Mental health crisis services

Promoting person-centred and rights-based approaches

World Health Organization

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QualityRights

Mental health crisis services: promoting person-centred and rights-based approaches

(Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches)

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The accompanying guidance document and technical packages are available here.

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Foreword

Around the world, mental health services are striving to provide quality care and support for people with mental health conditions or psychosocial disabilities. But in many countries, people still lack access to quality services that respond to their needs and respect their rights and dignity. Even today, people are subject to wide-ranging violations and discrimination in mental health care settings, including the use of coercive practices, poor and inhuman living conditions, neglect, and in some cases, abuse.

The Convention on the Rights of Persons with Disabilities (CRPD), signed in 2006, recognizes the imperative to undertake major reforms to protect and promote human rights in mental health. This is echoed in the Sustainable Development Goals (SDGs) which call for the promotion of mental health and wellbeing, with human rights at its core, and in the United Nations Political Declaration on universal health coverage.

The last two decades have witnessed a growing awareness of the need to improve mental health services, however, in all countries, whether low-, medium- or high-income, the collective response has been constrained by outdated legal and policy frameworks, and lack of resources.

The COVID-19 pandemic has further highlighted the inadequate and outdated nature of mental health systems and services worldwide. It has brought to light the damaging effects of institutions, lack of cohesive social networks, the isolation and marginalization of many individuals with mental health conditions, along with the insufficient and fragmented nature of community mental health services.

Everywhere, countries need mental health services that reject coercive practices, that support people to make their own decisions about their treatment and care, and that promote participation and community inclusion by addressing all important areas of a person's life – including relationships, work, family, housing and education – rather than focusing only on symptom reduction.

The WHO Comprehensive Mental Health Action Plan 2020–2030 provides inspiration and a framework to help countries prioritize and operationalize a person-centred, rights-based, recovery approach in mental health. By showcasing good practice mental health services from around the world this guidance supports countries to develop and reform community-based services and responses from a human rights perspective, promoting key rights such as equality, non-discrimination, legal capacity, informed consent and community inclusion. It offers a roadmap towards ending institutionalization and involuntary hospitalization and treatment and provides specific action steps for building mental health services that respect every person's inherent dignity.

Everyone has a role to play in bringing mental health services in line with international human rights standards – policy makers, service providers, civil society, and people with lived experience of mental health conditions and psychosocial disabilities.

This guidance is intended to bring urgency and clarity to policy makers around the globe and to encourage investment in community-based mental health services in alignment with international human rights standards. It provides a vision of mental health care with the highest standards of respect for human rights and gives hope for a better life to millions of people with mental health conditions and psychosocial disabilities, and their families, worldwide.

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Executive summary

Mental health has received increased attention over the last decade from governments, nongovernmental organizations (NGOs) and multilateral organizations including the United Nations (UN) and the World Bank. With increased awareness of the importance of providing person-centred, human rights-based and recovery-oriented care and services, mental health services worldwide are striving to provide quality care and support.

Yet often services face substantial resource restrictions, operate within outdated legal and regulatory frameworks and an entrenched overreliance on the biomedical model in which the predominant focus of care is on diagnosis, medication and symptom reduction while the full range of social determinants that impact people's mental health are overlooked, all of which hinder progress toward full realization of a human rights-based approach. As a result, many people with mental health conditions and psychosocial disabilities worldwide are subject to violations of their human rights – including in care services where adequate care and support are lacking.

To support countries in their efforts to align mental health systems and services delivery with international human rights standards, including the *Convention on the Rights of Persons with Disabilities* (CRPD), the WHO *Guidance on community mental health services: Promoting person-centred and rights-based approaches* calls for a focus on scaling up community-based mental health services that promote person-centred, recovery- oriented and rights-based health services. It provides real-world examples of good practices in mental health services in diverse contexts worldwide and describes the linkages needed with housing, education, employment and social protection sectors, to ensure that people with mental health conditions are included in the community and are able to lead full and meaningful lives. The guidance also presents examples of comprehensive, integrated, regional and national networks of community-based mental health services and supports. Finally, specific recommendations and action steps are presented for countries and regions to develop community mental health services that are respectful of peoples' human rights and focused on recovery.

