House, basically somewhere, other than casualty to go where you can keep safe and have people to talk to enable someone to talk if they need and can.

A space, not necessarily a hospital, that would give the patient a few days in a different environment, away from toxic coercive relationships.

Regulation of counselling, recognition that counselling can cause more harm than good, reduction in referral of people with a serious mental health condition to counsellor who do not have the knowledge, training or experience to recognize and deal whit serious mental health conditions.

Early intervention in psychosis, by its very nature the patient fails to recognize they are ill, therefore are unlikely to engage, life quality declines in all areas, culminating in suicide when the bottom has been reached.

Reducing barriers to access them

Improve working relationships between statutory and voluntary services

Improving work completed at the point of crisis, follow-up to include psychological therapies

Open access to alcohol and drug services, with reduced barriers

Increased cross-departmental collaboration, it's ludicrous that this is not happening. Each department seems to be working as a silo, when the needs of our most vulnerable young people could be much better addressed through DE, DoJ and HSCB, DfC being more unified in their approach.

More inpatient beds; a substance misuse holding area - a safe place for those under the influence (children and adults) to sober up prior to mental health assessment; increased community mental health team workers and crisis teams are dealing with the overflow of open cases to community teams who are unable to be seen face to face during the Pandemic; increased face to face sessions from community teams.

Operational policy with standardised practice by all staff in CRHTT which is agreed with and shared with all stakeholders

Improving staff resourcing. Improved funding and organisation of community groups, to allow appropriate support, as well as onward referral where needed. Improved input at GP level to allow early identification and management of mental health issues, alongside the multidisciplinary GP team.

The set up of emergency mental health centres where people in crisis are offered support rather than being sent off with a card for future contact.

More funding is needed for the children and young people's mental health budget, much much more money is needed to provide crisis services and bespoke respite accommodation needed right across the region!!

Meaningful and timely intervention for children who experience mental health challenges. Joined up services. Long term funding, rather than piecemeal short term funding streams, that result in projects / programmes that have limited benefits.

Empower community to help. Stop words like crisis. Create an expectancy normal emotion that can be resolved. Embed help seeking behaviour from early age. Incentive for getting support

We simply need more services, more teams, counsellors, more training for doctors, more talking.

Having services that are actually accessible to people who are in crisis. On so many occasions I have seen the crisis team, had an assessment and been sent home because they feel that I'm not in crisis but I would not present myself to them if I wasn't.

Joining up of care across crisis services, mental health services, addictions services and voluntary and community sectors.

Single point of entry for MH services - no wrong door approach to ensure those in crisis are directed to the most appropriate service.

Not EXCLUDING people from services, but an inclusive approach.

crisis services do not work in a silo, they are part of a broader comprehensive suite of supports available to children and young people, as outlined in the Stepped Care Model for CAMHS. For example, having better and more integrated drug / alcohol and mental health support for young people is likely to reduce the number of young people needing crisis support. More timely access to statutory CAMHS is also likely to reduce the number of young people deteriorating to the extent that they require crisis support.

Address the huge gap in support available for those who are at risk of harming themselves when they do not have a diagnosis of 'mental illness' eg those with BPD/undiagnosed.

7. **Do you have any further comments?**

My experiences of mental health crisis services have been poor. When attending a&e for the first time I overheard staff say that I was a "genuine case" when they contacted unscheduled care to come over, just because of my professional background. How are other people treated. Is it a case of deserving versus undeserving? I also think that although crisis support does not involve therapeutic work, staff should still have knowledge on trauma. I was continuously told that staff couldn't talk to me about my trauma, which kept me in my crisis.

We need more money invested and more services available - families and teachers are becoming impromptu therapists with no training to support those that are sitting on waiting lists or attending therapies that aren't working for them. It's dangerous and possibly making things worse.

Workforce planning needs to be considered within Mental health services

Services are continually being cut reduced and stretched and staff are expected to just get on with it this is a service that needs to show compassion integrity and empathy to all the service users staff and families involved

Issues causing poor mental health need to be addressed in our community

Themes from the findings

There were a number of key themes which were identified across the findings from the meetings and the online survey. These included:

- People in crisis should be able to access effective support when they need it
- Crisis services should be resourced to provide a range of evidence based interventions to meet the needs of people in crisis

- A balance is needed between an equitable, consistent regional service model and supporting local needs/service development and innovation
- A clear priority is the need to develop safe, accessible alternatives to ED – perhaps on or beside general hospital sites including access or links to appropriate accommodation
- Liaison services in hospital settings are an important and necessary but separate function to mental health crisis services
- Need to further support other services – community and voluntary sector; recovery colleges; CMHTs to be able to further prevent and respond to crises
- Need to further develop multi-disciplinary/inter-agency training for crisis work
- Key issue is the integration of and communication between all the relevant people and organisations involved
- The Covid-19 context has highlighted the further potential of telephone/online services
- It is important to consider mental health crisis services in societal context - crisis services are a necessary component of addressing mental health needs but are only one aspect of what is needed
- Co-production should be a central aspect of the change process and there is great potential for the further employment of people with lived experience in crisis services
- Need to consider the management of change/implementation plan and the ongoing evaluation and development of crisis services

Conclusion and recommendations

A Regional Mental Health Crisis Service

The Review Team has met with a diverse range of people to ask about their experiences of Mental Health Crisis services and what they feel would improve services in the future.

