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REVIEW ARTICLE

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# Explaining context, mechanism and outcome in adult community mental health crisis care: A realist evidence synthesis

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## Abstract

Mental health crises cause significant distress and disruption to the lives of individuals and their families. Community crisis care systems are complex, often hard to navigate and poorly understood. This realist evidence synthesis aimed to explain how, for whom and in what circumstances community mental health crisis services for adults work to resolve crises and is reported according to RAMESES guidelines. Using realist methodology, initial programme theories were identified and then tested through iterative evidence searching across 10 electronic databases, four expert stakeholder consultations and $n$=20 individual interviews. 45 relevant records informed the three initial programme theories, and 77 documents, were included in programme theory testing. 39 context, mechanism, outcome configurations were meta-synthesized into three themes: (1) The gateway to urgent support; (2) Values based crisis interventions and (3) Leadership and organizational values. Fragmented cross-agency responses exacerbated staff stress and created barriers to access. Services should focus on evaluating interagency working to improve staff role clarity and ensure boundaries between services are planned for. Organizations experienced as compassionate contributed positively to *perceived* accessibility but relied on compassionate leadership. Attending to the support needs of staff and the proximity of leaders to the front line of crisis care are key. Designing interventions that are easy to navigate, prioritize shared decision-making and reduce the risk of re-traumatizing people is a priority.

**KEYWORDS**
crisis intervention, crisis resolution, interagency services, mental health, realist methods, shared decision-making

## INTRODUCTION

Mental health crises cause significant distress and disruption to the lives of individuals and their families and can be life threatening (Mind, 2011). Crises present a complex aetiology linked to factors including general health, life stresses, treatment adherence, coping skills and social situation (Johnson, 2013). Mental health crises can be defined in different ways (Newbigging et al., 2020) including as a relapse in a psychiatric condition, characterized by increased symptom severity, such as voice hearing, suicidal thoughts and risky behaviours and decreases in social functioning including reduced self-care (Crompton & Daniel, 2006; The Department of Health, 2003). Irrespective of psychiatric diagnoses, crises can also be defined as a reaction to adverse life events, leading to increasing disruption for the person and their family where their usual coping strategies have not helped (Tobitt & Kamboj, 2011). Being in a state of crisis could for some people be conceived as an opportunity for change and may enable people to develop new ways of coping (Caplan, 1989). If however people are

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unsupported or the crisis response is delayed, this can lead to prolonged distress, harm to self or others and admission to hospital that may have been avoided with timely intervention.

The complexity of service structures and referral routes may present a barrier, resulting in people failing to access the most appropriate or timely crisis care for their needs (Care Quality Commission, 2015). Social stigma and a lack of public awareness about mental health may also contribute to delays in contacting services due to fear of being coerced into treatment or negatively labelled (Middleton et al., 2011) and may influence how and from whom people seek help in a crisis.

To provide community-based responses, crisis resolution services were developed in the late 20th century in the USA, Australia and mainland Europe and were established in the United Kingdom from 2000 (Johnson, 2013). Efforts to improve mental health crisis outcomes led to rapid expansion and diversification of available community-based services embodied in a complex range of services and providers (Agar-Jacomb & Read, 2009; Beecham, 2005; Crisis Care Concordat, 2021; National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020). Currently community crisis services often include involvement from, blue light emergency services, accident and emergency, voluntary sector services, telephone lines, day hospitals and Crisis Resolution Teams. Provision of these crisis services can be highly variable (Boscarato et al., 2014; Care Quality Commission, 2015) making timely access and navigation difficult (Care Quality Commission, 2015; Newbigging et al., 2020; Paton et al., 2016).

Crisis services aim to support people to resolve crises (National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020), reduce risk (NHS England, 2015), hospital admissions and urgent care use (Crisp et al., 2016; NHS England, 2015). Previous research has focused on the fidelity of NHS Crisis Resolution Teams (Lloyd-Evans et al., 2016, 2017; Morant et al., 2017), improving the mental health pathway through accident and emergency departments (Evans et al., 2019) and the contribution of the voluntary sector to crisis care (Newbigging et al., 2020). Health services are under ongoing financial pressures and inpatient care, although necessary for some is undesirable to many people, expensive (Parsonage et al., 2016) and scarce (Gilburt, 2015). Community-based crisis care presents an opportunity for cost-effectiveness, if interventions can be successfully developed, tested and implemented.

To understand what is working in this complex landscape of community crisis interventions, a realist approach seeks to identify the causal interaction between different crisis care contexts and mechanisms that produce optimal outcomes. In doing this, theory-driven insights are used to inform future service design and commissioning, ultimately aiming to improve access to support in a mental health crisis.

# METHODS

## Review aim

The aim of this realist evidence synthesis was to identify mechanisms to explain how, for whom and in what circumstances community mental health crisis services for adults work to resolve crises.

## Realist synthesis study design

Realist synthesis is an optimal approach for theoretical development of interventions by exploring how and why complex programmes (Skivington et al., 2021) such as crisis mental health services, may or may not work (Pawson et al., 2005; Wong et al., 2013). Through analysis exploring how the context (the situation around a person) affects any mechanism (resources and how people respond to them), to generate an outcome, intended or not (Dalkin et al., 2015; Wong et al., 2013), realist synthesis offers a participatory method for continual testing and refinement of programme theories against empirical evidence and primary data from stakeholders (Pawson et al., 2005).

A study protocol was registered with PROSPERO (CRD42019141680), an international prospective register of systematic reviews, and reported according to Realist and Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES; Wong et al., 2013). The study design included two phases; first scoping reviews identified initial programme theory and in a second phase, the initial programme theories were tested through iterative searching of published evidence, data from stakeholder consultations and stakeholder interviews (Figure 1). The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975,

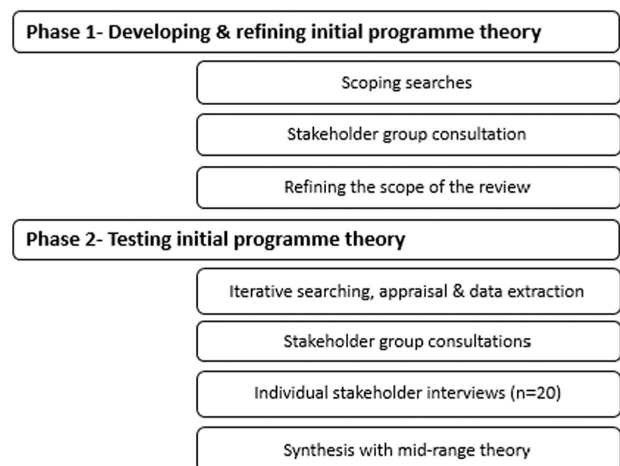


**FIGURE 1** Realist evidence synthesis study design.

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as revised in 2008. All procedures involving human subjects/patients, (Expert Stakeholder Group (ESG) consultations and individual interviews) were approved by the UK Integrated Research Application System (IRAS) Reference number: 261486; REC reference: 19/YH/0347.

## Phase 1: Developing and refining programme theories

Scoping searches to identify initial programme theories were conducted in Google Scholar between August and September 2019 in three concept combinations; (1) logic models and theory; (2) mental health; (3) crisis care settings. The primary search string, ("logic model" OR "theory of change" OR "theory of action" OR "outcomes chain" OR "program* theory" OR "program* logic "OR "logical framework*") AND ("mental health crisis")" repeated with search terms for each of 30 community crisis care settings identified from policy documents and through discussion between stakeholders and the research team. No date limits were applied. Data were extracted using a purpose-specific template from retained records ($n$=45) according to 'context, mechanism, outcome' along with associated interventions.

