Be the change

Ensuring an effective response to all in psychiatric emergency equal to medical care

Recommendations from the first international summit on urgent and emergency behavioural healthcare

Contents

Foreword

We were delighted to put together this first international summit of thought leaders on urgent and emergency care in behavioural health. It was jointly sponsored by RI International[1] and NHS Clinical Commissioners.[2] In this document, the term 'behavioural health' is used in preference to 'mental health'.

It was a stimulating and challenging two days with much food for thought. We heard some very emotional stories from individuals about the struggles they have faced during their times of crisis, but there was also a great deal of hope and aspiration about the future shape and coverage of services. We must never forget that people in crisis are at the most vulnerable time of their life and do not just need services but care, empathy, kindness, support and safety.

The hard work put in by over 50 leaders in urgent and emergency behavioural healthcare has resulted in ten clear recommendations that we believe can transform the crisis care delivered in many countries. The main focus of the event was the US and the UK, but the outcomes have global application and benefit.

We are convinced that it will take action at national level to deliver the transformation required. It needs to engage not only health services but also ambulance, hospital, police, judicial, social and voluntary services. We are keen to direct these recommendations to governmental agencies, policy makers and those implementing health and social services. In England for instance, we aim to influence the NHS long-term plan to ensure that urgent and emergency

behavioural healthcare is prioritised. In the United States, we similarly aim for the three Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) recommendations to Congress on crisis care be fully implemented.

This level of coordination needs national commitment and direction. There are some indications that this is beginning, and our hope is that the recommendations here will accelerate and facilitate the process.

We commend the joint wisdom of well over 1,000 years' senior expertise in behavioural health crisis to all who have a concern or interest, as a means of delivering the changes so desperately needed. For our part, we are all endeavouring, in Gandhi's words, to be the change we want to see in the world.

"The hard work put in by over 50 leaders in urgent and emergency behavioural healthcare has resulted in ten clear recommendations"

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Executive summary

Behavioural health crisis is a global problem

Behavioural health is an inclusive term that covers the emotions, behaviours and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self. It includes mental health, substance misuse and the physical consequences that result.

Using suicide as one indicator of crisis, the World Health Organisation (WHO) estimated[3] in 2018 that close to **800,000 people die due to suicide every year, which is one person every 40 seconds**. There are indications that for each adult who died of suicide there may have been **more than 20 others attempting suicide**. Many family and friends are profoundly affected by each person who takes their own life – estimates vary upwards from six to many tens of people.

A 2015 study[4] found that in the USA, the average cost of one suicide was more than **$1.3 million**, and the estimated cost of a completed suicide for someone of working age in the UK exceeds **£1.6 million**.[5] Importantly, every $1.00 spent on psychotherapeutic interventions and interventions that strengthened linkages among different care providers saved $2.50 in the cost of suicides.[4] Good crisis intervention services are therefore vital to **enable early intervention and prevention** of adverse outcomes.

The first international summit on urgent and emergency behavioural healthcare took place in London, England at the end of May 2018. For two days a group of 50 thought leaders from the UK and USA debated key themes and the urgent need for changes to our approach to behavioural health crisis care. In aggregate there was **well over 1,000 years' experience of working with behavioural health crisis**!

Summit attendees included clinical and non-clinical experts, with experience that included government and law enforcement, and people with lived expertise as a recipient of care or a family member. Thus, the themes helpfully represent views from various vantage points but provide a consistent perspective on urgent and emergency behavioural health services.

Examples of exceptional practice were shared, as were areas needing transformation. The summit defined clear recommendations to improve the health of those at risk of behavioural health crisis through better intervention and prevention, at the same time as delivering real cost improvements, allowing more resources to be invested in prevention. The report and the recommendations are aimed at an international audience, but we have referred to country-specific policies and how we aim to influence them.

Opening the summit, the Rt Hon Norman Lamb[6] MP, spoke of **a moral imperative to stop tolerating less than adequate mental healthcare**, such as shunting people around the country in search of crisis care.[7] He suggested we should all espouse **an audacious commitment** to see this change, to deliver equal access to treatment and support, a social movement of change engendering a sense of pride and excitement. He referred to the UK Crisis Care Concordat which contains a set of consensus principles to which all areas in England are signed up. "Now," he continued, "we need a significant investment of resources in crisis intervention and support."

The summit defined its aim as ensuring an effective response to all in psychiatric emergency, with an approach equal to medical care. We believe this constitutes the **minimally adequate crisis resolution system** with **full population coverage**. This declaration took note of Gandhi's exhortation to "be the change you want to see in the world."

These leaders came together to make a change; to make a difference in diverse communities on two continents that could be applicable globally. Despite the cultural, healthcare system and geographic differences, the challenges faced by all are remarkably similar. The consensus view of participants was that better care is within reach, but better standards must be defined, including minimum standards that can be used to drive changes.