This comprehensive guidance document is accompanied by a set of seven supporting technical packages which contain detailed descriptions of the showcased mental health services

1. **Mental health crisis services**
2. **Hospital-based mental health services**
3. **Community mental health centres**
4. **Peer support mental health services**
5. **Community outreach mental health services**
6. **Supported living for mental health**
7. **Comprehensive mental health service networks**

Key messages of this guidance

- **Many people with mental health conditions and psychosocial disabilities face poor-quality care and violations of their human rights, which demands profound changes in mental health systems and service delivery.**

- **In many parts of the world examples exist of good practice, community-based mental health services that are person-centred, recovery-oriented and adhere to human rights standards.**

- **In many cases these good practice, community-based mental health services show lower costs of service provision than comparable mainstream services.**

- **Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities.**

- **It is essential to scale up networks of integrated, community-based mental health services to accomplish the changes required by the CRPD.**

- **The recommendations and concrete action steps in this guidance provide a clear roadmap for countries to achieve these aims.**

Introduction

Reports from around the world highlight the need to address discrimination and promote human rights in mental health care settings. This includes eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion[a] and tackling the power imbalances that exist between health staff and people using the services. Sector-wide solutions are required not only in low-income countries, but also in middle- and high-income countries.

The CRPD recognizes these challenges and requires major reforms and promotion of human rights, a need strongly reinforced by the Sustainable Development Goals (SDGs). It establishes the need for a fundamental paradigm shift within the mental health field, which includes rethinking policies, laws, systems, services and practices across the different sectors which negatively impact people with mental health conditions and psychosocial disabilities.

Since the adoption of the CRPD in 2006, an increasing number of countries are seeking to reform their laws and policies in order to promote the rights to community inclusion, dignity, autonomy, empowerment and recovery. However, to date, few countries have established the policy and legislative frameworks necessary to meet the far-reaching changes required by the international human rights framework. In many cases, existing policies and laws perpetuate institutional-based care, isolation as well as coercive – and harmful – treatment practices.

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a Strategies to end seclusion and restraint. WHO QualityRights Specialized training. Course guide. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/329605/97892 41516754-eng.pdf).

Providing community-based mental health services that adhere to the human rights principles outlined in the CRPD – including the fundamental rights to equality, non-discrimination, full and effective participation and inclusion in society, and respect for people's inherent dignity and individual autonomy – will require considerable changes in practice for all countries. Implementing such changes can be challenging in contexts where insufficient human and financial resources are being invested in mental health.

This guidance presents diverse options for countries to consider and adopt as appropriate to improve their mental health systems and services. It presents a menu of good practice options anchored in community-based health systems and reveals a pathway for improving mental health care services that are innovative and rights-based. There are many challenges to realizing this approach within the constraints that many services face. However, despite these limitations, the mental health service examples showcased in this guidance show concretely – it can be done.

Examples of good practice community mental health services

In many countries, community mental health services are providing a range of services including crisis services, community outreach, peer support, hospital-based services, supported living services and community mental health centres. The examples presented in this guidance span diverse contexts from, for example, the community mental health outreach service, Atmiyata, in India, to the Aung Clinic community mental health service in Myanmar and the Friendship Bench in Zimbabwe, all of which make use of community health care workers and primary health care systems. Other examples include hospital-based services such as the BET unit in Norway, which is strongly focused on recovery, and crisis services such as Tupu Ake in New Zealand. This guidance also showcases established supported living services such as the KeyRing Living Support Networks in the United Kingdom and peer-support services such as the Users and Survivors of Psychiatry groups in Kenya and the Hearing Voices Groups worldwide.

While each of these services is unique, what is most important is that they are all promoting a person-centred, rights-based, recovery approach to mental health systems and services. None is perfect, but these examples provide inspiration and hope as those who have established them have taken concrete steps in a positive direction towards alignment with the CRPD.