Iterative engagement between the extracted data, the research team and the stakeholders resulted in a refined study (Wong et al., 2013) which focused on the initial stage of a person in crisis seeking help and securing support (Crisis Care Concordat, 2021; Gibson et al., 2016). Three initial programme theories were developed; (1) Crisis services can be accessed urgently; (2) Care in a crisis is compassionate and therapeutic; and (3) Community crisis agencies work together (Table 1).

## Phase 2: Testing the initial programme theories

### Search strategy

An information specialist conducted database and grey literature searches between January and July 2020 and iterative searching continued until March 2021. 10 academic databases were searched: MEDLINE; Embase, Web of Science Core Collection (Science Citation Index; Social Sciences Citation Index; Conference Proceedings Citation Indexes—Science and Social Science & Humanities); Cochrane Database of Systematic Reviews; Cochrane Central Register of Controlled Trials; Cumulative Index to Nursing & Allied Health; PsycINFO; Applied Social Science Index; ProQuest Dissertations & Theses A&I; HMIC. All searches were restricted to English Language. Search terms are summarized in Data S1. Grey

**TABLE 1** Summary of initial programme theories.

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

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literature searches were conducted in topic-specific websites, and additional searches identified relevant explanatory mid-range theories.

## Eligibility criteria

Documents were included if they related to people aged 16 years or older accessing adult mental health services for a crisis related to mental health in a community setting (Department of Health and Concordat signatories, 2014). Community settings were defined as any service where the person does not stay overnight away from their usual place of residence and included health and social care, voluntary sector, emergency departments, ambulance and police. Reports from United Kingdom, Europe, United States, Canada and Australasia were considered relevant. Journal articles, reports, theses and book chapters, published in English language were considered eligible. Included documents were published between 2000, when community crisis services were first mandated by the UK government (Johnson, 2013), and March 2021.

## Study selection and quality appraisal

Three reviewers screened documents according to the eligibility criteria and from a realist perspective for richness and relevance (Wong et al., 2013) assessed as low, medium or high, using a purpose-specific realist appraisal tool adapted from the Centre for Advancement in Realist Evaluation and Synthesis (CARES) training materials (J. Jagosh, unpulblished Data, 2021). Rigour was assessed for all those documents reporting an explicit methodology using a mixed method appraisal tool (MMAT; Hong et al., 2018). Documents were not excluded on study quality however the quality of the evidence was considered when generating the programme theories. Confidence in the findings was assessed using GRADE-CERQual (Lewin et al., 2018) against four components; (1) Methodological limitations, informed by a MMAT appraisal (Hong et al., 2018); (2) Relevance, supported by realist appraisal; (3) Coherence, the extent to which the finding is grounded in the data; and (4) Adequacy, the degree of richness and quantity of data (Lewin et al., 2018).

## Data extraction

Three reviewers iteratively extracted data between 20/07/2020 and 19/03/2021 using a purpose-specific analytical framework. Data on study characteristics including authors, year of publication, study setting, type of crisis intervention, country, number and characteristics of participants and study methods. Extracted data were attributed to explanatory links between context, mechanism or outcome (Pawson et al., 2005).

## Expert stakeholder group consultations

Fifteen expert stakeholders were recruited from across England via NHS Trusts, the voluntary sector and service user/carer networks. Experts provided written consent before participating in four stakeholder meetings between January 2020 and April 2021. Membership comprised nine stakeholders who were crisis care staff, a peer support worker, managers and commissioners, a policy expert and six who had recent experience of accessing crisis services for themselves or a family member. Diverse membership ensured that important, yet potentially hidden contextual factors were not overlooked (Harris et al., 2016). Members of the stakeholder group supported decisions about the scope of the review in phase 1 (Wong et al., 2013), provided a real-world perspective when testing programme theories in phase 2 (Murtagh et al., 2017) and supported preparation of dissemination materials.

## Individual realist interviews

Purposive strategies identified $n=19$ participants for $n=20$ individual interviews (The Rameses Projects, 2017). Participants provided expertise of crisis services from diverse perspectives including ambulance paramedic ($n=5$), police ($n=1$), mental health nursing ($n=3$), psychiatry ($n=2$), social work ($n=1$), academic ($n=1$), service managers ($n=2$), service users ($n=3$) and carer ($n=1$). Participants provided recorded verbal consent before taking part in semi-structured interviews conducted by four team members using a bank of questions developed during data extraction and were focused on phase 2 theory testing (Manzano, 2016).

## Data analysis and synthesis

Data were extracted and analysed according to each of the three initial programme theories according to a realist logic of context-mechanism-outcome (CMO) and linked to the type of crisis intervention and setting. Iterative searching, coding and grouping of CMO configurations continued until no new causal inferences were identified from the published evidence. The process of analysis was led by one research team member for each programme theory and supported by discussions between research team members and with the expert stakeholders. Individual interviews provided additional real-world insights about the veracity of the programme theories. Data from individual interviews and stakeholder consultations were synthesized with

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the programme theories and data examples presented as quotes (The Rameses Projects, 2017). A meta-synthesis across three initial programme theories identified 39 causally linked context, mechanism and outcome configurations described in three meta-synthesized themes: (1) The gateway to urgent support; (2) Values based crisis interventions and; (3) Leadership and organizational values.

# RESULTS

## Study inclusion and characteristics

A total of 77 documents were included across phase 2 theory testing (Figure 2). A summary table showing the characteristics of all included documents is available in Data S2. The research settings and focus of included documents is available in Data S3.

Thirty-eight documents were included to test Programme Theory 1 *Crisis services can be accessed urgently*. Included qualitative studies were theoretically rich and rigorous (Begum & Riordan, 2016; Chilman et al., 2021; Farrelly et al., 2015; Gudde et al., 2013; Morant et al., 2017; Olasoji et al., 2017; Sands et al., 2013a), some study samples lacked variance (Boscarato et al., 2014; Eales, 2013; Farrelly et al., 2014b, 2015; Sands et al., 2013b), and one study provided context but lacked rigour (Saurman et al., 2014). Documents included because they were highly relevant but less rigorous included literature reviews (Evans et al., 2019; O'Cathain et al., 2020; Sunderji et al., 2015), a case study (Grigg et al., 2007) and expert reports (Cambridgeshire and Peterborough NHS Foundation Trust, 2016; Duggan et al., 2020; Haslam, 2019; Mind, 2011, 2013; National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020; NHS England (NHSE), 2021b, 2021c). Mixed method studies deemed less (Lequin et al., 2021; NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M, 2020) or moderately relevant (Bendelow et al., 2019; Brown et al., 2020; Jespersen et al., 2016; Reveruzzi & Pilling, 2016; Wise-Harris et al., 2017), were limited by small samples, a lack of comparators and limited mixed method synthesis. Four Randomized Controlled Trials of joint crisis plans were less theoretically relevant (Barrett et al., 2013; Borschmann et al., 2013; Ruchlewska et al., 2014; Thornicroft et al., 2013), limited by small sample sizes (Barrett et al., 2013), under recruitment (Borschmann et al., 2013) and limitations in intervention fidelity (Thornicroft et al., 2013).