It is time to raise expectations, through political activation and systems leadership. The recommendations are aimed at governmental agencies, policy makers and those implementing health and social services. In making the recommendations, the summit recognised that working in behavioural health crisis is one of the toughest jobs out there and resolved to find ways to make it one of the most rewarding and effective.

This report sets out the ten recommendations and expands on some of the evidence and drivers for the changes required. It also seeks to identify good practice in systems around the world that can be adapted and adopted in other regions.

The status quo needs to be disrupted with a focus on saying 'yes' at times of behavioural health crisis. Crisis intervention technically includes triage, referral and linkage to supportive ongoing services. But it is far more. Kindness with emotional intelligence at the moment of crisis reduces distress. "A ministry of presence that focuses on engagement and collaboration increases comfort and strengthens autonomy and recovery."

The aspiration

The summit hopes that by raising the profile of the recommendations, there will be greater awareness of the need for change that will facilitate the implementation of improved crisis care for behavioural health globally. In England, we aim to do this by influencing the development of the NHS long-term plan, and in the United States, by ensuring implementation of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) recommendations to Congress on crisis systems and services.

"The aim must be 100 per cent access to services in a behavioural health crisis and zero suicide in healthcare"

Fundamental to the recommendations is the view that change is possible, and change is needed. It became clear, as the summit progressed, that a tremendous opportunity exists to immediately impact how systems and people care for those experiencing the most acute behavioural health needs in our communities, regardless of the country where they live.

The aim must be 100 per cent access to services in a behavioural health crisis and zero suicide in healthcare.

The recommendations that follow were created at the summit and are intended to promote achievement of this aim.

The ten recommendations

1. Nations should have an **integrated, systematic approach** to behavioural health crisis care at the national level – this is seen as the only way to end the current fragmentation of care.

2. **Crisis service alternatives** to the usual emergency measures of formal assessment and psychiatric inpatient care should be actively developed including:

   a. community crisis response (for example mobile crisis teams)

   b. shorter stay crisis facility services (for example crisis stabilization, temporary observation, living room models and crisis houses).

3. Special consideration should be included **to cater for veterans**.

4. An **integrated health information exchange-capable technology solution** should be implemented to enable seamless care across organisations. We can track a parcel worldwide but not the care of vulnerable people!

5. **Balanced scorecard dashboards** should be developed that display real-time, meaningful data and outcome measures that support continuous quality improvement.

6. Users, peers and carers should be embedded in the design and leadership of crisis systems – **co-production**; **peer support staff** should be **trained and integrated** in crisis service delivery.

7. The **zero-suicide aspiration** should be owned by governmental agencies, policy makers and those implementing health and social services.

8. **Family and friends should be fully engaged** in crisis care and inappropriate barriers created by confidentiality or privacy need to be sensitively overcome.

9. Each nation needs a **single national three-digit crisis hub number** that drives easy access in which:

   a. all callers are welcome, and the crisis is defined by the caller, whether this is the user, family, friend or professional

   b. promotion and intelligent social media to get the word out to those who need it.

10. **Significant investment** should be identified to deliver these recommendations.

The remainder of the report adds some detail around each of these recommendations.

Current state of the crisis delivery system

The summit heard from a variety of speakers who expressed the broad concerns that exist around the current state of urgent and emergency behavioural healthcare. In short, crisis care does not adequately address the needs of the community it is intended to serve, nor the needs of wider society.

Prevention and early intervention

Stories are told of people needing help having to wait until they are in a crisis to access appropriate support. While investment in top notch crisis care ought to be regarded as a human right, it must not lead to a situation where someone needs to be in a crisis to get any help at all. The best course is to support everyone and prevent a crisis in the first place. This means investing in effective prevention and early intervention, in accommodation and housing, in education and training, in employment support, and in high quality community services that help people and their carers sustain independent living. Crisis care is not the solution: it is a safety net.

"The best course is to support everyone and prevent a crisis in the first place"

The challenges

Summit experts from the United Kingdom and the United States described similar challenges and opportunities. It was acknowledged with increasing conviction through the two days that the consensus of exceptional behavioural health crisis services contained in the National Action Alliance for Suicide Prevention's *Crisis now*[8] document may well be the best guide to building a roadmap to better care. Sadly, there is limited implementation of these standards (which has happened primarily in the states of Georgia, Arizona, Colorado, and in New York City), notwithstanding the advancement of data-informed business case efforts that show clear economic advantages to delivering services that align with the unique needs of the individual experiencing an acute behavioural health crisis.

In the UK, where it has been reported that 30 per cent of calls to hospital services and law enforcement are psychiatric crises,[9] the National Health Service has defined its top two goals[10] as urgent care and mental healthcare. The previous UK Secretary of State for Health and Social Care, Jeremy Hunt, announced in January 2018 that the NHS is embracing the zero-suicide ambition[11] for inpatient care. All agreed there is a pressing need to 'keep pushing' to build the momentum for change.