The Review Team were extremely impressed by the high level of engagement from all those who took part in the Review process and their resolve to enhance the quality of care for those in mental health crisis.

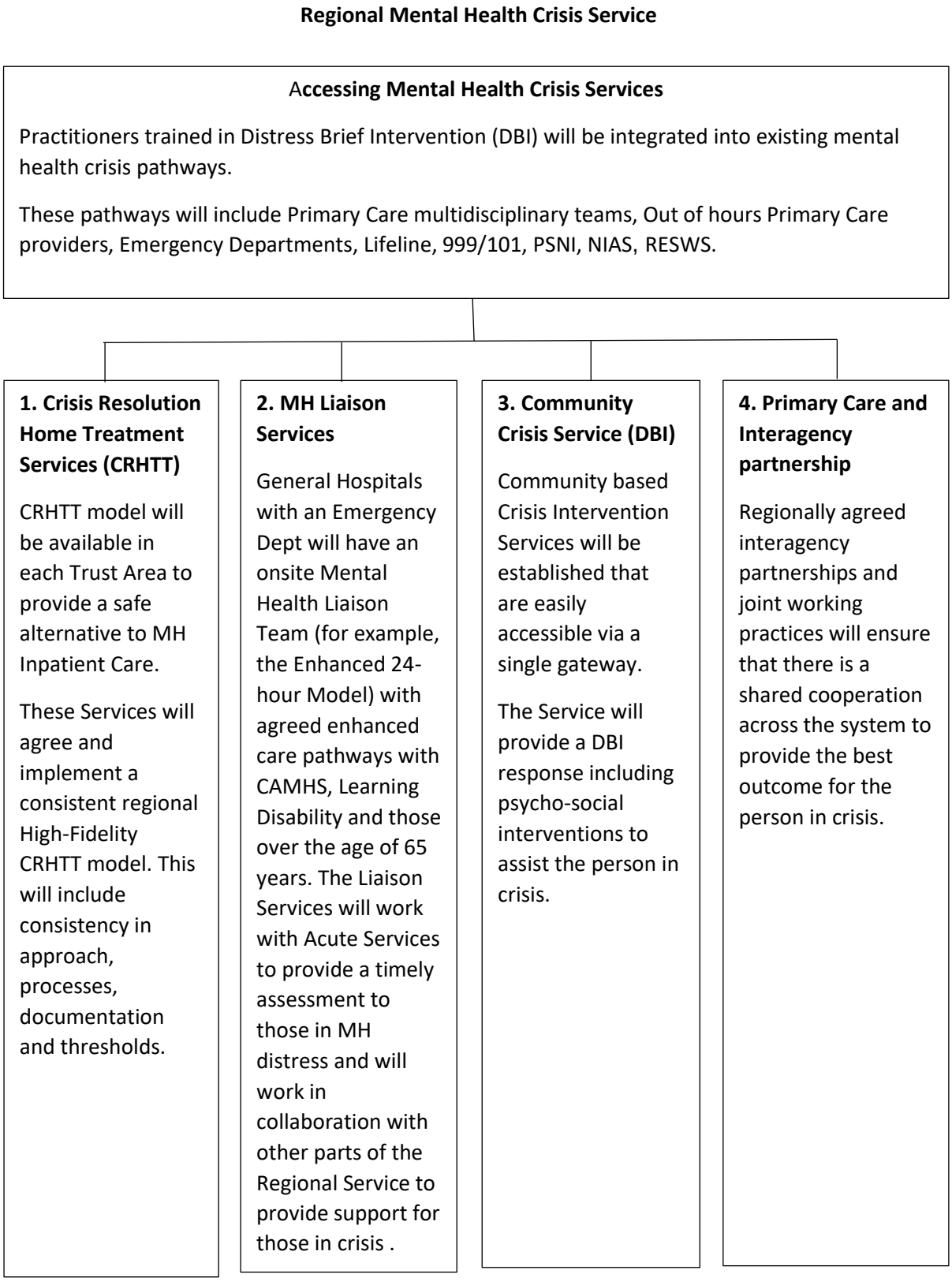
Recommendation 1

> The Review Team recommends the establishment of an integrated Regional Mental Health Crisis Service that provides for everyone who presents in mental health crisis. This crisis model specification would have four key components that are essential to ensuring that there is a robust framework in place that responds to those in mental health crisis irrespective of the nature of the crisis.

Although a Regional model is proposed it should be delivered locally and flexibly. The model specification must be consistently applied in each Trust Area through local commissioning thus reducing the variability in response that is currently experienced.

