BRIEFING 64

CENTRE FOR MENTAL HEALTH

CRISIS AND ACUTE MENTAL HEALTH CARE

Summary

- Urgent and emergency mental health care saves lives. It is an essential, but often overlooked, part of our NHS.
- Care in a mental health crisis is provided in a range of both hospital and community settings, including emergency departments, inpatient wards, community crisis services, and both residential and non-residential alternatives to admission.
- Crisis and inpatient mental health services are facing significant challenges. These include long waits in emergency departments, enduring workforce shortages, coercive treatment, a lack of therapeutic activity in wards, and outdated and unsuitable facilities.
- Models of crisis care in the community vary widely across the country. There is a mismatch between evidence and practice in the provision of crisis care, with variable implementation of evidence-based approaches and widespread adoption of models that do not yet have a clear evidence base.
- Some existing mental health crisis services operate with exclusion criteria which mean that certain groups of people, including children, young adults, and those with co-occurring conditions, are unable to access support.
- Adopting trauma-informed and relational approaches in acute inpatient services may help to reduce the risk of harm and restrictive interventions, but if they are not accompanied by systemic reform their benefits may be limited.
- Surveillance technology has been adopted in many inpatient mental health services without robust evidence of its safety or efficacy.

RECOMMENDATIONS

1. The NHS in England should invest in mental health crisis care, addressing gaps in provision and updating estates which are no longer fit for purpose, with decisions about investment priorities being led by the available evidence of what is safe and effective.
2. Integrated care boards and NHS mental health service providers should review whether their crisis and acute care provision is sufficient to meet the needs of their populations, and whether it is based on currently available evidence of safety and effectiveness.
3. Mental health service providers and commissioners should work in partnership with a wide range of service users, carers, and community- and user-led organisations to co-design crisis and acute mental health services.
4. Mental health service providers should not routinely use surveillance technology except as part of robust trials of its safety, acceptability, and effectiveness.
5. Research funders should prioritise evaluations and trials of community-based crisis care, of ways to avoid compulsory admissions, of ways to make hospitals safer and more therapeutic, and of alternatives to hospital admission.

The National Institute for Health and Care Research (NIHR) Policy Research Unit in Mental Health (MHPRU) at University College London (UCL), King's College London (KCL) and University of York (UoY) was established in 2017. It is commissioned to help the Department of Health and Social Care (DHSC) and others involved in making nationwide plans for mental health services to make decisions based on good evidence. It responds to requests from DHSC and arms' length bodies including NHS England and the Office of Health Improvement and Disparities (OHID) to make expert views and evidence available to policymakers in a timely way, and carries out research that is directly useful for policy.

The MHPRU is managed by academics at UCL and KCL in partnership with the UoY. Centre for Mental Health and The Mental Elf work alongside the Unit to ensure its work is accessible and relevant to policymakers, practitioners and the public. The MHPRU includes a team of Lived Experience Researchers: a diverse group of people with personal experience of mental health difficulties and involvement in research, who contribute to all its work.

INTRODUCTION

The MHPRU has recently conducted several studies gathering and exploring evidence relating to acute and crisis mental health care, in both hospitals and the community. It sought to understand the current evidence base about:

- The most effective ways of supporting people facing a mental health crisis
- Options for preventing or reducing levels of coercion
- Recent trends in the provision of both hospital and community care for people in a mental health crisis.

Acute and crisis care are essential elements of any mental health care system. At their best, they save lives and are there for people when they most need urgent help. Too often, however, people struggle to get help in a crisis, and many report that their experiences of crisis care and hospitalisation create traumas of their own.

POLICY CONTEXT

Mental health crisis care is under intense scrutiny. Rising levels of need for urgent and emergency mental health care in recent years, coupled with the effects of over a decade of austerity, have placed current support systems under pressure. People needing urgent mental health care are twice as likely to wait for more than twelve hours in an emergency department before they get the support they need (Royal College of Emergency Medicine, 2022).

Rising rates of use of the Mental Health Act over the last two decades, despite the provision of a range of alternatives to compulsory hospital admission, have been a major cause for concern, prompting reforms to the Act that are in Parliament at the time of writing.

The withdrawal of the police from some aspects of mental health crisis care, driven by the so-called 'Right Care, Right Person' approach, has exacerbated pressures on health and social services, as well as individuals and families when they need urgent help (Jefferson *et al*., 2024).