From the various contributions, the summit identified the following challenges in current provision:

- Fragmentation – both in funding and service delivery.

- A siloed approach to care – both in funding and service delivery.

- Health disparities – affecting certain populations who are not receiving services.

- Many individuals present in a crisis setting due to unmet social needs.

- Crisis services may meet the immediate need, but not the on-going care need.

- Emergency calls for health and police services – a high percentage are related to behavioural health needs – a UK ambulance service consultant paramedic quoted 70,000 behavioural health calls as opposed to 15,000 for stroke – a crisis intervention team training coordinator from the Phoenix Police Department quoted 68,000 behavioural health contacts annually.

"Many individuals present in a crisis setting due to unmet social needs"

- Behavioural health needs are too often being addressed by emergency departments (EDs) and correctional facilities/justice systems – people with lived experience shared their feelings that it is 'so distressing' seeking crisis services through an ED or accident and emergency department (A&E).

- Long waits for behavioural health services in EDs are prevalent and admissions through EDs are increasing, often related to lack of patient flow in crisis – the term 'psychiatric boarding' has been coined to describe this phenomenon – this has been declared unconstitutional in Washington State.[12]

- There is a need to continually reassess the role and place of psychiatric inpatient care in crisis management. If an inpatient stay is deemed to be important for the safety and effective treatment of the individual, their stay in hospital should also be used to focus explicitly on helping them manage suicidality. Otherwise, an expensive resource may be used purely for containment, which is unsatisfactory for the individual, their carers, professionals and the system. Good crisis care has the potential to help rationalize the use of the most expensive resource, avoiding providing inpatient care for those who do not want it and need something less restrictive.

- Fragmentation of joined up crisis delivery systems (phone, mobile and facility).

- Lack of adequate home and community-based service availability.

- Lack of aftercare services, including both referral and service delivery.

1 Nations should have an **integrated, systematic approach** to behavioural health crisis care at the national level – this is seen as the only way to end the current fragmentation of care

- Institutional care in place of adequate home and community-based care.

- Detention of minority populations is higher, especially of black and ethnic minorities, though other groups are at higher risk too (such as LGBT+).

"Ensuring every country has a minimally adequate crisis resolution system with full population coverage is achievable"

Consideration of these aspects led the summit to formulate ten recommendations that are internationally relevant. More importantly, **ensuring every country has a minimally adequate crisis resolution system with full population coverage is achievable**.

A key theme from the summit was that services delivered for those in or at risk of behavioural health crisis are fragmented. This includes:

- Fragmentation between the statutory agencies involved, including health, social services, police, third sector and others. The result is often a frequent 'hand-offs' between the various agencies that can mitigate against a good experience for the user. In addition, the geographic coverage of these providers may not align, leading to further fragmentation

- Not all crisis services are 24/7, leaving those in crisis without a specific behavioural health resource, often resulting in their attendance at the emergency room (ER) or emergency department (depending on the country).

- Often, the policy response to the need for crisis services is at regional level (state or other administrative unit) and there is a lack of a consistent national approach that encourages integration. An example of an initiative that has started to address this is the Crisis Care Concordat[13] in England.

- While experts at the conference accepted the need for business cases, they acknowledged that this was not needed for physical healthcare. No one questions whether or not a heart attack or a stroke needs immediate intervention services; these are considered human rights and social justice issues. However, the cost of crises, including suicides, is immense and there are significant savings to be made. The RAID[14] (Rapid

Assessment, Interface and Discharge) model, pioneered in Birmingham, UK, has demonstrated that for every £1 invested, £4 is saved – a net advantage of £3. If this is extrapolated across the UK and US, there are tens of millions in savings for hospitals and law enforcement.

Political activation and social movement

There was a consistent view from experts from the UK and US that services can be improved, and meaningful improvements attained through political activation. The National Action Alliance of Suicide Prevention (US) established a crisis work group that delivered a roadmap to creating a consensus about exceptional behavioural health crisis practice standards in the *Crisis now*[15] publication. Political activation is most effective when combined with a social movement, as evidenced by the various examples of city-wide behavioural wellbeing transformation (ThriveNYC,[16] ThriveLDN[17] and many others).

"Human stories are key to understanding and change"

Elements needed for a successful social movement include:

- Pride and excitement – the time is now to address the crisis delivery system.

- Acknowledgement that individuals with behavioural health conditions are being treated like second-class citizens.

- Human stories are key to lobbying along with the economic case for behavioural health crisis services.

Political activation and social movement activities mostly focus on the positive impact that can be realised when communities unite with a commitment to change the culture of the urgent and emergency behavioural health service delivery system.

