Crisis responses for children and young people: an evidence synthesis of effectiveness, experiences and service organisation (CAMH-Crisis)

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Scientific summary

Background

The mental health of children and young people (CYP) is a rising concern with one in six children aged 5-19 in England having a probable diagnosable mental disorder. A recent National Assembly inquiry found a 100% increase in demand for CYP mental health services in Wales between 2010 and 2014. With resources stretched and CYP often waiting lengthy periods to be seen, increasing numbers of CYP are seeking help at a point of crisis. During periods of crisis, it is vital that care is timely,

effective, and based on evidence. Crisis care for CYP has become a national and international policy priority, with substantial funding allocated to the development of crisis services. The needs of young people in crisis can be met through clinical services such as local child and adolescent mental health teams, crisis teams, accident and emergency departments, or through school counselling, youth services, and internet-based counselling. Within the UK, the landscape of crisis care delivery has shifted substantially in recent years: notably, investments have been made in community crisis teams which aim to provide care close to home and avoid the need for hospital admission. Different forms of crisis support from health, education, social care and third sector are available for CYP, with considerable regional variability in the way such care is delivered. However, little is known about how these different services are organised or experienced, whether they are effective, or how they are integrated within their local system contexts.

Objectives

The review objectives were to critically appraise, synthesise, and present the best available international evidence related to crisis services for CYP aged 5 to 25 years, specifically looking at:

1. The organisation of crisis services across education, health, social care and the third sector.
2. The experiences and perceptions of young people, families, and staff.
3. To determine the effectiveness of current models.
4. To determine the goals of crisis intervention.

Methods

The protocol was crafted following the guidance published by the Centre for Reviews and Dissemination at the University of York. The protocol was then registered with the International Prospective Register of Systematic Reviews.

All relevant English language international evidence was sought specifically relating to the provision and receipt of crisis support for CYP aged 5-25 from January 1995 to January 2021. All records were considered that related to the effectiveness, organisation, and goals of services that respond to CYP in crisis, and to the experiences of people using and working in these services. At a first stakeholder advisory group help was obtained in developing a search strategy, ensuring appropriate search terms were being used and assisting in the locating of otherwise unidentified sources of evidence, particularly grey literature. Types of evidence sought included quantitative, and qualitative research, and grey literature.

Following the development and testing of a search strategy, comprehensive searches were conducted across 17 databases: MEDLINE ALL; PsycINFO; EmCare; AMED; HMIC; CINAHL; ERIC; ASSIA; Sociological Abstracts; Social Services Abstracts; PQDT Open; Scopus; Web of Science; Open Grey; CENTRAL; EThOS; and Criminal Justice Abstracts. Supplementary searching was undertaken to identify grey literature and additional research material. This included use of online searches, and the targeted searching of organisational websites and journal tables of content. Reference lists of included studies were scanned, and forward citation tracking performed using Web of Science.

The title and abstract of each record were reviewed by two members of the team to establish if that paper was relevant, with a third member arbitrating if there was no consensus. The full texts of each record were accessed where a decision about relevance could not be made on abstract alone. All records deemed relevant on initial screening were then subject to a further review by two members of the team,

again using a third team member for arbitration. A specifically designed form was used to guide this process.

Two team members appraised all the research reports that had been identified through screening, using critical appraisal checklists. Where there were disagreements about quality, a third team member arbitrated. None of the grey literature was appraised for quality.

Demographic data from the appraised records were extracted into tables and checked by a second team member. All appraised research material and relevant extracts from the grey literature was managed using the NVIVO-12^{TM} software from where it was thematically analysed.

A separate analysis was conducted for each objective. For objective one, the types of crisis services/responses were categorised and summarised after consultation with the stakeholder advisory group. Next, thematic summaries that explored organisation of crisis services were conducted.

To meet objective two a thematic synthesis was conducted to explore the experiences and perceptions of young people, their families, and staff with regards to mental health crisis services. The confidence in the synthesised findings from the qualitative research to address this objective was assessed by two reviewers using the Confidence in the Evidence from Reviews of Qualitative Research approach.

The third objective was to determine the effectiveness of current models of mental health crisis services. Due to the heterogeneity of the included intervention studies, meta-analyses could not be performed, and thematic summaries were therefore conducted. The confidence in the certainty of the synthesised findings from the quantitative evidence was assessed by two reviewers using the Grading of Recommendations, Assessment, Development and Evaluation approach.

The final objective was to determine the goals of crisis intervention, and this was achieved using thematic summaries.

Findings

One hundred and thirty-eight reports were used to inform this evidence synthesis; 39 descriptive accounts on the organisation of crisis services (across 36 reports), 42 research studies (across 48 reports) and 54 grey literature documents.

For objective one, the organisation of crisis services were categorised as follows: triage/assessment-only; digitally mediated support approaches; intervention approaches and models. There were triage/assessment approaches provided for CYP who presented at emergency departments, within educational settings, via telephone triage, and at out of hours mental health services. Digitally mediated support approaches were facilitated through telephone, text-based or online facilities. A wide variety of different intervention approaches have been described ranging from intervention approaches that started in the emergency department then moved to outpatient services, inpatient care through hospitals or residential treatment centres, home-based programmes, child and adolescent mental health based services, using telepsychiatry or via a community resource such as mobile outreach through to school hospital partnerships and generic walk-in crisis services provided by voluntary organisations. The thematic summaries on the organisation of crisis services highlighted four themes. These were recommendations for initial assessment in the emergency department, the importance of providing home or community-based crisis support; places of safety; and general characteristics of a crisis response. Guidance relating to how assessments are carried out in the emergency department focused on risk assessments and broadly follow NICE guidelines. These should be undertaken in separate age-appropriate areas and there should be clear follow-up pathways. Assessments should be undertaken by skilled professionals, with expertise within this client group, who receive appropriate training. Where possible, crisis care should be offered as close to home as possible, so either at home or in community-based locations, recognising that families make an important contribution to the planning and provision of care. Places of safety need to be appropriately staffed, again with experienced and trained professionals, ideally in a dedicated space so that the use of adult mental health facilities and police cells

can be avoided. In general, crisis services should provide a timely response, be age-appropriate, have a single point of access, be accessible and available 24/7, be responsive and needs led, involve multi-agency working, be staffed by suitably qualified and experienced professionals, involve crisis planning and risk assessment using evidence-based practice.