Mental health inpatient services are also under increasing scrutiny. Concerns about the quality and safety of inpatient services have been raised consistently for many years, but media reports of neglect and abuse in some units have intensified the political impetus to take action. Reports by the Health Services Safety Investigations Body (HSSIB, 2025) have identified significant shortcomings in patient safety in inpatient services. In some areas of the country, legal proceedings and public inquiries into the most serious safety breaches have underlined the urgency of action to protect patients.

The NHS in England is seeking to ease the pressure on urgent and emergency care services, to improve the quality of inpatient care, and to invest in alternatives to hospital. The current programme of 24/7 neighbourhood centres is a significant example of the latter, accompanied by investment in six areas and independent evaluation. At the same time, the Government has earmarked capital funding for mental health crisis assessment services, and the Ten Year Plan for the NHS in England includes a pledge to create 85 'mental health emergency departments' alongside existing A&E services (DHSC, 2025).

The need for reform of both crisis and inpatient care is furthered by the imminence of a new Mental Health Act. While the effects of the new Act on the numbers of people admitted to hospital cannot be accurately predicted, it is likely at the very least that fewer autistic people or those with learning disabilities should be subject to long-term hospital stays as long as there is sufficient alternative provision in communities. And those who are admitted to hospital should be able to make more decisions for themselves (including in advance of becoming unwell), and have care and treatment plans to make their hospital stay more purposeful.

A major driver of Mental Health Act reform was the longstanding inequity in the treatment of people from racialised communities in mental health services. Crisis and inpatient services are where those inequities are most sharply focused. The NHS in England has responded by creating the Patient and Carer Race Equality Framework (PCREF), a systemic anti-racism framework which is now mandated for every provider of NHS mental health services.

All of these developments are also taking place in the context of enduring workforce challenges. While the NHS mental health services workforce overall grew at an unprecedented rate between 2016 and 2024, inpatient services continue to struggle to staff wards. Mental health inpatient services continue to have high vacancy and sickness absence rates, and a far lower skill mix than their community-based equivalents.

THE STUDIES AND THEIR RESULTS

COMMUNITY-BASED CRISIS SERVICES

Dalton-Locke and colleagues (2021) explored models of community-based crisis care in England in the years up to the start of the Covid-19 pandemic, mapping the availability of some of the different types of service across the country. They found that almost all areas had crisis resolution teams for adults of 'working age', while 42% had equivalents for children and young people and 37% for older people. Beyond this, other crisis services were variable between areas. About half of crisis teams had access to a crisis house. The study noted that acute day units were few and far between and declining (despite having good evidence of benefits) while crisis cafes were becoming more commonplace (despite having little evidence). Worryingly, the authors note that a growing number of crisis teams now separate crisis assessment from home treatment, even though this is not recommended in guidance.

This theme is picked up by Rojas-Garcia and colleagues (2023) who assess evidence about patterns of service use associated with different models of crisis care. They find that having separate crisis assessment services from home treatment is associated with higher hospital admissions, while phone-based crisis support and crisis cafes are associated with lower admission rates. The reason for higher admission rates in areas with a separate crisis assessment service is unclear – it may reflect pressures on the service prior to separation, or it could be a consequence of the move.

In their qualitative study of crisis cafes, Staples and colleagues (2024) explore the factors that make them work well – in the views of their managers – which include staffing levels, accessibility, their ability to provide person-centred care, and their relationships with other local services. Many are required to make trade-offs between competing ambitions: for example between having an open-door policy and managing demand, between managing risks and providing a non-clinical environment, and between raising awareness of their service and risking stigmatising perceptions. Crisis cafes are an increasingly popular model but have been the subject of very little research.

ALTERNATIVES TO INPATIENT CARE

Griffiths and colleagues (2025a) sought to classify the wide range of alternatives to inpatient care for people in a mental health crisis. In such a diverse field, they identified three different overall categories, within each of which was a wide variety of types of provision. The three categories were: alternatives to 'standard' inpatient care for adults; alternatives to longer-term admissions; and alternatives to inpatient care for children and young people.

For each of the three categories, alternatives to inpatient care included a mixture of:

- Residential services outside hospital, such as crisis houses and family placement schemes
- Hospital-based services, such as enhanced liaison services in general hospitals, acute day units or brief admission units
- Home-based services, such as crisis resolution and home treatment (CRHT)
- Services connected to the emergency services, such as street triage
- Drop-in services such as crisis cafes.

The authors also included approaches used in a range of settings, such as Open Dialogue and Therapeutic Communities.