Each mental health service description presents the core principles underlying the service including their commitment to respect for legal capacity, non-coercive practices, community inclusion, participation and the recovery approach. Importantly, each service presented has a method of service evaluation, which is critical for the ongoing assessment of quality, performance and cost-effectiveness. In each case, service costs are presented as well as cost comparisons with regional or national comparable services.

These examples of good practice mental health services will be useful to those who wish to establish a new mental health service or reconfigure existing services. The detailed service descriptions in the technical packages contain practical insights into challenges faced by these services as they evolved, and the solutions developed in response. These strategies or approaches can be replicated, transferred or scaled up when developing services in other contexts. The guidance presents practical steps and recommendations for setting up or transforming good practice mental health services that can work successfully within a wide range of legal frameworks while still protecting human rights, avoiding coercion and promoting legal capacity.

Significant social sector changes are also required

In the broader context, critical social determinants that impact people's mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, and lack of access to housing, social safety nets, and health services, are factors often overlooked or excluded from mental health discourse and practice. In reality, people living with mental health conditions and psychosocial disabilities often face disproportionate barriers to accessing education, employment, housing and social benefits – fundamental human rights – on the basis of their disability. As a result, significant numbers are living in poverty.

For this reason, it is important to develop mental health services that engage with these important life issues and ensure that the services available to the general population are also accessible to people with mental health conditions and psychosocial disabilities.

No matter how well mental health services are provided though, alone they are insufficient to support the needs of all people, particularly those who are living in poverty, or those without housing, education or a means to generate an income. For this reason, it is essential to ensure that mental health services and social sector services engage and collaborate in a very practical and meaningful way to provide holistic support.

In many countries, great progress is already being made to diversify and integrate mental health services within the wider community. This approach requires active engagement and coordination with diverse services and community actors including welfare, health and judiciary institutions, regional and city authorities, along with cultural, sports and other initiatives. To permit such collaboration, significant strategy, policy and system changes are required not only in the health sector but also in the social sector.

Scaling up mental health service networks

This guidance demonstrates that scaling up networks of mental health services that interface with social sector services is critical to provide a holistic approach that covers the full range of mental health services and functions.

In several places around the world, individual countries, regions or cities have developed mental health service networks which address the above social determinants of health and the associated challenges that people with mental health and psychosocial conditions face daily.

Some of the showcased examples are well-established, structured and evaluated networks that have profoundly reshaped and reorganized the mental health system; others are networks in transition, which have reached significant milestones.

The well-established networks have exemplified a strong and sustained political commitment to reforming the mental health care system over decades, so as to adopt a human rights and recovery-based approach. The foundation of their success is an embrace of new policies and laws, along with an increase in the allocation of resources towards community-based services. For instance, Brazil's community-based mental health networks offer an example of how a country can implement services at large scale, anchored in human rights and recovery principles. The French network of East Lille further demonstrates that a shift from inpatient care to diversified, community-based interventions can be achieved with an investment comparable to that of more conventional mental health services.

Finally, the Trieste, Italy network of community mental health services is also founded upon on a human rights-based approach to care and support, and strongly emphasizes de-institutionalization. These networks reflect the development of community-based mental health services that are strongly integrated and connected with multiple community actors from diverse sectors including the social, health, employment, judiciary and others.

More recently, countries such as Bosnia and Herzegovina, Lebanon, Peru, and others, are making concerted efforts to rapidly expand emerging networks, and to offer community-based, rights-oriented and recovery-focused services and supports at scale. A key aspect of many of these emerging networks is the aim of bringing mental health services out of psychiatric hospitals and into local settings, so as to ensure the full participation and inclusion of individuals with mental health conditions and psychosocial disabilities in the community. While more time and sustained effort is required, important changes are already materializing. These networks provide inspiring examples of what can be achieved with political will, determination and a strong human rights perspective underpinning actions in mental health.