For objective two, four themes were identified which were: barriers and facilitators to seeking and accessing appropriate support; what CYP want from crisis services; children's, young people's, and families' experiences of crisis services; and service provision. Twenty-severn synthesis summary statements were generated, of which only two were judged as having a high degree of confidence and 15 were moderate using the Confidence in the Evidence from Reviews of Qualitative Research approach. The remainder were low or very low. The statements of high confidence related to what CYP want from crisis services which were centred around the need for different forms of support and pathways to services. This included support via telephone (via a direct line, with out of hours availability and staffed by trained counsellors) as well as via text and email.

For objective three, the findings are summarised by type of service and were generated from single heterogenous studies. Therefore, no meta-analysis was possible. Outcomes across the studies were graded as moderate for randomised controlled trials, and very low for observational studies. Crisis services initiated within emergency departments are effective in reducing depression and improving family functioning or empowerment. Children and young people receiving these services are more likely to be referred to and attend intensive outpatient care and are less likely to be hospitalised. They report greater satisfaction with services. Health care staff are satisfied with some aspects of mental health crisis services that they provide but are generally dissatisfied with the lack of out-of-hours availability. Telepsychiatry initiatives are effective in decreasing length of stay and costs, staff satisfaction is improved, and parents report high levels of satisfaction. When a dedicated mental health team is implemented in the emergency department, CYP

are less likely to be hospitalised, length of stay is decreased, and CYP are more likely to return home. Carrying out assessment approaches within the emergency department bring success in prompting referral to community services. CYP receiving mobile crisis services are less likely to attend the emergency department post-discharge.

Home or community-based programmes are effective in reducing depression, psychiatric symptoms, the number of suicide attempts and completed suicides. Moreover, home and community-based programmes can improve self-concept, family adaptability or cohesion and are more cost-effective. CYP receiving these services are more likely to remain in the community post-treatment and less likely to be hospitalised, reporting greater satisfaction with services. CYP receiving outpatient mental health programmes are less likely to be hospitalised and experience quicker access to additional resources. An association also exists between parental satisfaction and increased adherence to outpatient treatment.

Specific inpatient programmes for crisis care for CYP are effective in reducing psychiatric symptoms, and suicidality and improving psychosocial functioning. Both crisis programmes within residential treatment centres and inpatient programmes are effective in reducing length of stay and costs.

No completed suicides or suicide attempts are reported within educational settings when assessment approaches are introduced. A variety of referral destinations are noted and in some cases referrals to more acute levels of care are avoided, and levels of staff satisfaction are high.

There were seven clear goals of crisis intervention identified for objective four. These were: to keep CYP in their home environment as an alternative to admission; to assess need and to plan; to improve CYP and/or their families' engagement with community treatment; to link CYP and/or their families to additional mental health

services as necessary; to provide peer support; to stabilise and manage the present crisis over the immediate period; and to train and/or supervise staff.

Summary

. Despite multiple approaches to the organisation and provision of mental health crisis care, there was moderate evidence that CYP and their families do not know how to access such services and may not be eligible due to threshold criteria. Even when accessing services some CYP are not able to talk whilst they are in crisis and there is high quality evidence that alternative methods of communicating such as text, phone and online provision is welcomed. There is moderate evidence that CYP would like access to peers at this time or access age-appropriate out-of-hours services. Attendance at an emergency department was the default service given the lack of alternatives and this is experienced as stressful for the CYP, noisy, busy and generally unsuitable. There was evidence to suggest that much of the care provided in an emergency department was effective: improvement of family functioning following a crisis service; intervention initiated in the emergency department; increased referral for the CYP to intensive outpatient care post emergency department; increased satisfaction with crisis services; reduction in psychiatric symptoms and improving psychosocial functioning; no increase in rate of attendance for crisis care after being seen in emergency department. Being seen in an emergency department for a mental health crisis is not the policy preference in the UK.

Limitations

The literature that informed this evidence synthesis was largely drawn from the USA. Any models or approaches of crisis care operating in the USA may not be directly applicable to the UK given the differences in the way healthcare is commissioned and delivered in the USA compared to the UK. Aside from that issue, a wide range of crisis provision was reported across many different settings which made comparison of these models difficult. It was therefore not possible to determine their relative efficacy, meaning that only general conclusions can be drawn.

Future work

As only three research studies included in this evidence synthesis had been completed in the UK, a clear case exists for the commissioning of new high-quality studies investigating discrete aspects of service delivery of crisis care in the UK, to generate knowledge about efficacy and acceptability of these models. It would also be helpful to investigate models of peer support during crises given this was welcomed by CYP.

Attempts could be made to discern the distinct needs of particular subgroups of CYP and which types of crisis intervention models are more effective for them. This is particularly pressing given the proliferation of service responses to crisis but the relative absence of a programme of research to evaluate the varying models on offer.

Findings suggest that support prior to the point of reaching crisis point is important, but further research needs to identify precisely which kinds of community support would be most effective in preventing CYP from reaching crisis and/or feeling the need to attend an emergency department.

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