Each component (see Figure 1 below) in the framework has separate functions for specific target groups but is equally important for providing a holistic and compassionate approach to providing support for those in mental health crisis.

Figure 1 The four components of the Regional Mental Health Crisis Service



Structures to Support the development, implementation and embedding of the Regional Integrated Mental Health Crisis Service

The New Regional Integrated Mental Health Crisis Service will involve a significant change in culture.

The initiative will require from an agreed organisational structure that will further develop the model proposed and prepare for its implementation, delivery and embedding.

These structures should be established from the outset so that a regional specification can be agreed which will support a consistent approach to Mental Health Crisis Care.

It is anticipated that the new service will be realised through modernisation of existing services, with additional investment to accommodate the new developments within the framework. Those who currently provide Mental Health Crisis Services, users of the services and carers must be actively involved in the modernisation programme and to assist in the realisation of the integrated objectives of the initiative.

Recommendation 2

The Review Team recommends the establishment of structures that will support the development of the Integrated Regional Mental Health Crisis Service. It is recommended that the structure should include:

(i) A Regional Partnership Board that will have responsibility for agreeing and supporting the overall implementation of the model;

(ii) Local implementation teams which will organise subgroup activity and, implement and monitor the new service in designated areas. They will report to the Regional Partnership Board;

(iii) A phased implementation of the model initially in two test sites. All Trust areas will be invited via an open procurement process to be one of the test sites.

Service Specific Recommendations (based on Figure 1)

Accessing the integrated Mental Health Crisis Service. All those who need access to Mental Health Crisis Services must be offered help irrespective of the nature of their distress and directed in a timely and compassionate way to the best place that meets their needs.

Recommendation 3

The Review recommends that the Distress Brief Intervention (DBI) response is introduced as part of the integrated model. Frontline staff including those in Primary Care, Emergency Departments, NIAS, RESWS, PSNI and Lifeline should be trained in DBI (Level 1) and can refer individuals for up to 14 days of support from Level 2 DBI practitioners based in community based crisis services.

The Distress Brief Intervention approach offers consistency for those presenting in crisis with a response which is compassionate and well informed and will navigate the care system to ensure the person is directed to the best service which meets their needs.

DBI is designed to meet the needs of those who do not require acute psychiatric intervention by professionals. It is a new service which is additional to the existing statutory crisis services.

Crisis Resolution Home Treatment Teams

All the components in the integrated model are important in providing services for those experiencing mental health crisis. The existing Crisis Resolution Home Treatment Teams will continue to provide assessment and treatment for those with more severe conditions, and in particular those who would otherwise be considered for admission to a mental health hospital.

Across the five Trusts there are differences of approach in the models of CRHT. While a degree of variability is inevitable, it is important that patients always receive the best standard of care in a timely manner, no matter where they live.

Recommendation 4

The Review Team recommends that Crisis Resolution Home Treatment Teams will concentrate all their resources to provide effective and safe alternatives to inpatient care for those in mental health crisis.

Recommendation 5

The Review Team recommends that a Regional Subgroup (of the Regional Partnership Board) is established to work together to produce a high-fidelity regional approach to Home Treatment using evidence-based Fidelity Tools and Quality Standards such as the Home Treatment Accreditation Scheme (HTAS).

The working group will also identify opportunities to standardise approaches to Home Treatment, in relation to criteria for acceptance, assessment protocols, safety plans and evidence-based outcome measures. The aim is to introduce a standardised approach that will reduce variability from Trust to Trust.

Mental Health Liaison Services

The Review Team recognises that a significant number of people attend the Emergency Department with mental health problems. Some will have a physical health problem with underlying mental health issues, some will attend following an episode of deliberate self-harm and some will access help for suicidal ideation.

There is wide variability across the region in how mental health support is provided to the General Hospital sites. Some Trusts operate this function through their Home Treatment Service. The Review acknowledges the need for conformity in approach so that irrespective of where the person lives in Northern Ireland, they can expect the same level of service.

Mental health assessment in General Hospital facilities should be provided in a timely way, working in partnership with medical teams to commence assessment at the earliest opportunity within the Emergency Department and provide support to those who are accompanying the person.

Recommendation 6

The Review Team recommends that all the main General Hospitals in Northern Ireland have a discrete onsite Mental Health Liaison Service.

An Enhanced 24 Model would ensure that there are staff available 24 hours a day to provide mental health assessments in line with NICE Guidelines. This will also reduce waiting times for assessment, allow for the cessation of Card Before You Leave and reduce the number of people who leave the Emergency Department without an assessment. Development of this multidisciplinary Liaison approach will deliver on enhanced care pathways with other Services such as CAMHS and Learning Disability Services to ensure that there is full equity of access. It will also allow for smooth transitions of care between partnership agencies such as the PSNI and NIAS to ensure that they have the capability to return to their other functions in a timely way.

It is recognised that the Emergency Department is often not an environment that is conducive to providing a mental health assessment.

