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

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

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

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

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

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

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

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

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

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

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

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

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Authors' competing interests

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Scientific Summary

Background

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

Aim

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

Objectives

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

Design

A four-phase realist evidence synthesis, reported according to RAMESES reporting guidelines and comprising (i) identification of candidate programme theories from academic and grey literature; (ii) iterative consultation with an Expert Stakeholder Group and individual interviews to prioritise, test and refine programme theory; (iii) focused realist reviews of prioritised theory components; (iii) synthesis to mid-range theory.

Main Outcome Measures

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

Data Sources

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

Analysis

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

Data analysis involved using realist logic to identify initial programme theories (Objectives 1-3); test and refine the programme theories through focused review of the literature, to extract and configure explanatory causal relationships between context, intervention, mechanism, and outcome (CIMO) (Obj. 3-5). Expert stakeholder consultations supported analysis through linking theories to real world experience enabling exploration and explanation of contextual variation as it related to putative mechanisms (Obj. 3-5). Individual interviews with experts who were purposively selected for their topic expertise related to the programme theory components, were deductively analysed according to the CIMOs. An inductive process identified any new mechanisms not identified from other data sources (Obj. 3). Pen portraits were developed as illustrative exemplars of the link between context, intervention, mechanism, and outcome and were refined in collaboration with expert stakeholders (Obj. 4). Findings from the focused review of the three theory components were synthesised with mid-range theories to produce a framework for future empirical testing developed (Obj. 5).

Results

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

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

where information and decisions are shared from commissioning through to frontline delivery.

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

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

The *perception* of whether a service and service providers are accessible carry more of an inhibitive effect than *the way that the service is actually organised.* People experiencing a crisis choose to access services they perceive as providing a guaranteed response, that are easy to navigate to, and fit with their definition of the crisis. Whilst the timing of responses remains unclear in relation to outcomes, what is clear is that people feel safer and have a reduced sense of urgency when they trust services. Trust is established through

compassionate interactions and proactive management of transitions and waiting. Involvement of the person and their family, or support network in decisions supports a sense of trust and relational safety which may help meet a need for continuity for some.

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

This is achieved in an interagency context where there is interpersonal contact between all levels of worker from commissioning through to frontline delivery that facilitates learning, communication, and appreciation of different roles. Furthermore, co-production of crisis care can be facilitated within the interagency system enabling crisis care to be recognised and valued by the community it serves. Service users perceive a crisis when they feel overwhelmed and anxious and when they perceive that they lack a sense of control. Familiar contacts and a safe environment, coupled with reassurance, can help to shape their perception of the service but, more importantly, can help to reduce distress thereby mitigating risk and making it more likely that a service user is able to respond to suggested strategies. With an emphasis on rapport and compassion, professionals are encouraged to exhibit positive behaviours that mitigate against the dehumanising and stigma that service users may perceive when they encounter a service and that may precipitate or exacerbate a crisis.

Compassion shown to frontline staff by leaders leads to compassionate care. A tension between exerting control and providing support was evident at all levels. As integrated care systems are introduced, there is an aspiration that strategic partnerships will reduce competing priorities, which appear debilitating to organisations. Alongside these strategic partnerships, there is a need for coherent local strategies for compassionate and psychologically safe crisis care cognisant of the fact that high quality care can coexist

alongside the worst examples of care in the same organisation. Strategies should include how compassionate and psychologically safe crisis care is provided. Different values and definitions of crisis are accommodated allowing challenge and debate to become accepted as an opportunity to drive quality improvement.

Strengths and Limitations

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

Conclusion

Community crisis care is likely to continue to be delivered by a complex array of agencies responding to a heterogeneous population that presents with different mental health concerns and perceptions of crisis. Interagency working provides a platform for seamless transitions between services and timely responses. To deliver desired outcomes, interagency working requires continual systems of engagement locally and nationally involving all providers of crisis care through compassionate leadership, sharing of values and shared understanding of systems. Compassion is central and begins with leaders who can influence the culture of crisis organisations. Compassionate leadership is focused on people over systems enabling frontline staff to retain their compassion and hope, work collaboratively across agencies and provides a platform for shared decision making and co-production. All of this helps people in crisis to recognise the service as designed for them and to have trust in community crisis services.

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

Future Work

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

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

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

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

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