National leadership and policy issues

The participants called for national leadership to:

- Commit to the development of national leadership with local engagement and execution – the challenge is that while national leadership and standards are needed, implementation will need to be regional (crisis systems) as well as local (provision of crisis alternatives). The distinction is key. These systems are too complex to be national in scope. Regional hubs to handle calls, dispatch mobile teams, and maintain real time data on available beds and seats make sense.

- Develop a set of national principles for crisis delivery systems.

- Create an agreed-upon language for behavioural health.

- Align policy with how services are delivered. There could be a need for business case templates to be developed with service specifications, for example. This could include national or international mandating of minimum functions and standards for behavioural health crisis care, which should include post-care, coproduction and workforce, with ring-fenced funding but local autonomy on the model and organisation.

- Adopt evidence-based practices (EBPs) as appropriate for the service setting.

- Enhance diagnostic capabilities to prevent misdiagnosing.

- Support complete biopsychosocial assessments to inform treatment.

- Create solutions for complex and high need individuals who are fewer in number but use most of the services.

- Focus on university students among whom behavioural health issues are increasing.

Caring for front line services workers

The summit considered the need to be proactive in caring for front-line service workers exposed to trauma. If truly effective crisis care is to be delivered, it is essential to care for first responders and uniformed services. There are good examples of this such as following the London terror attacks and major fire at the Grenfell Tower apartment block in 2017.[18]

2 Crisis service alternatives to the usual emergency measures of formal assessment and psychiatric inpatient care should be actively developed including:

a. community crisis response (such as mobile crisis teams)

- In many situations, there is a lack of services that can respond quickly to the person in crisis where they are. The summit heard of some excellent examples of outreach to the person at the time of crisis (such as street triage in the UK,[19] mobile crisis teams in the USA).[20]

b. shorter stay crisis facility services (such as crisis stabilisation, temporary observation, living room models and crisis houses)

- A senior programme manager in the UK admitted that although he had led policy for three years, he sometimes does not know where someone in crisis is supposed

to go. A consultant paramedic from the UK asserted that there is a need for more triage destinations than for ambulances to hospital EDs. There are very effective examples of crisis resolution facilities that operate on the basis that they will accept anyone, referred from any agency, to support and assess as necessary. An example from Arizona[21] enabled the police service to handle behavioural health problems much more effectively and rapidly. These facilities are perceived as better for the person involved and the police find much less of their time is taken up when supported by such services. More of these services could be very effectively used.

"I do not know where someone in crisis is supposed to go"

A UK police sergeant with a history of behavioural health crises shared that spending 14 hours in a police cell changed his perspective on behavioural health crisis. As a result, he has developed the Serenity Integrated Monitoring[22] (SIM) model that aims to support those who frequently have crises.

These themes are pulled together in a coherent approach with the Crisis Now[23] model from the USA. The model works at three levels – a call centre hub, mobile crisis outreach and crisis facilities that provide sub-acute stabilisation. The model includes a framework for regional self-assessment. The summit acknowledged that the concept, like 'zero suicide', must have the solutions hard-wired to the services.

The summit agreed that resolution is the goal of crisis care, moving people from agitation and crisis to a state of comfort. A speaker from the UK voluntary sector told the summit that people want services that are simple, kind and human. People in crisis need a safe place, a sanctuary where hope and connection can be rebuilt.

"Resolution is the goal of crisis – from agitation to comfort"

National leadership and policy issues

Because of the overrepresentation of substance use disorder in crisis care, with individuals having a high degree of co-morbid behavioural health, the summit recommends attention to the following:

- Espouse a 'no wrong door' to getting individuals to the right setting for their care.

- Rural issues will require creativity and models will need to be adapted for dispersed populations.

- Access to detoxification services is needed in rural areas as well as urban.

- Substance use disorder, behavioural health and medical

conditions must be addressed in an integrated manner.

- The use of apps, telemedicine, social media and other technological solutions need national policy drivers to realise, partly because the market is saturated with options without an evidence base for the effectiveness of a particular one. In the UK, the National Institute for Health and Care Excellence (NICE) is publishing non-guidance briefings on mobile technology health apps, to be known as 'Health App Briefings'. An example is for the sleep app 'Sleepio'.[24] There is also the NHS App Library, which only hosts apps which have been assessed for quality and safety by their team of experts.[25]

"No wrong door to getting the right care"

Culture change is needed

Summit experts were unanimous in asserting that the culture in service delivery must change:

- Caregivers must say "yes" when an individual or a family member or close friend reaches out and work with them to address their needs.[26] In any case, saying "no" creates additional workload and distracts from the delivery of care.

- The starting place for help is to support the individual in creating hope.

- To deliver true recovery – a word being used much more often now – health services need to learn how to effectively collaborate with community assets and partners.