The work completed by the No More Silos Team in the Department of Health offers future opportunities for partnership working between Mental Health and Acute Care.

There is potential for Mental Health trained DBI Practitioners in the Enhanced 24 Liaison Model to work alongside other Acute colleagues.

They would be able to respond to mental health calls, as part of the phone first initiative, to support and direct people in mental health crisis to the best place to receive help including psychosocial assessment in an Acute Care Facility adjacent to Emergency Departments if appropriate.

(It is envisaged that five General Hospitals regionally will have Acute Care Centres and we would propose that they would have Enhanced 24 Liaison Service onsite).

Recommendation 7

The Review Team recommends that Mental Health practitioners from the Liaison Teams will work in partnership with proposed Acute Care Centres, (which will ideally be co-located with EDs) providing telephone support for those in mental health crisis and Mental Health Assessment in the Acute Care Centre for those not requiring the Emergency Department.

There is a need for regional consistency in the development of the enhanced 24 liaison model in Trusts to ensure that that the objectives for the Service are met.

Recommendation 8

The Review Team recommends that a Regional subgroup (of the Regional Partnership Board) is established to develop an agreed specification for Mental Health Liaison Services based on an Enhanced 24 Model.

The Subgroup should also agree on best evidence approaches in suicide prevention initiatives that can be regionally implemented.

Community Crisis Service (DBI)

The findings of the Review have outlined the need for Mental Health Crisis Services for those who do not meet the criteria for Secondary Care Crisis Resolution Home Treatment Services.

There are many people who are in distress, but not as a result of a diagnosable mental health condition, whose needs are clearly not being met by the existing services. Often, what these individuals need is general support from a reliable team of trained workers over a period of up to two weeks, while the crisis resolves.

In Scotland, practitioners from the Distress Brief Intervention programme contact the person within 24 hours of referral and help will be offered for up to 14 days. Problem-solving, wellness and distress management planning, supported connections and signposting are among the range of interventions provided. The staff are from the voluntary and community sector, and have been trained in DBI by the University of Glasgow. The services are typically provided in community rather than NHS facilities, and there is a strong locality focus, particularly in regard to some very practical supports.

A number of users and user groups spoke enthusiastically about the 'Crisis Café' model, of which there are a number of examples in England. These are user run, and operate on a 'drop-in' basis. Some open primarily on weekend nights specifically for those in crisis while others function mainly during the week.

The Review was impressed with the plan for the opening of a facility by PIPS in Newry, and would encourage the development of similar innovative projects, which would be evaluated to see if they could be set up on a wider basis.

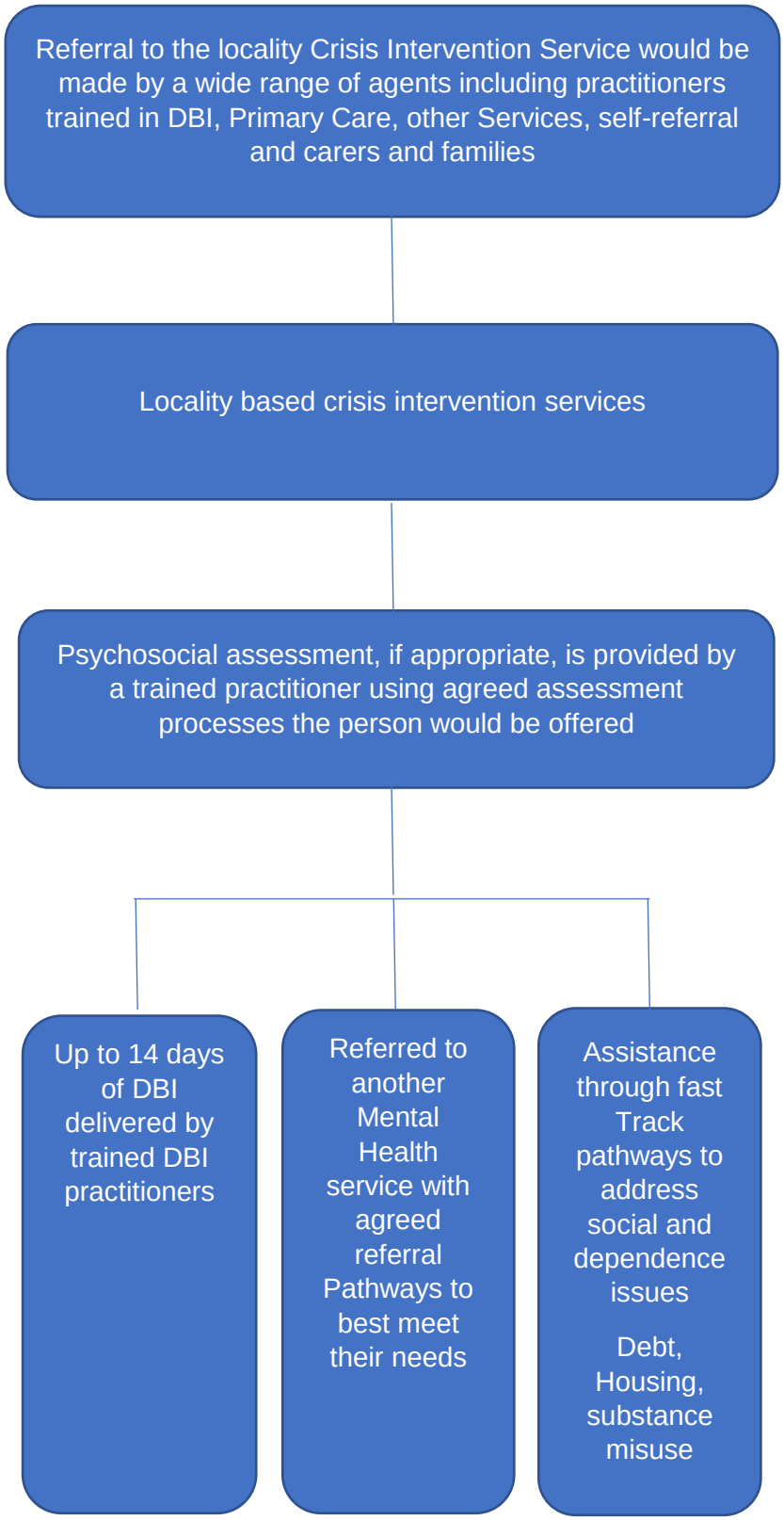
Throughout the Review it was evident that there must be a greater degree of cohesion between all the elements of the service, including in particular the statutory and the voluntary sectors, which too often seem to run in parallel. There is much to be gained from a synergy of both, and it was encouraging that this appears to be increasingly recognised.