Key recommendations

Health systems around the world in low-, middle- and high-income countries increasingly understand the need to provide high quality, person-centred, recovery-oriented mental health services that protect and promote people's human rights. Governments, health and social care professionals, NGOs, organizations of persons with disabilities (OPDs) and other civil society actors and stakeholders can make significant strides towards improving the health and well-being of their populations by taking decisive action to introduce and scale up good practice services and supports for mental health into broader social systems while protecting and promoting human rights.

This guidance presents key recommendations for countries and organizations, showing specific actions and changes required in mental health policy and strategy, law reform, service delivery, financing, workforce development, psychosocial and psychological interventions, psychotropic drugs, information systems, civil society and community involvement, and research.

Crucially, significant effort is needed by countries to align legal frameworks with the requirements of the CRPD. Meaningful changes are also required for policy, strategy and system issues. Through the creation of joint policy and with strong collaboration between health and social sectors, countries will be better able to address the key determinants of mental health. Many countries have successfully used shifts in financing, policy and law as a powerful lever for mental health system reform. Placing human rights and recovery approaches at the forefront of these system reforms has the potential to bring substantial social, economic and political gains to governments and communities.

In order to successfully integrate a person-centred, recovery-oriented and rights-based approach in mental health, countries must change and broaden mindsets, address stigmatizing attitudes and eliminate coercive practices. As such, it is critical that mental health systems and services widen their focus beyond the biomedical model to also include a more holistic approach that considers all aspects of a person's life. Current practice in all parts of the world, however, places psychotropic drugs at the centre of treatment responses whereas psychosocial interventions, psychological interventions and peer support should also be explored and offered in the context of a person-centred, recovery and rights-based approach. These changes will require significant shifts in the knowledge, competencies and skills of the health and social services workforce.

More broadly, efforts are also required to create inclusive societies and communities where diversity is accepted, and the human rights of all people are respected and promoted. Changing negative attitudes and discriminatory practices is essential not just within health and social care settings, but also within the community as a whole. Campaigns raising awareness of the rights of people with lived experience are critical in this respect, and civil society groups can play a key strategic role in advocacy.

Further, as mental health research has been dominated by the biomedical paradigm in recent decades, there is a paucity of research examining human rights-based approaches in mental health. A significant increase in investment is needed worldwide in studies examining rights-based approaches, assessing comparative costs of service provision and evaluating their recovery outcomes in comparison to biomedical-based approaches. Such a reorientation of research priorities will create a solid foundation for a truly rights-based approach to mental health and social protection systems and services.

Finally, development of a human rights agenda and recovery approach cannot be attained without the active participation of individuals with mental health conditions and psychosocial disabilities. People with lived experience are experts and necessary partners to advocate for the respect of their rights, but also for the development of services and opportunities that are most responsive to their actual needs.

Countries with a strong and sustained political commitment to continuous development of community-based mental health services that respect human rights and adopt a recovery approach will vastly improve not only the lives of people with mental health conditions and psychosocial disabilities, but also their families, communities and societies as a whole.

What is the WHO QualityRights initiative?

WHO QualityRights is an initiative which aims to improve the quality of care and support in mental health and social services and to promote the human rights of people with psychosocial, intellectual or cognitive disabilities throughout the world. QualityRights uses a participatory approach to achieve the following objectives:

1 **Build capacity to combat stigma and discrimination, and to promote human rights and recovery.**
- WHO QualityRights face to face training modules
- WHO QualityRights e-training on mental health and disability: Eliminating stigma and promoting human rights

2 **Improve the quality of care and human rights conditions in mental health and social services.**
- WHO QualityRights assessment toolkit
- WHO QualityRights module on transforming services & promoting rights

3 **Create community-based and recovery-oriented services that respect and promote human rights.**
- WHO guidance and technical packages on community mental health services: Promoting person-centred and rights-based approaches
- WHO QualityRights guidance module one-to-one peer support by and for people with lived experience
- WHO QualityRights guidance module on peer support groups by and for people with lived experience
- WHO QualityRights person-centred recovery planning for mental health and well-being self-help tool