Eighteen documents were included to test Programme Theory 2 *Care in a crisis is compassionate and therapeutic*. Three documents were highly relevant and provided rich descriptions of context and mechanism (Newbigging et al., 2020; Prytherch et al., 2020; The Royal College of Psychiatrists, 2015), of these, a qualitative study lacked sample diversity (Prytherch et al., 2020) and an expert report lacked rigour (The Royal College of Psychiatrists, 2015). Documents moderately framed to the theory, reported multiple relevant phenomena (Cole-King & Gilburt, 2011; Dixon-Woods et al., 2014; Farr & Barker, 2017; Farr & Cressey, 2015; NHS England, 2014; Rafferty et al., 2017; Rees et al., 2017; Simpson, 2007; Simpson et al., 2016). Of these, four were mixed method

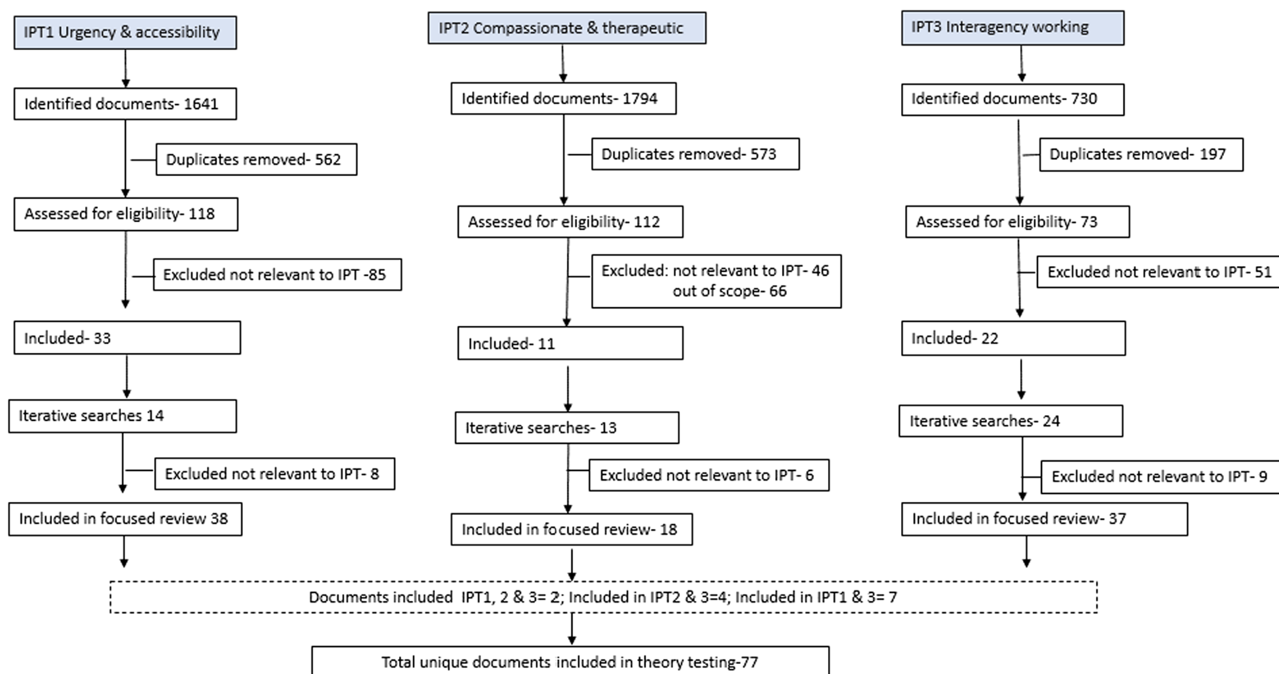


**FIGURE 2** Study selection flow chart.

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studies (Dixon-Woods et al., 2014; NHS England, 2014; Rafferty et al., 2017; Simpson et al., 2016) reporting rigorous methods, but were limited by; low response to a survey (Simpson et al., 2016); the narrow focus of the research setting (Dixon-Woods et al., 2014; Rafferty et al., 2017). A realist evaluation provided rich data related to mechanism but did not report outcomes related to the implemented Schwartz rounds (Farr & Barker, 2017). Two qualitative studies provided rich data limited by a lack of sample variation (Farr & Cressey, 2015; Simpson, 2007). Six documents were less relevant (Bögle & Boden, 2019; Farrelly et al., 2014a; Judkins et al., 2019; O'Connor & Glover, 2017); two lacked mechanisms but were retained for context related to understanding risk (Faulkner, 2012) and leadership (Firth-Cozens & Cornwell, 2009). A meta-synthesis lacked focus on community settings (O'Connor & Glover, 2017) and two qualitative studies provided rich data from small samples (Bögle & Boden, 2019; Farrelly et al., 2014a). Three documents were expert reports (Faulkner, 2012; Firth-Cozens & Cornwell, 2009; Judkins et al., 2019).

Thirty-seven documents were included to test Programme Theory 3 *Community crisis agencies work together*. Two rigorous mixed-methods studies provided rich description of context, mechanism and outcomes (Newbigging et al., 2020); however, one was limited by inconsistencies in clinical data recording (Reveruzzi & Pilling, 2016). A mixed method evaluation of the implementation of the crisis care concordat was rich in context and outcome but reported only 12 months of implementation data (Gibson et al., 2016). Three studies were less relevant providing data on contexts (Edmondson & Cummins, 2014; Hollander et al., 2012; RAND Europe et al., 2012). Although included qualitative studies provided rich description of context related to integration of police and health services they were limited in reference to mechanism and outcome (Horspool et al., 2016; McKenna et al., 2015). One qualitative study was less substantially relevant and reported a very small sample (Carson, 2018). Two literature reviews provided context related to police (Parker et al., 2018) and paramedics (Rees et al., 2015). Expert reports containing rich description of context and mechanism were moderately framed to the theory (Goodwin et al., 2012; Mental Health Foundation, 2013; National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020). Less relevant expert reports (Association of Mental Health Providers (AMHP), 2021; Griffith, 2018; Iacobucci, 2015; Lancaster, 2016; National Voices, 2013; NHS England, 2018) and policy documents (Crisis Care Concordat, 2021; Department of Health and Concordat signatories, 2014) were limited to providing local inter-agency context (Healthy London Partnership, 2016) or wider context beyond mental health services (Public Health England, 2017).

## Meta-synthesis themes

The findings are presented according to three meta-synthesized themes; (1) the gateway to urgent support; (2) values-based crisis interventions and (3) leadership and organizational values. The confidence assessment of each finding is shown in Table 2 a version including the CMO configurations is in Data S4.

## Meta-theme 1: The gateway to urgent crisis support

Eleven CMO configurations contributed to this meta-theme and the overall confidence in these findings was mixed with two CMOs assessed as high confidence, five moderate and four low or very low (Table 2).

Despite a policy focus on urgent and timely crisis interventions (National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020; National Institute for Health and Care Excellence et al., 2016; NHS England (NHSE), 2021b), and an expectation from service users to be seen the same day, and for crisis support to be available 24/7 (Morant et al., 2017), no evidence was located that linked the timing of crisis responses or waiting times with outcomes. The UK Mental Health Triage Scale (NHS England (NHSE), 2021a; Sands et al., 2013a, 2013b) designed to support decisions about the timing of responses according to assessed urgency and to facilitate resource management reports limited evidence of efficacy, measurement integrity (Sands et al., 2016) or evidence of at scale implementation (Newbigging et al., 2020). Despite the limitations of triage tools, using the structure they provide increased staff confidence when making decisions and appeared to provide a greater sense of role clarity (Brown et al., 2020; Sands et al., 2013a, 2013b).