- Crisis care is hard work, so it is important to ask how teams are resourced and supported. Only then can improving the quality of crisis care provided be properly addressed – we standardise care for a heart attack; now it is time to standardise care for behavioural health crises.

- Stigma and discrimination must be addressed not only in society but in care delivery.

- Individuals must be treated with humanity and in an environment where it is safe, and to be able to voice their opinion, even if it is to complain.

"Support the individual in creating hope"

- Disruptive innovation must be embraced to creatively address needs of the individual.

- Cultural competency and sensitivity must be central to care delivery.

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Education and training

To achieve the scale of change required, attention must be given to education and training within all sectors:

- Behavioural health education and training is foundational to healthcare and the crisis delivery system and must be made available in all areas of all countries.

- In the UK, general practitioners and primary care nurses are trained in behavioural health but there needs to be a mandate for on-going training; in the US, training of the primary care sector needs to be addressed.

- Those involved in crisis intervention need to be trained as teams and must include law enforcement officers, paramedics and other first responders.

- Behavioural health literacy is lacking; awareness needs to be raised for management and administrative staff and the general population.

- Behavioural Health First Aid training should be expanded to more individuals both in healthcare and in the general population.

- Individuals in EDs, general medical floors of hospitals and other settings often have significant behavioural health conditions, yet general medical staff are often underprepared to support them. In the UK, the use of psychiatric liaison teams supports medical staff through a scheme known as Core 24.[27]

- Peer training should be expanded and include trauma informed care.

"Training is foundational"

3 Special consideration should be given to cater for armed forces veterans

There is a particular case for the needs of armed forces veterans to be catered for. Special consideration should be given to their unique needs based on the trauma many have experienced while in service. Military service also comes with its own unique culture and services should be tailored to meet those unique needs.

In the UK it is estimated there are 24 million veterans and 18,000 have accessed psychological services. The UK has nationally commissioned a transition, intervention and liaison service (TILS) and a complex treatment service (CTS) for complex PTSD.[28]

Summit members noted

• The current delivery system is not adequately meeting the needs of the armed forces community, although the UK service is starting to make some inroads.

• Some evidence suggests that veterans are seeking services at a younger age than previously.[29]

• Individuals are surviving more serious physical injuries that may have taken their lives in previous eras and have co-morbid behavioural health conditions that increase the need and demand for services.

• Service delivery has been enhanced in efforts to prevent substance use disorder, criminal activities and subsequent charges, financial problems and loss of their homes, etc. but needs further development.

• Social programmes are also being enhanced – housing and employment have become a focus.

• Severity of post-traumatic stress disorder is high and the average amount of time spent in behavioural services has increased as a result.

• Service providers with military experience seem to be more effective in treating veterans, partly related to their ability to 'speak military'.

• Efforts to partner behavioural health services with primary care and family practice are underway. One example is the veteran-friendly practice scheme run by the Royal College of General Practitioners in the UK.[30]

"Military service comes with its own unique culture"

4 An **integrated health information exchange-capable technology solution** should be implemented to enable seamless care across organisations – we can track a parcel worldwide but not the care of vulnerable people!

Healthcare worldwide is bedeviled by the lack of interoperability between the systems of different providers of healthcare. We have already identified the fragmentation of care between multiple provides and this is compounded by the lack of IT integration. We can track a parcel worldwide but not the care of vulnerable people! The summit called for urgent action to address this and shared some examples of best practice.

National leadership and policy issues

• There is a need for information sharing agreements to be promoted.

• Alignment of IT systems to be interoperable is urgently needed.

"We can track a parcel worldwide but not the care of vulnerable people!"

5 **Balanced scorecard dashboards** should be developed that display real-time, meaningful data and outcome measures that support continuous quality improvement

Quality and outcomes

There is a clear need to use data to inform service system delivery design. Clear outcome metrics communicated through easy-to-use dashboards will be more effective in driving continuous quality improvement. The summit heard from the National Action Alliance for Suicide Prevention[31] who have pioneered work in monitoring the data required to design services. In Phoenix, Arizona, they estimated that there would be 200 people in crisis per 100,000 population on a monthly basis. The number of people requiring care at a variety of levels can then be predicted for planning service capacity.

"Clear outcome metrics, communicated through easy-to-use dashboards, will drive continuous quality improvement"

Efficiency comes from aligning service intensity to the needs of the person and monitoring outcomes to ensure implemented practices are achieving the desired results which should include:

• Diversion of those with clear behavioural health issues from the criminal justice system (police cells, prison, and so on) to ensure treatment and recovery is the focus of intervention.

• Lower healthcare costs.

• Reduction in 'psychiatric boarding'.

• Increased service satisfaction.

- Better performance in health metrics (social determinants of health such as employment, accommodation, education and training should be included as well as health outcomes such as recovery).