4 **Support the development of a civil society movement to conduct advocacy and influence policy-making.**
- WHO QualityRights guidance module on advocacy for mental health, disability and human rights
- WHO QualityRights guidance module on civil society organizations to promote human rights in mental health and related areas

5 **Reform national policies and legislation in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards.**
- WHO guidance currently under development

For more information visit the WHO QualityRights website

About the WHO Guidance and technical packages on community mental health services

The purpose of these documents is to provide information and guidance to all stakeholders who wish to develop or transform their mental health system and services. The guidance provides in-depth information on the elements that contribute towards the development of good practice services that meet international human rights standards and that promote a person-centred, recovery approach. This approach refers to mental health services that operate without coercion, that are responsive to people's needs, support recovery and promote autonomy and inclusion, and that involve people with lived experience in the development, delivery and monitoring of services.

There are many services in countries around the world that operate within a recovery framework and have human rights principles at their core – but they remain at the margins and many stakeholders including policy makers, health professionals, people using services and others, are not aware of them.

The services featured in these documents are not being endorsed by WHO but have been selected because they provide concrete examples of what has been achieved in very different contexts across the world. They are not the only ones that are working within a recovery and human rights agenda but have been selected also because they have been evaluated, and illustrate the wide range of services that can be implemented.

Showing that innovative types of services exist and that they are effective is key to supporting policy makers and other key actors to develop new services or transform existing services in compliance with human rights standards, making them an integral part of Universal Health Coverage (UHC).

This document also aims to highlight the fact that an individual mental health service on its own, even if it produces good outcomes, is not sufficient to meet all the support needs of the many people with mental conditions and psychosocial disabilities. For this, it is essential that different types of community-based mental health services work together to provide for all the different needs people may have including crisis support, ongoing treatment and care, community living and inclusion.

In addition, mental health services need to interface with other sectors including social protection, housing, employment and education to ensure that the people they support have the right to full community inclusion.

The WHO guidance and technical packages comprise a set of documents including:

- ***Guidance on community mental health services: Promoting person-centred and rights-based approaches*** – This comprehensive document contains a detailed description of person-centred, recovery and human rights-based approaches in mental health. It provides summary examples of good practice services around the world that promote human rights and recovery, and it describes the steps needed to move towards holistic service provision, taking into account housing, education, employment and social benefits. The document also contains examples of comprehensive, integrated networks of services and support, and provides guidance and action steps to introduce, integrate and scale up good practice mental health services within health and social care systems in countries to promote UHC and protect and promote human rights.

- ***Seven supporting technical packages on community mental health services: Promoting person-centred and rights-based approaches** –* The technical packages each focus on a specific category of mental health service and are linked to the overall guidance document. The different types of services addressed include: mental health crisis services, hospital-based mental health services, community mental health centres, peer support mental health services, community outreach mental health services, supported living services for mental health, and networks of mental health services. Each package features detailed examples of corresponding good practice services which are described in depth to provide a comprehensive understanding of the service, how it operates and how it adheres to human rights standards. Each service description also identifies challenges faced by the service, solutions that have been found and key considerations for implementation in different contexts. Finally, at the end of each technical package, all the information and learning from the showcased services is transformed into practical guidance and a series of action steps to move forward from concept to the implementation of a good practice pilot or demonstration service.

Specifically, the technical packages:

- showcase, in detail, a number of mental health services from different countries that provide services and support in line with international human rights standards and recovery principles;

- outline in detail how the good practice services operate in order to respect international human rights standards of legal capacity, non-coercive practices, community inclusion, participation and the recovery approach;

- outline the positive outcomes that can be achieved for people using good practice mental health services;

- show cost comparisons of the good practice mental health services in contrast with comparable mainstream services;

- discuss the challenges encountered with the establishment and operation of the services and the solutions put in place to overcome those challenges; and

- present a series of action steps towards the development of a good practice service that is person-centred and respects and promotes human rights and recovery, and that is relevant to the local social and economic context.