The range of offers was notably greater for adults than for children. The authors noted from previous research that with such a varied patchwork of provision, availability of different interventions was subject to a postcode lottery. And many services had multiple exclusion criteria. There were particular gaps for some specific groups of people including younger children, young people moving into adulthood, and those with co-occurring conditions. Finally, the study notes that voluntary, community and social enterprise (VCSE) sector organisations tend to offer a more social, and less clinical, response to crisis situations than statutory bodies. But these were hampered by poor or non-existent evaluation, and again what is available varies from place to place or is short-lived because of volatile funding arrangements.

Johnson and colleagues (2022) explored evidence about the range of responses to acute mental health need and the different settings where this is provided. They note that in a majority of cases, both in the UK and internationally, acute mental health care is provided in hospitals. General hospital emergency departments (EDs) are, in many countries, the 'default' option for someone in a mental health crisis, especially following serious self-harm or attempted suicide; but for many they can be poorly adapted or even harmful environments. Alternatives to emergency departments for mental health crises (for example crisis assessment centres or brief admission wards) have been established in many places, though with limited evidence of benefits to patients. And the authors note that, even if alternatives are available, "mental health care is still needed in EDs" because many people will also need urgent physical health care during a mental health crisis.

This paper explores the role of crisis resolution and home treatment (CRHT) services, which show evidence of effectiveness in reducing hospital admissions and improving satisfaction in studies, but have often struggled to work according to the prescribed model in practice. The relationship between these and other community mental health teams is also unclear in many places, which can have implications for continuity of care following a crisis.

The paper also explores acute day units. These are an alternative to admission that the authors find has some of the most robust evidence, and yet which has been declining in the UK in recent years. They note that this trend may be due to perceptions that day care is more institutional than other types of alternative to inpatient care.

A clear theme in this study is the importance of voluntary and community sector provision of crisis care, which the authors find is able to support people who do not trust or feel safe in statutory mental health services, including the most disadvantaged, oppressed and marginalised. Despite this, there has been little robust research into the value of not-for-profit organisations in providing mental health crisis care.

DEVELOPMENTS IN INPATIENT CARE

Johnson and colleagues (2022) also explore the role of inpatient units in the period following a crisis. They note that inpatient wards have an important role in enabling urgent treatment when there is no safe community-based alternative; but that for many people, inpatient services bring further safety risks, including of violence, the use of restrictive interventions, and longer-term institutionalisation. They conclude that while shifting service models towards communities is important, efforts must also be made to improve inpatient environments, staffing levels, and practices.

Saunders and colleagues (2023) carried out a scoping review of trauma-informed approaches in acute, crisis and residential mental health services. They found some evidence – most of it from acute settings, where most research has taken place – that trauma-informed care is associated with reductions in the use of restraint and seclusion, and that staff have greater empathy with service users. But they also found a lack of a clear framework for trauma-informed care and gaps in staff training in how to implement it. The authors also noted a lack of lived experience involvement in the development of trauma-informed care; a gap also highlighted by the Lived Experience Commentary, which noted the risks of superficially adopting trauma-informed practices within harmful systems and environments.

Griffiths and colleagues (2025b) review quantitative evidence about 'relational care.' This is a concept they define as including a wide range of interventions and approaches that prioritise interpersonal relationships and are grounded in the values of respect, trust and compassion, including trauma-informed practices and psychological therapies. They are defined as such in opposition to structured risk assessments and restrictive practices. Available current evidence suggests some 'relational care' approaches, when practised in acute or emergency department settings, are associated with lower rates of self-harm and suicide. But Griffiths *et al*. (2025) also note a number of challenges to implementing relational care, including power imbalances (between staff and service users), busy environments, and ward designs.

Similarly to the review of trauma-informed approaches, the Lived Experience Commentary to this study raises concerns about the risk of tokenism in the adoption of 'relational care.' If it is simply a 'semantic repackaging' of an unreformed, unchanged system of care, it will mean little in practice.

Griffiths and colleagues (2024) review evidence about the controversial practice of using surveillance-based technologies (such as video monitoring, body-worn cameras, and GPS trackers) in acute care. They find that much of the evidence about these technologies comes from low-quality studies with conflicts of interest, and even with that, evidence about outcomes is "inconsistent and weak", with little regard to their impacts on people's health and wellbeing. The views of patients, carers and staff in inpatient services about these technologies were mixed, with some raising serious ethical concerns about their use. The authors note further that some studies claim that the use of these technologies saves health services money. But these studies had significant methodological limitations, and the main cost reductions they claimed were due to reductions in one-to-one observations by staff, despite guidance that they should not be used as a substitute for human interaction. They also note that guidance and regulation of the use of surveillance technologies is made difficult by the rapid emergence of new products. This study informed NHS England's guidance on the topic (NHS England, 2025).