Co-locating mental health practitioners in emergency control rooms improved the timeliness of responses (NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M, 2020; Reveruzzi & Pilling, 2016) this was related to the use of telehealth technologies in rural areas (Trondsen et al., 2014) supported by tentative evidence of cost effectiveness and sustainability (Reveruzzi & Pilling, 2016). Co-response models provide opportunity for parallel assessments that reduced the likelihood of traumatic re-telling (Haslam, 2019), improve collaboration between staff (Evans et al., 2019), led to more rapid responses (Eales, 2013; Evans et al., 2019; NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M, 2020; Reveruzzi & Pilling, 2016) that an interviewee believed saved time and were more accurate (NC1, mental health nurse).

Complex referral processes such as gatekeeping are viewed by service users as a barrier (Gudde et al., 2013).

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**TABLE 2** Summary of confidence in findings.

| Meta-synthesized themes | Summary CMO focus | IPTs | Studies | CERQUal assessment | Explanation of CERQual |
|---|---|---|---|---|---|
| The gateway to crisis support | Routes into crisis services | 1,3 | Newbigging et al. (2020), Ball et al. (2005), Allen and Campbell (2018), Olasoji et al. (2017), O'Cathain et al. (2020), Grigg et al. (2007), Reveruzzi and Pilling (2016), Borschmann et al. (2013), Rees et al. (2017) | Moderate confidence | Moderate methodological limitations and minor concerns about coherence, adequacy and relevance. |
| | Early navigation to help | 1 | Mind (2011), Newbigging et al. (2020), Morant et al. (2017), Boscarato et al. (2014), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), Olasoji et al. (2017), O'Cathain et al. (2020), Wise-Harris et al. (2017), Jespersen et al. (2016), Eales (2013), Goodwin et al. (2012) | Moderate confidence | Moderate methodological limitations, minor concerns about coherence, adequacy and relevance. |
| | Ease of access and referral | 1,2 | Mind (2012), Newbigging et al. (2020), Morant et al. (2017), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), NHS England (NHSE) (2021c), NHS England (NHSE) (2021a), Bendelow et al. (2019), O'Cathain et al. (2020), Brown et al. (2020), NHS England (NHSE) (2021b), Bögle and Boden (2019), O'Connor and Glover (2017), Judkins et al. (2019), Prytherch et al. (2020) | Low confidence | Serious concerns regarding methodological limitations, moderate concerns about adequacy of data and minor concerns about coherence and relevance. |
| | Services fit around personal circumstances | 1,2 | Mind (2012), Newbigging et al. (2020), NHS England (NHSE) (2021c), Bendelow et al. (2019), O'Cathain et al. (2020), Reveruzzi and Pilling (2016), NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M (2020), Mind (2013), Jespersen et al. (2016), Eales (2013), Saurman et al. (2014), Trondsen et al. (2014), Carson (2018) | Moderate confidence | Moderate methodological limitations, minor concerns about coherence, adequacy and relevance. |
| | 24/7 access and same day responses | 1 | Mind (2011), Newbigging et al. (2020), Morant et al. (2017), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), Sands et al. (2013b), Olasoji et al. (2017), O'Cathain et al. (2020), Wise-Harris et al. (2017), Eales (2013), Barrett et al. (2013), Farrelly et al. (2014a), Farrelly et al. (2015) | Moderate confidence | Minor methodological limitations. Minor concerns about coherence, adequacy and relevance. |
| | System navigators | 3 | Edmondson and Cummins (2014), National Voices (2013), Dixon-Woods et al. (2014), Goodwin et al. (2012), Mental Health Foundation (2013), RAND Europe et al. (2012) | Very low confidence | Serious methodological limitations, moderate concerns about adequacy and minor concerns about coherence and relevance. |
| | Gatekeeping | 1 | Mind (2011), Morant et al. (2017), Sands et al. (2013b), Begum and Riordan (2016), Gudde et al. (2013), Grigg et al. (2007), NHS England (NHSE) (2021b) | High confidence | Minor methodological limitations and no concerns about coherence and adequacy and relevance. |
| | Shared decision-making | 1,2 | Mind (2011), Bendelow et al. (2019), NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M (2020), Begum and Riordan (2016), Mind (2013), Trondsen et al. (2012), Barrett et al. (2013), Borschmann et al. (2013), Farrelly et al. (2014a), Farrelly et al. (2015), Ruchlewska et al. (2014), Thornicroft et al. (2013) | High confidence | Minor methodological limitations and no concerns about coherence and adequacy and relevance. |
| | Trauma-informed parallel assessment | 1–3 | Reveruzzi and Pilling (2016), Hollander et al. (2012), Prytherch et al. (2020), Farrelly et al. (2014a), Haslam (2019), NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M (2020) | Low confidence | Moderate methodological limitations. Moderate concerns about coherence and adequacy, minor concerns about relevance. |
| | Evidence-based decision-making | 1,3 | Brown et al. (2020), Morant et al. (2017), Newbigging et al., (2020), NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M (2020), Reveruzzi & Pilling (2016), Sands et al. (2013a, 2013b), Thornicroft et al. (2013) | Low confidence | Moderate methodological limitations and moderate concerns about coherence. Minor concern about adequacy and relevance. |
| | Time for assessment | 1 | Bendelow et al. (2019), Chilman et al. (2021), Duggan et al. (2020), Eales (2013), Farrelly et al. (2014a, 2015), Gudde et al. (2013), Haslam (2019), Mind (2011), Newbigging et al. (2020), Olasoji et al. (2017), Sands et al. (2013a), Wise-Harris et al. (2017) | Moderate confidence | Minor methodological limitations and no concerns about coherence, adequacy and relevance. |

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**TABLE 2** (Continued)