Consideration should be given to:

- Reducing length of stay in hospital, but this should not be seen as an isolated measure of quality, as the best approach remains home and community-based services.

- Mortality reports that reveal failures in the delivery system.

- Standards need to be developed to address service timeliness. This has commenced in the UK with standards in improving access to psychological services,[32] early intervention in psychosis,[33] children and young people with eating disorders,[34] and there is currently a proposal to develop waiting time standards for children's and young people's services.[35]

- Reducing the use of seclusion and restraints, which remains a problem, especially with younger females. An example of best practice is Mersey Care's 'No Force First'.[36]

- Ensuring that reporting of insult, injury, incident and accident is occurring consistently.

- Improving performance and outcome data that is vital to prove the need for enhanced funding.

Improving the quality of evidence by sharing internationally

All involved acknowledged the variability of the evidence base for crisis behavioural healthcare. It is important that where there is a good evidence base (such as for crisis resolution home treatment teams) this should be implemented faithfully in order to deliver the best outcomes. Other approaches have a thinner evidence base but show much promise (such as street triage or crisis houses) and need more robust testing over time. There is huge potential to expedite this process by sharing learning internationally to develop high quality evidence.

6 Users, peers and carers should be embedded in the design, leadership and delivery of crisis systems; **peer support staff** should be **trained and integrated** in crisis service delivery

The summit had good representation from people with lived experience of behavioural health crisis. Their

contribution was enormously helpful in framing a clear commitment to their full engagement in the whole process of crisis care, from leadership and design through to delivery. The need to train and pay those who provide their expertise was emphasized, endeavouring to progress together from lived experience to lived expertise.

One speaker was clear that what people want is a common-sense approach to wellness. This process commences with the individual in crisis being fully engaged and informing their own treatment. This acts as an excellent training ground for future involvement as a peer, quite apart from being an essential human right.

People's lived experience of interventions was helpful to understand the changes required. One shared that "deliberate and strategic intervention worked for me, with a specific person being a lifeline, a friend and providing 48 hours of safety in a crisis." Another related that, "out of two crisis experiences, the first provider kept me alive, the second helped me become well."

The group again considered the experiences of many who relate the traumatic nature of the way crisis care is delivered in some instances. Norman Lamb MP told of a famous sportsperson who explained the trauma, when in crisis, of having police vehicles arrive at his door with blue lights flashing, others spoke of being conveyed in locked vehicles, or being restrained in hospital, and the lack of dignity these actions bring. Crisis care needs to acknowledge these experiences and learn from people's narratives. One of the undoubted benefits of co-production, co-design and co-implementation is to create systems that are less likely to traumatise or re-traumatise people. There are excellent examples of providers listening to those with lived experience and adjusting their services accordingly, such as No Force First delivered by Mersey Care, UK.[37]

Collaboration and relationships

Trained Peer Support is a role that needs value and respect. Urgent and emergency behavioural health service providers need to become equal partners with those who use the services and their families and friends. This joint approach will commit to designing and delivering services that truly address community needs. These collaborations need to include local law enforcement, justice systems, hospitals and fire, ambulance and other first responders. The whole will become much stronger than the sum of its parts once all the pieces are engaged in meeting a common goal with a shared understanding of how they all fit into a comprehensive community supporting better health and wellbeing.

Peer support in crisis

As an extension to this, the summit experts (both by profession and experience) were adamant that peer support is inadequately utilised in the urgent and emergency behavioural health system. However, they also

identified that training is essential to enable peer support staff to be fully integrated in service delivery. One example is part of ThriveNYC,[38] although there are other examples and review articles.

Individuals with a lived behavioural health experience are uniquely positioned to engage others who are experiencing behavioural health challenges. Peers are widely recognized as possessing an enhanced ability to engage individuals experiencing a crisis and represent a cost-effective, widely-available workforce to address the escalating demand for crisis care. In the US, peers have been important contributors to phone line, mobile team and facility-based crisis services, representing a core element of the Crisis Now consensus exceptional practice standards. To move this forward, the following should be addressed:

• Certification and access to certification programmes.

• The effectiveness of peer-to-peer services in most settings: EDs, crisis services, home and community-based services, universities, and so on.

• Trained and certified peer specialists will help meet workforce needs and services in a cost-effective manner.

• Data must be collected and collated to support funding for peer services.

"Training helps to move peers from lived experiences to live expertise"

National leadership and policy issues
• Create opportunities for training and employment for peers with ongoing support.

• Create an open environment for anyone to disclose lived experience and receive support and learn from others.

• National leadership to ensure training, funding and support for peer workers and guard against discrimination.

• Crisis support is a community responsibility.

• Relationships and collaboration are essential to making the system work, including healthcare providers of all types, law enforcement and ambulance and fire departments.

• Community leaders, businesses and other local groups can contribute hugely to crisis prevention and early intervention in a developing crisis.