Recommendation 9

The Review Team recommends that partnership proposals are submitted from each Trust area to tender for the integrated crisis service including pilot DBI community based crisis intervention services in two areas. Following evaluation, if deemed effective, this type of service should be extended across the whole of N. Ireland.

The Review Team also recommends the piloting and evaluation of 'Crisis Cafés', as well as other innovative models of care including 'safe spaces' for all age groups.

Figure 2 Proposed specification for the Community Based Crisis Intervention Service



Primary Care and Interagency Partnerships

The Review Team recognises that many people in Mental Health Crisis present to their GP at a time of Crisis or in the days or weeks before the Mental Health Crisis occurs.

It is important that people can access help and prevent a mental health crisis occurring.

The development of Multidisciplinary Teams in Primary Care has and will provide opportunities for Mental Health Crisis preventative work to take place.

They also provide immediate support to people in crisis and assist primary care colleagues in referrals to other mental health crisis services currently.

By being part of an integrated service mental health practitioners in Primary Care will have the opportunity to develop processes and referral pathways, and to avail of collaborative training programmes in line with other parts of the Service.

Recommendation 10

The Review Team recommends that the rollout of Primary Care Multidisciplinary Teams is completed as a matter of urgency.

Mental Health Practitioners within these Primary Care Multidisciplinary Teams can play a valuable role in the prevention of mental health crises.

The Review Team recommends the development of shared interagency, multi-sectoral care pathways, processes and training programmes to ensure that people who present to Primary Care in Mental Health Crisis are directed in a compassionate way to where they will find help.

Alongside Primary Care the Review Team also acknowledges the work that PSNI and NIAS provide for people in Mental Health Crisis. It is clear they cannot do this in isolation to other parts of the Mental Health Crisis System, and therefore are included as part of the integrated service.

The Regional Emergency Social Work Service is also an important stakeholder in providing assessments under mental health and mental capacity law.

In line with best practice guidelines a detained admission to hospital should be a last resort when all other options are exhausted. It is therefore important that the Regional Emergency Social Work Service is included in any Service specification that is agreed in the future, so that staff can work in partnership with the Regional Mental Health Crisis Service, with access to all the supports available to help prevent admission, where possible.

Recommendation 11

The Review Team recommends that the Regional Partnership Board oversees the piloting and evaluation of innovative, multi-disciplinary first response models so that anyone experiencing a mental health crisis is given an appropriate and compassionate frontline response from a Mental Health Practitioner. Effective models should become an integral part of a future Crisis Service Model, appropriate to the locality. For example, practitioners/frontline staff, trained in DBI, working in control centres within NIAS and PSNI, can play a vital part in providing a first line mental health response to mental health crises. The Multi Agency Triage Team has shown that mental health crisis response and assessment can be provided by Mental Health Practitioners in venues other than the Emergency Department.

The Review Team recommends that the Regional Emergency Social Work Service works in close partnership with the Regional Crisis Service. This will ensure that there is a range of crisis interventions that can be accessed in line with best practice, and that all available alternatives to compulsory intervention can be explored and, if compulsory intervention is the least restrictive option possible, then all the necessary safeguards are put in place.

Training Programme to support the Regional Mental Health Crisis Service

The success of this Service change Model will be in how well all stakeholders engage in the vision and ethos of the New Service Framework.