| Meta-synthesized themes | Summary CMO focus | IPTs | Studies | CERQUal assessment | Explanation of CERQual |
|---|---|---|---|---|---|
| Values-based crisis interventions | Guaranteed service response | 1 | Boscarato et al. (2014), Eales (2013), Goodwin et al. (2012), Jespersen et al. (2016), Mind (2011), Morant et al. (2017), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), Newbigging et al. (2020), O'Cathain et al. (2020), Olasoji et al. (2017), Wise-Harris et al. (2017) | Moderate confidence | Moderate methodological limitations, no concerns about adequacy and minor concerns about coherence and relevance. |
| | Safe spaces | 1,3 | Bögle & Boden (2019), Dixon-Woods et al. (2014), Farrelly et al. (2014a), Healthy London Partnership (2016), Newbigging et al. (2020), Prytherch et al. (2020) | Low confidence | Moderate methodological limitations, moderate concerns about coherence and adequacy and minor concerns about relevance. |
| | Non-clinical safe spaces, open access and peer support | 1–3 | Newbigging et al. (2020), Mind (2013), Eales (2013), Farrelly et al. (2015), Bögle and Boden (2019), Judkins et al. (2019), Healthy London Partnership (2016) | Moderate confidence | Moderate methodological limitations, minor concerns about adequacy and no concerns about coherence and relevance. |
| | Family and friends first | 1 | Newbigging et al. (2020), NHS England (NHSE) (2021b), Sands et al. (2013a), Bendelow et al. (2019), Olasoji et al. (2017), Begum and Riordan (2016), Brown et al. (2020), Eales (2013), Trondsen et al. (2014), Farrelly et al. (2014a) | Moderate confidence | Moderate methodological limitations and minor or no concerns about coherence, adequacy and relevance. |
| | A proxy for family | 1,3 | Newbigging et al. (2020), Bendelow et al. (2019), Farrelly et al. (2014a), Farrelly et al. (2015), Judkins et al. (2019), National Voices (2013) | Moderate confidence | Minor methodological limitations and minor concerns about coherence, adequacy and relevance. |
| | Peer support | 1 | Newbigging et al. (2020) | Very low confidence | Minor methodological limitations, serious concerns about coherence and adequacy and no concerns about relevance. |
| | Therapeutic skills, risk and relational safety- Frontline | 1,2 | Mental Health Foundation (2013), Newbigging et al. (2020), Simpson et al. (2016), Prytherch et al. (2020), Faulkner (2012), Dixon-Woods et al. (2014) | Moderate confidence | Minor methodological limitations and minor concerns about coherence and adequacy and relevance. |
| | Immediate supportive responses | 1,2 | Mind (2011), Newbigging et al. (2020), NHS England (NHSE) (2021a), Chilman et al. (2021), Eales (2013), Borschmann et al. (2013), Farrelly et al. (2014a), Lequin et al. (2021), Rees et al. (2015), Judkins et al. (2019), Faulkner (2012) | Moderate confidence | Moderate methodological limitations. Minor concerns about coherence, adequacy and relevance. |
| Leadership and organizational values | Compassionate crisis responses | 1,2 | Newbigging et al. (2020), Chilman et al. (2021), Cambridgeshire and Peterborough NHS Foundation Trust (2016), Trondsen et al. (2014), Farrelly et al. (2014a), Ruchlewska et al. (2014), The Royal College of Psychiatrists (2015), Rafferty et al. (2017), Strauss et al. (2016), Rees et al. (2015), Bögle and Boden (2019), O'Connor and Glover (2017), Judkins et al. (2019), Dixon-Woods et al. (2014), Farr and Barker (2017) | Moderate confidence | Minor methodological limitations. Minor concerns about coherence, adequacy and relevance. |
| | Crises as part of recovery | 1–3 | Mind (2011), Newbigging et al. (2020), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), Sands et al. (2013b), Bendelow et al. (2019), Wise-Harris et al. (2017), Mind (2013), Duggan et al. (2020), Eales (2013), Haslam (2019), Trondsen et al. (2014), Thornicroft et al. (2013), Judkins et al. (2019) | Low confidence | Serious methodological limitations. Moderate concerns about coherence and adequacy and minor concerns about relevance. |

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**TABLE 2** (Continued)

| Meta-synthesized themes | Summary CMO focus | IPTs | Studies | CERQUal assessment | Explanation of CERQual |
|---|---|---|---|---|---|
| | Managed waiting | 1,2 | Mind (2011), Newbigging et al. (2020), Morant et al. (2017), Sunderji et al. (2015), Sands et al. (2013a), Sands et al. (2013b), O'Cathain et al. (2020), Gudde et al. (2013), Eales (2013), Haslam (2019), The Royal College of Psychiatrists (2015), Bögle and Boden (2019), Judkins et al. (2019), Prytherch et al. (2020) | Moderate confidence | Moderate methodological limitations and minor concerns about coherence, adequacy and relevance. |
| | Organizational culture and therapeutic relationships | 1,2 | Barrett et al. (2013), Farrelly et al. (2014b), Lequin et al. (2021), Borschmann et al. (2013), Simpson et al. (2016), O'Connor and Glover (2017), Ruchlewska et al. (2014) | Low confidence | Moderate methodological limitations and concerns about coherence. Minor concerns about adequacy and relevance. |
| | Co-production and stigma reduction | 2,3 | Mind (2011), Newbigging et al. (2020), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), Mind (2013), Farrelly et al. (2014a), Faulkner (2012), Farr and Cressey (2015), Mental Health Foundation (2013), Iacobucci (2015), National Voices (2013) | Very low confidence | Serious methodological concerns. Serious concerns about coherence, moderate concerns about relevance and minor concern about adequacy. |
| | Diversity and inclusion | 3 | Farr and Cressey (2015), Mind (2013), Mind (2011), Newbigging et al. (2020), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), Farrelly et al. (2014a) | Low confidence | Moderate methodological limitations, minor concerns about coherence, moderate concerns about relevance and serious concerns about adequacy. |
| | Supportive clinical leaders | 1–3 | Newbigging et al. (2020), Sands et al. (2013a), Brown et al. (2020), Grigg et al. (2007), Trondsen et al. (2014), Farr and Barker (2017), The Royal College of Psychiatrists (2015), Farr and Cressey (2015) | Moderate confidence | Moderate methodological limitations and minor concerns about coherence, adequacy and relevance. |
| | Leaders buffer external demands | 1,3 | Newbigging et al. (2020), Sands et al. (2013a), Chilman et al. (2021), Brown et al. (2020), Grigg et al. (2007), Trondsen et al. (2014), The Royal College of Psychiatrists (2015), Simpson et al. (2016), Firth-Cozens and Cornwell (2009), NHS England (2014), Farr and Cressey (2015), McKenna et al. (2015) | Moderate confidence | Moderate methodological limitations and moderate concerns about coherence. Minor concern about adequacy and relevance. |
| | Definitions, values and interagency affiliation | 1,3 | Newbigging et al. (2020), Olasoji et al. (2017), Mind (2013), Duggan et al. (2020), Rafferty et al. (2017), The Royal College of Psychiatrists (2015), Dixon-Woods et al. (2014), Farr and Cressey (2015), Simpson (2007), Mental Health Foundation (2013) | Low confidence | Serious methodological limitations. Moderate concerns about coherence and adequacy and minor concerns about relevance. |
| | Interagency co-location | 1,3 | Reveruzzi and Pilling (2016), Evans et al. (2019), NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M (2020), Eales (2013) | Low confidence | Minor methodological limitations. Serious concerns about adequacy, minor concerns about coherence and relevance |
| | Technology and information sharing | 1,3 | Newbigging et al. (2020), Sands et al. (2013a), Olasoji et al. (2017), Reveruzzi and Pilling (2016), NHS (2020), Mental Health Foundation (2013), Horspool et al. (2016) | Low confidence | Moderate methodological limitations and concerns about coherence, adequacy and relevance. |
| | Compassionate leadership | 2,3 | NHS England (2014), Faulkner (2012), Strauss et al. (2016), Farr and Barker (2017), Simpson et al. (2016), Rafferty et al. (2017), Prytherch et al. (2020), Dixon-Woods et al. (2014), Thornicroft et al. (2013), Lancaster (2016), O'Cathain et al. (2020) | Moderate confidence | Moderate methodological limitations and minor concerns about coherence, adequacy and relevance. |
| | Interagency role clarity | 1,3 | Newbigging et al. (2020), Morant et al. (2017), Rees et al. (2017), Hollander et al. (2012), Lancaster (2016), Bowles and Jones (2005) | High confidence | Minor methodological limitations and minor concern about coherence, adequacy and relevance. |