• Regular standing meetings of stakeholders should be organised to maximise participation of service recipients and their families and friends.

• Consider employing trained peer workforce in EDs (including motivational interviewing, resources and referrals).

7 The zero-suicide aspiration should be owned by governmental agencies, policy makers and those implementing health and social services

The summit heard from a person with lived expertise who was bereaved by the suicide of his teenage son. His presentation was a powerful message that services are glaringly not in place to prevent suicides. As a result of his experience, he jointly set up the UK Zero Suicide Alliance[39] to campaign for better services and responses in crisis and to promote simple training for the general public.[40] Zero Suicide International,[41] based in the USA, is also pressing for better suicide care and runs annual international conferences on suicide prevention.

The summit accepted his premise that '**one life lost is one life too many**.' The important thing after a loss is that society cares, and resources are provided.

"One life lost is one life too many"

Suicide postvention
He also raised the issue that there are inadequate services to support those bereaved by suicide (family and friends) with so-called postvention. Postvention is needed for families and loved ones following a suicide and is important for first responders and service delivery staff, as they may suffer emotional trauma as a result of the event.

Another summit expert set up the organisation Suicide Bereavement UK,[42] to support bereavement counselling following suicide, providing training for many groups. She advocated words that should be in the vocabulary of caregivers – courage, speak out, action, belief.

The summit was reminded that clinicians are human and while any loss must be professionally reviewed and involve family and friends, the system must remember to support those involved as part of a just culture. Many professionals who have cared for someone who takes their own life are profoundly affected by the experience and need specific and sensitive support, especially as an investigation may also take place during their difficulties post-suicide.

The zero suicide movement is now gaining ground worldwide, with many Thrive cities adopting this as an aspiration. While there is debate around the concept, the summit endorsed the adoption of zero suicide as an aspiration not a target and to endorse the evidence base that is accumulating. In fact, an estimated 200 – 300 fewer

suicides a year are linked to national recommendations for improved patient safety.[43] There is a need to build on this research base.

Suicide prevention

Behavioural health crisis system providers are an essential part of creating a zero suicide community. However, there is a need for national recognition that while suicide prevention must be carried out in healthcare settings, zero suicide is also an array of specific practices that cover screening/assessment, safety planning intervention, follow-up contacts, restricting means, and psychological care by therapists who know something about suicide prevention. To date there is more global enthusiasm than improvement in care. To use a parallel, it would be unthinkable to have a zero diabetes initiative that did not require the assessment of HbA1c levels. Progress is being made with implementing structured first episode care, but unless an equally structured approach is extended throughout the process, it is unlikely to save many lives.

"...there is more global enthusiasm than improvement in care"

These key pieces of the zero suicide provider community are often engaged during an individual's most significant behavioural health crisis, including suicidal thoughts as well as attempts. Summit participants backed the following actions:

• Suicide prevention work must continue – zero suicide remains the aspiration.

• Encouraging training of the general public using a means like the Zero Suicide Alliance that promotes 'see, say, signpost' as an easy guide to helping.

• Early access to care is essential for suicide prevention and crisis lines remain important to make the connection when an individual is in need of help and support.

• Access to lethal means, such as firearms, medications and places to jump (buildings, cliffs, bridges, rail tracks and stations) must be addressed.

• Suicide is a public health issue and should be addressed using the expertise they can provide.

"Zero Suicide Alliance training: See, say signpost"

8 Family and friends should be fully engaged in crisis care and inappropriate barriers created by confidentiality or privacy need to be sensitively overcome

There were consistent messages from those with lived experience and professionals that at times of crisis, family members and friends can feel isolated and unable to provide support as behavioural health services refuse to communicate because of confidentiality and privacy considerations. Services are often fearful of the consequences of breaching perceived legal boundaries. However, this leads to genuine and unhelpful difficulties in the care and management of people at an extremely vulnerable phase in their lives.

"Family members and friends can feel isolated and unable to provide support"

Stories were shared of detriment and even harm to individuals as family and friends were unaware of their difficulties. This seems to be particularly problematic with young adults, especially those away from home, often for the first time, at university or other educational, training or work-based venues. To address this, there was a clear call for the duty of care to the individual to override the duty of confidentiality, though all recognised the potential difficulties and conflicts inherent in this.

In the UK there is a move to encourage students to give permission for parents to be contacted in the event of a crisis.[44] This could be considered as a general way of enabling much more caring communication in a crisis.

National leadership and policy issues
• Clarify confidentiality misconceptions that prevent information-sharing in crisis.