The success in the implementation of the Scottish Brief Intervention Model is that the agreed specification identified essential training early in the process. In partnership with the University of Glasgow, a training programme was developed that helped in the implementation of the model regionally in Scotland.

A similar approach would be essential in Northern Ireland as training will not only inform skills but also engage practitioners and all those involved in the spirit and vision of the New Service.

Recommendation 13

The Review Team recommends that the Service Development Team will engage with Education and Training Providers at the earliest point in the design of the model to develop a regional training programme that will provide the skills required for the new functions of the team and communicate the vision and ethos of the Regional Mental Health Crisis Service.

Recommendation 14

The Review Team recommends that all first responders receive appropriate mental health awareness and suicide prevention training. Mental health champions should also be identified within these agencies to support the effective provision of compassionate and appropriate response to people in mental health crisis.

Evaluation of the Regional Mental Health Crisis Service

It is extremely important that evaluation of all aspects of the Regional Mental Health Crisis Service is developed as a core component of the Services.

Recommendation 15

The Review Team recommends that an independent evaluation, following realist evaluation principles, is commissioned to inform the implementation of the full model.

References

Bamford Review of Mental Health and Learning Disability (2005) *A Strategic Framework for Adult Mental Health Services*. Belfast: Bamford Review.

Bamford Review of Mental Health and Learning Disability (2006) *Mental health improvement and well-being - A personal, public & political issue*. Belfast: Bamford Review.

Bamford Review of Mental Health and Learning Disability (2007) *A Comprehensive Legislative Framework*. This is available (along with an Executive Summary and an Easy Read Summary) at: http://www.dhsspsni.gov.uk/index/bamford/published-reports/cl-framework.htm

Borschmann, R., Henderson, C., Hogg, J., Phillips, R. and Moran, P. (2012) Crisis interventions for people with borderline personality disorder. *Cochrane Database of Systematic Reviews* 2012, Issue 6. Art. No.: CD009353. DOI: 10.1002/14651858.CD009353.pub2.

Boscarato, K., Lee, S., Kroschel, J., Hollander, Y., Brennan, A., & Warren, N. (2014). Consumer experience of formal crisis-response services and preferred methods of crisis intervention. *International Journal of Mental Health Nursing*, *23*(4), 287-295.

Compton, J. (2011) *Transforming Your Care - A Review of Health and Social Care in Northern Ireland*. Belfast: Department of Health, Social Services and Public Safety.

Cook, A. (2019) Taking a holistic approach to acute mental health crisis. *Journal of Paramedic Practice*, 02.10.19.

Davidson, G., Fargas, M., Hamilton, B., Connaughty, K., Harvey, K., Lynch, G., McCartan, D., McCosker, J. and Scott, J. (2021) Mental health law assessments: interagency cooperation and practice complexities. *Journal of Mental Health*, 30(1), pp.74-79.

Department of Health (2001) *Mental Health Policy Implementation Guide*. London: Department of Health.

Department of Health (2016) *Health and Wellbeing 2026: Delivering Together*. Belfast: Department of Health.

Department of Health (2019) *Protect Life 2 - A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*. Belfast: Department of Health.

Department of Health (2020) *Mental Health Action Plan*. Belfast: Department of Health.

Department of Health (2020a) *Mental Health Action Plan*. Belfast: Department of Health.

Department of Health (2020b) *Mental Health Strategy 2021-2031 Consultation* Draft. Belfast: Department of Health.

Department of Health (England) (1999) *National Service Framework for Mental Health*. London: Department of Health.

Department of Health (England) (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform*. London: Department of Health.

Department of Health (England) (2001) *The Mental Health Policy Implementation Guide*. London: Department of Health.

Department of Health (England) (2016) *Five Year Forward View for Mental Health*. London: Department of Health.

Department of Health (England) and Concordat signatories (2014) *Mental Health Crisis Care Concordat*. London: Department of Health.

Department of Health (Ireland) (2020) *Sharing the Vision: A Mental Health Policy for Everyone*. Dublin: Department of Health.

Department of Health and Social Security (1975) *Better Services for the Mentally Ill*. London: DHSS.

Department of Health and Social Services (1990) *People First: community care in Northern Ireland in the 1990s*. Belfast: DHSS.

Department of Health and Social Services (1997) *Health and wellbeing into the next millennium: Regional strategy for health and social wellbeing 1997-2002 Executive Summary*. Belfast: DHSS.

Department of Health, Social Services and Public Safety (2006) *Protect Life - A Shared Vision, the Northern Ireland Suicide Prevention Strategy and Action Plan (2006-2011)*. Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2009) *Bamford Action Plan 2009-11*. Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2012a) Protect Life - A Shared Vision, the Northern Ireland Suicide Prevention Strategy and Action Plan 2012 - March 2014. Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2012b) *Bamford Action Plan 2012-15*. Belfast: DHSSPS.