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**TABLE 2** (Continued)

| Meta-synthesized themes | Summary CMO focus | IPTs | Studies | CERQUal assessment | Explanation of CERQual |
|---|---|---|---|---|---|
| | Interagency staff support | 2,3 | Rafferty et al. (2017), NHS England (2014), Dixon-Woods et al. (2014), Cole-King and Gilburt (2011), Judkins et al. (2019), Farr and Barker (2017), Faulkner (2012) | Low confidence | Serious methodological limitations. Minor concerns about coherence, adequacy and relevance. |
| | Interagency commissioning | 3 | Lancaster (2016), Cole-King and Gilburt (2011), Department of Health (2000), Newbigging et al. (2020), Parker et al. (2018), Public Health England (2017), O'Cathain et al. (2020) | Moderate confidence. | Minor methodological limitations, minor concerns about coherence, adequacy and relevance. |
| | Boundary management | 1,3 | Newbigging et al. (2020), Morant et al. (2017), Sands et al. (2013b), Cambridgeshire and Peterborough NHS Foundation Trust (2016), Farr and Cressey (2015), Public Health England (2017), Simpson (2007), Hollander et al. (2012), Mental Health Foundation (2013), Begum and Riordan (2016), Department of Health and Concordat signatories (2014), Goodwin et al. (2012), Edmondson and Cummins (2014), Healthy London Partnership (2016) | Low confidence | Serious methodological limitations, moderate concerns about coherence and minor concerns about adequacy and relevance. |
| | Continuity and stability | 1,3 | Mind (2011), Newbigging et al. (2020), Sands et al. (2013b), Brown et al. (2020), Trondsen et al. (2014), Borschmann et al. (2013), Farrelly et al. (2014a), Farrelly et al. (2015), Public Health England (2017), Mental Health Foundation (2013), Begum and Riordan (2016), Faulkner (2012), Healthy London Partnership (2016) | Moderate confidence | Minor methodological limitations. Moderate concern about adequacy, minor concern about coherence and relevance. |
| | Implementation and change | 1,3 | Borschmann et al. (2013), Thornicroft et al. (2013), Farrelly et al. (2015), Lequin et al. (2021) | Very low confidence | Moderate methodological limitations. Serious concerns about coherence, moderate concerns about adequacy and minor concerns about relevance. |
| | Evaluating interagency crisis services | 2,3 | Newbigging et al. (2020), NHS England (2014), Faulkner (2012), Farr and Cressey (2015), Dixon-Woods et al. (2014) | Low confidence | Moderate methodological limitations, concerns about coherence and relevance. Serious concerns about adequacy. |
| | National standards and local implementation | 3 | Department of Health and Concordat signatories (2014), Crisis Care Concordat (2021), National Collaborating Centre for Mental Health and Positive Practice in Mental Health (2020), Horspool et al. (2016), Gibson et al. (2016), NHS England (NHSE) (2021a), Reveruzzi and Pilling (2016), Goodwin et al. (2012), Healthy London Partnership (2016) | Low confidence | Serious methodological limitations. Moderate concern about adequacy and minor concerns about coherence and relevance. |

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People are reassured when crisis services that require low effort to navigate, are available 24/7 (Mind, 2011; Morant et al., 2017; Newbigging et al., 2020; O'Cathain et al., 2020; Reveruzzi & Pilling, 2016) and are not burdensome to access (Newbigging et al., 2020; NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M, 2020; O'Cathain et al., 2020; Reveruzzi & Pilling, 2016; Saurman et al., 2014) with minimum unnecessary disruption to family life (Newbigging et al., 2020; Reveruzzi & Pilling, 2016; Trondsen et al., 2014). Conversely, staff in Crisis Resolution Teams valued the role of gatekeepers, originally intended to reduce hospital admissions, but also viewed by staff as a means to control workload (Begum & Riordan, 2016), although the evidence did not clearly show that gatekeeping achieves these outcomes. Fears about being overwhelmed made NHS frontline staff reticent about the open access service designs (Begum & Riordan, 2016).

The timeliness of responses improved when frontline staff had knowledge about available crisis services (National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020), adequate resources (Haslam, 2019; Morant et al., 2017) and training, support and supervision (Brown et al., 2020; Newbigging et al., 2020; Sands et al., 2013b; Thornicroft et al., 2013). Staff confidence improved when there was adequate time to complete assessments and support for them was *immediately* available (Brown et al., 2020; Newbigging et al., 2020; Sands et al., 2013a; Trondsen et al., 2014). This in turn improved the process of access to crisis care through improved assessment accuracy (Brown et al., 2020) increased likelihood of staff acknowledging the person's perception of urgency (Chilman et al., 2021; Farrelly et al., 2014a, 2015; Mind, 2011; Olasoji et al., 2017), meaning that people in crisis were more likely to report being taken seriously (Mind, 2011; National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020; Newbigging et al., 2020; Trondsen et al., 2014), and this reduced their sense of urgency (Lequin et al., 2021; Mind, 2011; Newbigging et al., 2020; Sands et al., 2013b) and enabled shared decision-making (Thornicroft et al., 2013).

## Meta-theme 2: Values based crisis interventions

Eleven CMO configurations contributed to this meta-synthesized theme. The confidence in these findings was mixed, none assessed as high, eight moderate and three low or very low (Table 2).

Service users placed high importance on continuity and relational safety (Newbigging et al., 2020) but often report added stress due to service fragmentation and discontinuity between crisis services (Farrelly et al., 2014a). Successfully integrated care can provide an opportunity for exploring different values within an interagency system, especially when integration includes voluntary sector services that challenge stigmatizing attitudes (Newbigging et al., 2020). Integration of services, such as between police and mental health services, can contribute to reduced Mental Health Act detentions (Carson, 2018; Horspool et al., 2016) through knowledge sharing and collaboration at the front line. Although based on single site evaluations and limited health economic data, there are suggested resource efficiencies through reduced need for transportation by ambulance or police (NHS England, & NHS Improvement, London Ambulance Service, & Trainer, M, 2020) and emergency department attendance (Reveruzzi & Pilling, 2016).

In a crisis, people often contacted family or friends first, but when this was not an option (Bendelow et al., 2019; Farrelly et al., 2014a), contact with community services providing non-clinical approaches including peer support (Mind, 2011; Newbigging et al., 2020) appeared to offer a proxy for the continuity and relational safety family and friends may often provide (Newbigging et al., 2020). User-focused interventions such as peer support (National Voices, 2013) enabled people in crisis to recognize services as being designed ‘for them’ and this generated engagement (Healthy London Partnership, 2016; National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020; Newbigging et al., 2020; Public Health England, 2017). More generally, crisis services are perceived as approachable when frontline staff, provided *immediate* interventions to reduce distress (Sands et al., 2013b) thereby generating hope, relational safety (Newbigging et al., 2020), improved therapeutic relationships (Barrett et al., 2013; Thornicroft et al., 2013) and help to calm the crisis situation (Eales, 2013; Newbigging et al., 2020).

Compassion is hard to evaluate and as a result, some included studies were descriptive, and findings relied on expert reports rather than rigorous evaluation. Compassionate care is experienced by people in crisis when they form supportive person-centred (Farr & Barker, 2017), trusting relationships (Bögle & Boden, 2019), they retain control (Farrelly et al., 2014a) and when safety is balanced with independence in a collaborative way (Faulkner, 2012; Prytherch et al., 2020). This can be achieved when compassion forms part of a transparent organizational philosophy (Simpson et al., 2016) that can be modelled by leaders (Cole-King & Gilburt, 2011; Firth-Cozens & Cornwell, 2009) and emulated by staff (Dixon-Woods et al., 2014) thereby connecting staff to their humanity and the goals of the organization (NHS England, 2014) and generating status for those who provide compassionate care (Firth-Cozens & Cornwell, 2009; The Royal College of Psychiatrists, 2015). When compassionate care is prioritized in these ways, the professional and personal values of staff can become aligned, there is affiliation between the staff, leaders and the organization and this improves

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satisfaction at work (Dixon-Woods et al., 2014; Farr & Cressey, 2015).