"Misconceptions prevent information-sharing in crisis"

9 Each nation needs a single, national three-digit crisis hub number that drives easy access in which:

a. all callers are welcome, and the crisis is defined by the caller, whether that is the user, family, friend or professional

• Some mentioned that single points of access can become single points of rejection through the inappropriate use of access criteria. There were some

excellent examples of services that bucked this trend by welcoming all-comers, such as the Living Rooms community respite centres in the USA.[45] The summit believes that all crisis should be defined by the caller, be they the user or a member of their close circle who knows them. If a professional calls, there should be no question of accepting the patient.

b. promotion and intelligent social media to get the word out to those who need it

• Social media can identify people who have a need and drop adverts into their use of the internet, directing them to reliable sites that can help. In London,[46] this is being used by The Healthy London Partnership and Thrive LDN to target low-level behavioural health needs but can be expanded with time to more severe behavioural health issues.

National leadership and policy issues
The summit identified urgent actions required:

• UK – 111 number has an option for behavioural health but is not operational in all areas – this needs to extend to all areas and is dependent on every region having an effective 24/7 behavioural health crisis line.

• US – x11 emergency number for behavioural health will be established in the near future. There needs to be urgent work nationally to ensure this is not delayed and adequate work in regions to ensure it connects to effective crisis lines. The US Congress has passed the National Suicide Hotline Improvement Act of 2018 and implementation is underway.[47] However, the move to a "x11" three-digit number nationally for suicide prevention is likely, but not assured, as implementation will need to be regional and provide access to local services (as set out under recommendation 1).

"Single points of contact should not become single points of rejection"

10 Significant system-wide investment is needed to deliver these recommendations

The summit recognises that there are limited funds for healthcare services throughout the world. Nonetheless, all thought leaders were adamant that sufficient funding was needed to provide an effective response to all in psychiatric emergency, with an approach equal to medical care for physical conditions. We believe this constitutes a minimally adequate crisis resolution system with full population coverage. If we were dealing with cancer or heart attacks, lack of a 24/7 response available to all sections of the population would be unacceptable and cause a public outcry. We need to speak up for those who need this service and call on funders, policy makers and those responsible for implementing systems to ensure this is delivered.

"… an effective response to all in psychiatric emergency, with an approach equal to medical care for physical conditions"

Funding and accountability
Significant investment is needed to build a crisis delivery system and enhance home- and community-based services. To achieve this, summit members identified key actions:

• Update service codes for behavioural health as these are lacking and not aligned.

• Urgently strengthen the research base to provide clear outcomes and 'proof' points for funding requests to those who determine fiscal allocations.

• Communicate more widely that home- and community-based treatment remains better for the individuals and is more cost efficient than inpatient treatment. For example, in the UK, it is widely quoted that for each inpatient bed opened, 44 individuals go un-served in home and community-based settings.

• Focus on a business 'best practice' case for developing a crisis delivery system from a total cost perspective, including law enforcement, fire departments, ambulance, medical and behavioural service costs.

"This may be an audacious commitment but how else will we see global change?"

Targeted funding
The participants acknowledged that certain groups of people are at higher risk of crisis and called for work to ensure that access to crisis care for these individuals is not compromised by the design of crisis services – the design needs to take account of their specific needs, and, where appropriate, target funding to achieve this:

• Black and minority ethnic groups,[48] especially black men where the specific inequality is less in being able to access, but more in over representation, the experiences people face, and the over-use of formal detention.

• Children and young people.[49]

• People with a diagnosis of personality disorder.[50]

• LGBT+ community.[51]

• Older adults.

- People with co-occurring drug and alcohol problems.

- Homeless people.[52]

- Refugees.[53]

- Those who have been subjected to violence, neglect or abuse.[54]

Next steps

The summit hopes that by raising the profile of the recommendations, there will be greater awareness of the need for change to address the significant inequalities in behavioural health crises, and that this will facilitate the implementation of improved crisis care for behavioural health globally. However, recommendations are only of value if they lead to action.

We recognise in these recommendations that action is needed at **national** level in many countries. We are therefore keen to take these recommendations to policy makers in both the US and the UK, as a start. In England, we aim to do this by influencing the development of the NHS long-term plan,[55] and in the US, by ensuring implementation of the ISMICC recommendations to Congress[56] on crisis systems and services.

We will also promote the findings more widely across international networks, including Institute of Healthcare Leadership and Management (IHLM),[57] International Initiative for Mental Health Leadership (IIMHL)[58] and others. Our intention is that clear actions will be specified relating to the recommendations, with people identified who will work to deliver them, in line with national policy.

As emphasised near the start of the document, national policy then needs to be implemented regionally and locally. We will encourage this implementation process by sharing widely examples of good practice and successful change.

This may be an audacious commitment but how else will we see global change in crisis care for those with behavioural health challenges? As Gandhi said, 'be the change.'

Collectively, NHS Clinical Commissioners and RI International, working with national and local partners, will try to bring about this change.

We hope that many others will try too, joining a social movement to influence those with power to deliver change with pace and at scale.

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