The Lived Experience Commentary for this study is unequivocal. It states that the use of surveillance technology "strips away our most basic dignity", giving mental health service providers an "illusion of control" as an institutional response to fears about high-risk incidents. They conclude that the UK's mental health system is not a safe place for monitoring to be used, and when it is, the power imbalances within it are reinforced.

KEY THEMES AND IMPLICATIONS

Taken together, the studies in this series, and research elsewhere, indicate that the current system of crisis and acute inpatient care needs to change. People facing a mental health crisis too often struggle to get timely help that meets their needs. Emergency departments are not as safe or welcoming for people in a mental health crisis as they should be. Acute inpatient services are not always able to offer people the care they need in a suitable environment. And alternatives to hospital care are patchy, inconsistent, and sometimes exclude people who need them most.

A major theme in the studies is a mismatch between research evidence and practice. Some well-evidenced approaches to supporting people in a crisis are poorly or rarely implemented, while approaches lacking evidence are being widely picked up. Mental health crisis and acute services are negotiating complex problems without robust evidence to help them. As the NHS both nationally and locally seeks to address shortcomings in crisis and inpatient care, it is essential that these lessons are learned. The separation between crisis assessment and home treatment in many localities is a case in point: while increasingly commonplace in practice, it has been implemented ahead of any convincing evidence base, diverting from the established, effective CRHT model in the process. An implication of this is that attention should be paid as much to improving the services that do exist as to adding new ones, especially those that have not been robustly tested.

While the studies in this series all note serious gaps in the available evidence – predominantly due to gaps in research, and the difficulty of implementing clinical trials in crisis services – there are some clear messages for policymakers about where investment can make a difference. For example, previous reviews (e.g. Bone *et al.*, 2019) have found that crisis planning and self-management approaches can prevent compulsory admissions to hospital – an important finding that bolsters the forthcoming changes to the Mental Health Act that will strengthen the role of advance choice documents.

Gaps in service provision are also evident. There remains a pervasive postcode lottery in the provision of crisis and acute mental health care, with very different offers from one place to another. This is a result of many years of devolved decision-making in mental health crisis care without nationally prescribed models or standards.

While variations between local areas are endemic, some groups of people are particularly poorly served in most areas of the country – for example children and young people and people with co-occurring conditions. These gaps in the system come to the surface when individuals are made to wait for many days in emergency departments in need of urgent care that isn't there for them. Such situations, which are all too frequent, reflect systems that are unable to provide sufficient support to meet the needs of their populations.

Throughout the research, fundamental questions about our current system of crisis and inpatient care have arisen. A system characterised by deeply entrenched power imbalances, institutionalisation, restrictive interventions and traumatic experiences cannot be transformed through superficial changes that don't really address the problems at their roots.

In such circumstances, the adoption of trauma-informed approaches or quality improvement initiatives may be helpful where they bring about real change, but they risk becoming a façade if they are implemented in isolation or are watered down so as to lose their value.

The use of surveillance technology in inpatient environments raises especial concerns. Given the lack of evidence of benefits, the serious concerns raised by user-led groups, and the very considerable risks, it is hard to justify their widespread use until their safety, acceptability and efficacy have been established robustly.

The studies collectively demonstrate the importance of understanding mental health crisis and acute care as a whole system. Most research has focused on individual interventions or settings, rather than seeing them as a whole, or understanding people's experiences of the system more widely. Yet the way people experience crisis and acute care is more complex, and the individual parts can only be understood as part of a wider system of care. Simplistic solutions that seek to change one part of the system without reforming the others may at best bring marginal improvements, and at worst create bigger problems elsewhere.

It isn't possible to understand the challenges of providing crisis and acute care without reference to resources: to money, people, and buildings. Underfunded services, struggling with chronic staffing difficulties, and existing in inadequate environments, are never going to be able to meet people's needs as quickly, comprehensively, compassionately or effectively as they should.

Most fundamentally of all, crisis and acute care exists to serve people. Yet the views and voices of people facing mental health emergencies are often the least heard or heeded in policymaking, commissioning and service development. Coproduction and co-design are yet to be adopted widely as the basis for creating and planning mental health services, especially in acute and crisis care. In their absence, decisions often fall short of meeting people's needs.

RECOMMENDATIONS

1. The NHS in England should invest in mental health crisis care, addressing gaps in provision and updating estates which are no longer fit for purpose, with decisions about investment priorities being led by the available evidence of what is safe and effective.
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