An embedded culture of reflective practice is fundamental to enabling compassionate care, not only for staff but also for leaders (Farr & Cressey, 2015). Supervision and debriefing (Farr & Cressey, 2015; O'Connor & Glover, 2017) with 'someone senior who has more experience than you' safeguards against the 'echo chamber you get with peers' (LS7, Psychiatrist) and provides opportunities for feedback and discussion (Firth-Cozens & Cornwell, 2009). In these circumstances, frontline staff feel empowered (Simpson, 2007) to engage in problem solving (The Royal College of Psychiatrists, 2015) and to challenge poor practice (NHS England, 2014; The Royal College of Psychiatrists, 2015).

Limited options for primary care crisis support coupled with stringent crisis services access thresholds (Newbigging et al., 2020; Sands et al., 2013b) can leave people in crisis feeling abandoned (Gudde et al., 2013). In these circumstances, they lose trust in crisis services and resort to calling blue light services (Olasoji et al., 2017), attending emergency departments where they believe they are guaranteed a response (O'Cathain et al., 2020) or through a sense of frustration, resort to contacting multiple services (Gudde et al., 2013; Mind, 2011; Morant et al., 2017; Newbigging et al., 2020; Wise-Harris et al., 2017). Negative staff attitudes about those who attend services more than once may be related to a belief that a crisis is a single event (Newbigging et al., 2020) rather than part of a recovery process and may be causal in driving multiple crisis contacts rather than preventing them;

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

If however services are perceived by those in crisis as providing a guaranteed response (Eales, 2013; O'Cathain et al., 2020) this generates trust (Jespersen et al., 2016; Morant et al., 2017; Newbigging et al., 2020; O'Cathain et al., 2020; Olasoji et al., 2017) and a sense of safety (Jespersen et al., 2016; Mind, 2011; Newbigging et al., 2020; Olasoji et al., 2017) leading to a greater tolerance for the discomfort of waiting for follow-up (Eales, 2013; O'Cathain et al., 2020) and may reduce the likelihood of multiple or repeat attendances.

## Meta-theme 3: Leadership and organizational values

Seventeen CMO configurations contributed to this meta-synthesized theme. Overall confidence in findings was mixed with one CMO assessed as high, five as moderate and 11 as low or very low (Table 2).

Staff ability to focus on the psychosocial context of distress and provide emotional safety (Prytherch et al., 2020) is optimized when they are supported by their organization (Farr & Barker, 2017; Farr & Cressey, 2015) and work within a stable staff group (The Royal College of Psychiatrists, 2015). When leaders are accessible and close to the frontline of service delivery, staff understand their accountability, implement care within clear and predictable boundaries, which maintain safety (O'Connor & Glover, 2017), enabling the deployment of 'the least restrictive intervention' (LS7, Psychiatrist). This is because anxieties about risk are managed through clear organizational structures, procedures, and collaborative working (O'Connor & Glover, 2017). Frontline staff respond by focusing on care, shared decision-making and negotiation (Faulkner, 2012) rather than enforcing potentially traumatizing, coercive or rule-bound practices (Prytherch et al., 2020; The Royal College of Psychiatrists, 2015).

Tension between service efficiency and the interpersonal and relational aspects of care (Farr & Cressey, 2015; NHS England, 2014) detract from service user priorities such as compassion and psychological safety (Farr & Barker, 2017; NHS England, 2014). Co-production enables service user and staff feedback to be heard, even when the content is uncomfortable or challenging (Dixon-Woods et al., 2014; NHS England, 2014; The Royal College of Psychiatrists, 2015), optimizing the likelihood that the aspirations of service users will be encapsulated in the delivery, monitoring and evaluation of services. Co-production also connects individuals and communities with local crisis services (Mind, 2011; Newbigging et al., 2020) because there is mutual trust and ownership (Mental Health Foundation, 2013; National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020) and opportunity for inclusion of people from diverse backgrounds (Mind, 2013). Involvement in this way reduces fear and shame (Farrelly et al., 2014a; Mind, 2012; National Collaborating Centre for Mental Health & Positive Practice in Mental Health, 2020) motivating people to become active in their own recovery (Newbigging et al., 2020) and to 'give back' [ESG member] in their community.

Outcome data related to how interagency crisis care operates across geographical, organizational and professional boundaries (Faulkner, 2012; McKenna et al., 2015) is lacking and yet this data is crucial when commissioning services to avoid boundary disputes (Newbigging et al., 2020). Successful interagency working requires agencies to have links across the whole system (Department of Health and Concordat signatories, 2014) yet these links are subject to temporal changes as services are commissioned and decommissioned in isolation from system requirements. This often results

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in high staff turnover and frequent service reconfiguration (Newbigging et al., 2020) making it impossible for staff to have a systemic understanding of the network they are part of. A lack of integration results in fragmented services that may lead to 'responsibility cordons' creating service gaps that leave people in crisis ill informed, distressed and at risk (Dixon-Woods et al., 2014; Newbigging et al., 2020).

Co-response models of crisis care (Horspool et al., 2016; Reveruzzi & Pilling, 2016) can facilitate interpersonal contact between colleagues with different expertise providing instant access to specialist advice and sharing of good practice (Crisis Care Concordat, 2021; Reveruzzi & Pilling, 2016). By drawing on each other's expertise, decision-making becomes collaborative and frontline staff draw on reciprocal links to services and service knowledge (Gibson et al., 2016). This may promote professional trust and mutual respect for expertise (Horspool et al., 2016) and generate a shared language (Hollander et al., 2012). When frontline staff have clarity about their own role (McKenna et al., 2015) confidence and decision-making are enhanced thereby reducing suspicion and cynicism about other roles across an interagency landscape (Newbigging et al., 2020). Frontline staff respond by engaging in development of shared goals in the context of mutual understanding of each other's role, and the overall '*landscape of demand*' (Gibson et al., 2016; p. 22). All of this points to the relationships between staff in different agencies being as important to successful interagency working as the structural aspects of the system (Mental Health Foundation, 2013).

# DISCUSSION

The aim of this realist review was to identify mechanisms to explain how, for whom and in what circumstances community mental health crisis services for adults work to resolve crises. Our synthesis focused on the initial help-seeking phase of crisis care and through testing of three initial programme theories identified 39 CMO configurations that were organized into three meta-synthesized themes; (1) the gateway to urgent support; (2) values based crisis interventions and (3) leadership and organizational values.

Findings from the meta-synthesis resonates with several middle range theories related to interagency collaboration, feeling in control, breaking points in a crisis, strengths perspectives, interpersonal relationships and protection motivation theory. Although urgency (linked to perceived need) and accessibility (linked to a response that meets that need) are conceptually different they are very closely related in the minds of people in crisis who adopt strategies to negotiate access to mental health care when emotions become overwhelming and harmful behaviours become likely (Fallon, 2003). A sense of urgency may increase when there are interpersonal difficulties or delays in accessing services which may drive people to contact urgent care (Heyman, 2020) or make multiple contacts with different agencies. There is a paucity of research exploring the link between decisions in triage and access to appropriate crisis responses across an interagency system and how this is experienced by people in crisis. Taking an interagency approach to such research may uncover important insights into differences in values driving decisions and support closing of gaps and delays between services.