Donnelly, O. (2019) *Churchill Fellowship – Bringing Zero Suicide to Northern Ireland*. Winston Churchill Memorial Trust. Available online at https://www.wcmt.org.uk/fellows/reports/towards-zero-suicide.

Duncan, E., Harris, F., Calveley, E., Maxwell, M., McLean, J., Shields, J., Scholes, A., MacGregor, A., Mason, H., Fenocchi, L. and White, C. (2020) Evaluation of the Distress Brief Intervention Programme: Interim Report. Stirling: University of Stirling.

Ennis, E. & Walker, E. (2020) *An Evaluation of the Community Crisis Intervention Service*. Ulster University.

Flowers, M, Hoult, J (2008) 'Planning and implementing a local service'. In *Crisis Resolution and Home Treatment in Mental Health* (eds Johnson, S, Needle, J, Bindman, JP et al): 295–306. Cambridge: Cambridge University Press.

Goldsmith, L. P., Smith, J. G., Clarke, G., Anderson, K., Lomani, J., Turner, K., & Gillard, S. (2020). What is the impact of psychiatric decision units on mental health crisis care pathways? Protocol for an interrupted time series analysis with a synthetic control study. *BMC Psychiatry*, *20*, 1-9.

Gossrau-Breen, D. & Mallon, K. (2021) *[Draft] Evaluation of the Multi Agency Triage Team Summary Report March 2021*. Health Intelligence.

Government Inquiry into Mental Health and Addiction (2018) *He Ara Oranga* [Pathways to Wellness]. Wellington: Ministry of Health and the Department of Internal Affairs.

Griffiths, M., Allen, J., Patel, K., & Bell, V. (2020). Promoting family inclusive practice in home treatment teams. *Journal of Mental Health Training, Education and Practice*, 15(5), 261-273.

Health and Social Care Board (2013) *Transforming Your Care Strategic Implementation Plan*. Belfast: Health and Social Care Board.

Health and Social Care Board (2014) *Regional Mental Health Care Pathway*. Belfast: Health and Social Care Board.

Health and Social Care Board and Public Health Agency (2013) *Evaluation of the operation and effectiveness of the "Card Before You Leave" scheme in the context of other suicide prevention initiatives within Northern Ireland*. Belfast: Health and Social Care Board and Public Health Agency.

Health Foundation (2021) *Policy Navigator - Enoch Powell's 'water tower' speech*. Accessed online on 11/03/21 at https://navigator.health.org.uk/theme/enoch-powells-water-tower-speech

International Mental Health Collaborating Network (2020) *Acute and Crisis Mental Health Services.* Accessed online at imhcn.org/bibliography/transforming-services/acute-and-crisis-mental-health-services/ on 30/12/20.

Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., Ambler, G., Milton, A., Davidson, M., Christoforou, M. and Sullivan, S., (2018). Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial. *The Lancet*, *392*(10145), pp.409-418.

Joint Commissioning Panel for Mental Health (2020) *What is a crisis?* Accessed online at www.jcpmh.info/commissioning-tools/cases-for-change/crisis/what-is-a-crisis/ on 30/12/20.

Killaspy, H. (2006). From the asylum to community care: learning from experience. *British Medical Bulletin*, *79*(1), 245-258.

Lamb, D., Lloyd-Evans, B., Fullarton, K., Kelly, K., Goater, N., Mason, O., Gray, R., Osborn, D., Nolan, F., Pilling, S. and Sullivan, S.A. (2020). Crisis resolution and home treatment in the UK: A survey of model fidelity using a novel review methodology. *International Journal of Mental Health Nursing*, *29*(2), pp.187-201.

Lloyd-Evans, B., Bond, G. R., Ruud, T., Ruud, T., Ivanecka, A., Gray, R., . . . Johnson, S. (2016). Development of a measure of model fidelity for mental health Crisis Resolution Teams. BMC Psychiatry, 16(1), 427. Retrieved 3 30, 2021, from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-016-1139-4

Lloyd-Evans, B., Osborn, D., Marston, L., Lamb, D., Ambler, G., Hunter, R., Mason, O., Sullivan, S., Henderson, C., Onyett, S. and Johnston, E. (2020). The CORE service improvement programme for mental health crisis resolution teams: results from a cluster-randomised trial. *The British Journal of Psychiatry*, *216*(6), pp.314-322.

McCallion, M., & O'Hare, U. (2014). A new legislative framework for mental capacity and mental health legislation in Northern Ireland: an analysis of the current proposals. *International Journal of Mental Health and Capacity Law* (20), 84-88. Retrieved 4 11, 2021, from http://journals.northumbria.ac.uk/index.php/ijmhmcl/article/view/262

McDaid, S., Adell, T., Cameron, J., Davidson, G., Knifton, L., McCartan, C. and Mulholland, C. (2020). *International learnings on mental health plans, policies and implementation: Findings from an informal data collection exercise*. Glasgow: Mental Health Foundation.

McGarry, P. (2019). Progress in home-based treatment. *Irish Journal of Psychological Medicine*, *36*(1), 3-5.