Kindness and compassion are highly valued by people in crisis (Dalton-Locke et al., 2021), yet, these attributes are often lacking in mental health crisis care (Care Quality Commission, 2015). When services resort to dispassionate or coercive powers, people lose their sense of personal control (Ball et al., 2005) which may cause trauma (Mirabito, 2017) and may serve to 'frame' the service users' subsequent perceptions of crisis mental health services (Stangl et al., 2019). Research is needed to develop evaluation approaches that can measure the presence and impact of mechanisms including psychological and relational safety, compassion and trust, as these are important to producing positive outcomes in crisis care.

The identity of an organization as compassionate can be perceived from early contact and contributes positively to impressions of accessibility. Through the presence of a rapport between professionals and service users, the recovery alliance theory (Shanley & Jubb-Shanley, 2007) can be seen as a facilitator of access but requires a compassionate environment. Seminal theories explaining person-centred care approaches strongly resonate with our analysis including recovery alliance theory (Shanley & Jubb-Shanley, 2007), Goffman's sociological theory, Forms of Talk (Goffman, 1981) and compassion in psychotherapy (Vivino et al., 2009). This emphasizes the need for staff to receive training and supervision to enable them to sustain their compassion when engaging with distress daily (Allen & Campbell, 2018; Brown et al., 2020; McEwan et al., 2020).

Our synthesis identified compassion as not simply an attribute of individual staff with whom service users come into contact. Organization leaders hold the potential to influence the culture of their organization; to make it more compassionate. Routes to achieving culture change lie within Social Innovation theory (Farmer et al., 2018) whereby organization leaders consciously strive to innovate, they do this within structures that facilitate change, they are open to cross-fertilization of ideas, including from other agencies and the communities they serve.

Managing access in a complex interagency landscape is challenging because it not only requires a knowledge of the needs of individuals in crisis, but it also requires an overview of the current usage and availability of the services as a whole (Dalton-Locke et al., 2021). Inconsistency of coverage, particularly

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at the boundaries of different crisis agencies and in rural areas remains an important issue. The findings suggest that a fragmented cross-agency response may exacerbate the challenges of the first response (Winters et al., 2015). This can operate at a practical level, in terms of delays, or in having to repeat one's history multiple times to different agencies risking trauma (Eales, 2013; Mirabito, 2017). This leads to service users being hastily referred from one agency to the next, often without reaching any intervention, because agencies are working in isolation. Equally, a disjointed response may lead to those in crisis believing that their concerns are unimportant (Gudde et al., 2013). These experiences signal a need for services to offer integrated help-seeking pathways for people in crisis (Hollander et al., 2012) that include a range of providers that together can accommodate and respond to different values and definitions of mental health crises.

Help seeking pathways can be conceptualized in two ways; the 'contingency' approach, that correlates service usage with clinical and sociodemographic profiles of service users, and the 'process oriented' approach, that focuses on social and interpersonal processes that affect help-seeking behaviour (Pescosolido, 1991). Pathways into mental health crisis services align to both 'contingency' and 'process' approaches as the route into care can be a product of personal choice (O'Cathain et al., 2020). Similarly, the perceived accessibility of the response depends upon the configuration of the collective inter-agency response. Where collaboration works well it can lead to an improved understanding of roles and responsibilities in the 'other' agency and lead to the development of local agreements for information sharing. Furthermore, referral to existing services is a key function (Horspool et al., 2016) that may require a response that bypasses repeated contact, and reinforcement of relationships within the same single agency, requiring instead targeted, co-developed responses from multi-agencies. Different models of interagency working operating in crisis services provide an opportunity for mixed method case study approaches to evaluate configurations that produce optimal outcomes.

This complexity extends to interventions such that joint training may include mutual understanding that facilitates appropriate referral and may also help in extending a compassionate and caring environment beyond an organization's peripheries to its points of contact and interactions with other agencies. Nevertheless, tensions may arise as agencies working towards a common goal find themselves competing for available resources (Horspool et al., 2016). Often however, help seeking in a crisis is less than optimal and conflicts with expectations for accessible service responses because people feel coerced or simply manage by 'muddling through' (Amaral et al., 2018).

### Strengths and limitations

This review is the first realist evidence synthesis of community crisis services and includes a wider range of settings than previous reviews to reflect the complexity of the community crisis care landscape. This review conceived a mental health crisis as an urgent event with a limited time window within which the first point of contact must demonstrate accessibility and a responding organization must reveal its response as compassionate and caring. Existing literature has represented a mental health crisis as a biographical disruption (Newbigging et al., 2020). While some of this difference may be attributed to contrasting individual and service provider perspectives, once beyond the initial issue of access, a compassionate and supportive environment can similarly accommodate a biographical disruption model.

One constraint is that many of the studies included in our review give only a cursory description of the context and content of the crisis management services described. Outcomes extracted, particularly at an individual level, were theoretical and often based on methodologically limited studies. The use of iterative searching and adherence to documented realist methodologies has provided confidence that data inclusion was optimized. The inquiry has focused on those areas considered most important to stakeholders, including service users, commissioners and crisis care clinicians. Changes to the protocol included delays in obtaining NHS ethical approvals and recruitment to interviews, a smaller than planned interview sample and a move to online stakeholder consultation due to the impact of COVID-19 pandemic.

## CONCLUSION

Compassionate care is central to positive outcomes in crisis care and starts with leaders who have influence over the culture of organizations. Therefore, compassion is as relevant from commissioning processes through leaders and frontline staff, as it is to the service user experience. These findings suggest that there is no single definition of a mental health crisis, and they are rarely single events. Interagency working may improve accessibility of crisis care but requires commitment and leadership to succeed. Interpersonal contact between frontline staff within an interagency system can improve communication, generate positive values and improve understanding of different responsibilities and roles across the interagency crisis services landscape. The complexity of crisis services can be managed through greater clarity at the boundaries of services and how they operate together, facilitating seamless and timely referral. This would also enable crisis responses to be easier to navigate, reduce the risk

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of trauma through unnecessary re-telling thus generating trust in the people and communities they serve.

## RELEVANCE FOR CLINICAL PRACTICE

To provide optimal care, community crisis services should be conceptualized and configured, to deliver joined-up interagency care that minimizes risks of re-traumatizing people in crisis and providing care that is experienced as compassionate. This relies on availability of clinical leaders who model compassion and operate close to service delivery to support staff. Such leadership can improve decision-making and avoiding the harm caused to all concerned by compassion fatigue. People with lived experience and their family members have valuable expertise and should be involved in organizational decision-making as well as in their own care.

### AUTHOR CONTRIBUTIONS

Nicola Clibbens, Andrew Booth, John Baker and Scott Weich designed the study. Andrew Booth and an information specialist conducted iterative literature searches. Nicola Clibbens, Leila Sharda and Kathryn Berzins extracted and analysed data. All authors were involved in realist synthesis of data. Andrew Booth integrated middle range theory. Michael Ashman recruited stakeholders, and Michael Ashman and Jill Thompson co-chaired the expert stakeholder group and integrated stakeholder data with the synthesis. Jill Thompson, Leila Sharda, Nicola Clibbens, Kathryn Berzins collected and synthesized data from individual interviews. Nicola Clibbens and Sarah Kendal wrote the study report. All authors have contributed to and approved the final version of the manuscript.

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Ruth Wong, Information specialist University of Sheffield designed the search strategy and carried out all evidence searches.

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### CONFLICT OF INTEREST STATEMENT

All authors declare no conflict of interest.

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