Mental Health Foundation (2020) *Crisis Care.* Accessed online at www.mentalhealth.org.uk/a-to-z/c/crisis-care on 30/12/20.

Mind (2020) *Crisis services and planning.* Accessed online at www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/ on 30/12/20.

Ministry of Social Affairs and Health (2020) *National Mental Health Strategy and Programme for Suicide Prevention 2020–2030*. Helsinki: Ministry of Social Affairs and Health.

Molyneaux, E., Turner, A., Candy, B., Landau, S., Johnson, S., & Lloyd-Evans, B. (2019). Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. *BJPsych Open*, *5*(4), 1-9.

Murphy, S.M., Irving, C.B., Adams, C.E. and Waqar, M. (2015) Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews* 2015, Issue 12. Art. No.: CD001087. DOI: 10.1002/14651858.CD001087.pub5.

Newbigging. K., Rees, J., Ince, R., Mohan, J., Joseph, D., Ashman, M., Norden, B., Dare, C., Bourke, S. & Costello, B. (2020) The contribution of the voluntary sector to mental health crisis care: a mixed-methods study. *Health Services Delivery Research* 2020;8 (29).

Northern Ireland Commission for Children and Young People's (2018) report *Still Waiting – A rights based review of mental health services and support for children and young people in Northern Ireland*. Belfast: NICCY.

O'Neill, S., & O'Connor, R. C. (2020). Suicide in Northern Ireland: Epidemiology, risk factors, and prevention. *The Lancet Psychiatry*, *7*(6), 538-546.

P.M. Prior (ed.) (2012) *Asylums, Mental health care and the Irish: Historical studies 1800-2010*. Dublin: Irish Academic Press.

Parker, A., Scantlebury, A., Booth, A., MacBryde, J. C., Scott, W. J., Wright, K., & McDaid, C. (2018). Interagency collaboration models for people with mental ill health in contact with the police: a systematic scoping review. *BMJ Open*, *8*(3), e019312.

Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Simpson, A., Webber, M. and Meader, N. (2016). Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. *Health Technology Assessment*, 20(3), doi: 10.3310/hta20030.

Prior, P.M. (1993) *Mental Health and Politics in Northern Ireland*. Aldershot: Avebury.

Prior, P.M. (1998) *Mental health policy in Northern Ireland* in Campbell, J. and Manktelow, R. (eds.) (1998) *Mental health social work in Ireland: Comparative issues in policy and practice*. Aldershot: Ashgate.

Public Health Agency (2014) *Lifeline Crisis Response Service. Consultation Report. A summary of the feedback to the Public Health Agency's public consultation process on the Lifeline Crisis Response Service*. Belfast: Public Health Agency.

Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayes, A., Harriss, E. and Molodynski, A. (2018). A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry*, *18*(1), p.256.

Regulation and Quality Improvement Authority's (2019) *Review of Emergency Mental Health Service Provision across Northern Ireland*. Belfast: RQIA.

Royal College of Psychiatrists (2019) *Expert consensus: Home Treatment Accreditation Scheme*. Standards Development Group.

Royal Commission into Victoria's Mental Health System (2019) *Interim Report*. Melbourne: Royal Commission.

Royal Commission into Victoria's Mental Health System (2021) *Final Report - Summary and recommendations*. Melbourne: Royal Commission.

Scottish Government (2020) *Mental Health – Scotland's Transition and Recovery.* Edinburgh: Scottish Government.

Shepperd, S., Doll, H., Gowers, S., James, A., Fazel, M., Fitzpatrick, R. and Pollock, J. (2009) Alternatives to inpatient mental health care for children and young people. *Cochrane Database of Systematic Reviews* 2009, Issue 2. Art. No.: CD006410. DOI: 10.1002/14651858.CD006410.pub2.

Sloper, B. (2016) London's Innovative Response for Patients Presenting with Mental Health Problems. *Journal of Emergency Medical Services*, 11(41).

Social Care Commissioning Lead for Adult Mental Health (2019) *Regional Interagency Protocol on the Operation of Place of Safety & Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986* (Version 4). Belfast: Health and Social Care Board.

Social Market Research (2020) *Evaluation of Crisis De-escalation Service*. Belfast: Social Market Research.

Substance Abuse and Mental Health Services Administration (2020) *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary*. Rockville, Maryland: SAMHSA.

Welsh Government (2020) *Review of the Together for Mental Health Delivery Plan 2019-2020 in response to Covid 19*. Cardiff: Welsh Government.

Wheeler, C., Lloyd-Evans, B., Churchard, A., Fitzgerald, C., Fullarton, K., Mosse, L., Paterson, B., Zugaro, C.G. & Johnson, S. (2015). Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review. *BMC Psychiatry*, *15*(1), 74.

White, C. J. (2021). An inevitable response? A lived experienced perspective on emergency responses to mental health crises. *Journal of Psychiatric and Mental Health Nursing*. (28), 90–93.