It is important to acknowledge that no service fits perfectly and uniquely under one category, since they undertake a multitude of functions that touch upon one or more of the other categories. This is reflected in categorizations given at the beginning of each mental health service description.

These documents specifically focus on services for adults with mental health conditions and psychosocial disabilities. They do not include services specifically for people with cognitive or physical disabilities, neurological conditions or substance misuse, nor do they cover highly specialized services, for example, those that address eating disorders. Other areas not covered include e-interventions, telephone services (such as hotlines), prevention, promotion and early intervention programmes, tool-specific services (for example, advance planning), training and advocacy. These guidance documents also do not focus on services delivered in non-specialized health settings, although many of the lessons learned from the services in this document also apply to these settings.

How to use the documents

Guidance on community mental health services: Promoting person-centred and rights-based approaches is the main reference document for all stakeholders. Readers interested in a particular category of mental health service may refer to the corresponding technical package which provides more detail and specific guidance for setting up a new service within the local context. However, each technical package should be read in conjunction with the broader Guidance on community mental health services document, which provides the detail required to also integrate services into the health and social sector systems of a country.

These documents are designed for:

- relevant ministries (including health and social protection) and policymakers;

- managers of general health, mental health and social services;

- mental health and other health and community practitioners such as doctors, nurses, psychiatrists psychologists, peer supporters, occupational therapists, social workers, community support workers, personal assistants, or traditional and faith based healers;

- people with mental health conditions and psychosocial disabilities;

- people who are using or who have previously used mental health and social services;

- nongovernmental organizations (NGOs), and others working in the areas of mental health, human rights or other relevant areas such as organizations of persons with disabilities, organizations of users/survivors of psychiatry, advocacy organizations, and associations of traditional and faith-based healers;

- families, support persons and other care partners; and

- other relevant organizations and stakeholders such as advocates, lawyers and legal aid organizations, academics, university students, community and spiritual leaders.

A note on terminology

The terms "persons with mental health conditions and psychosocial disabilities" as well "persons using mental health services" or "service users" are used throughout this guidance and accompanying technical packages.

We acknowledge that language and terminology reflects the evolving conceptualization of disability and that different terms will be used by different people across different contexts over time. People must be able to decide on the vocabulary, idioms and descriptions of their experience, situation or distress. For example, in relation to the field of mental health, some people use terms such as "people with a psychiatric diagnosis", "people with mental disorders" or "mental illnesses", "people with mental health conditions", "consumers", "service users" or "psychiatric survivors". Others find some or all these terms stigmatizing or use different expressions to refer to their emotions, experiences or distress.

The term "psychosocial disability" has been adopted to include people who have received a mental health-related diagnosis or who self-identify with this term. The use of the term "disability" is important in this context because it highlights the significant barriers that hinder the full and effective participation in society of people with actual or perceived impairments and the fact that they are protected under the CRPD.

The term "mental health condition" is used in a similar way as the term physical health condition. A person with a mental health condition may or may not have received a formal diagnosis but nevertheless identifies as experiencing or having experienced mental health issues or challenges. The term has been adopted in this guidance to ensure that health, mental health, social care and other professionals working in mental health services, who may not be familiar with the term 'psychosocial disability', nevertheless understand that the values, rights and principles outlined in the documents apply to the people that they encounter and serve.

Not all people who self-identify with the above terms face stigma, discrimination or human rights violations. a user of mental health services may not have a mental health condition and some persons with mental health conditions may face no restrictions or barriers to their full participation in society.

The terminology adopted in this guidance has been selected for the sake of inclusiveness. It is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere. Above all, a diagnosis or disability should never define a person. We are all individuals, with a unique social context, personality, autonomy, dreams, goals and aspirations and relationships with others.

1.

Introduction

The goal of crisis services is to support people experiencing acute mental distress. However, these are the very services where people are at a heightened risk of their human rights being violated, including through forced admissions and treatment, the use of other coercive practices such as seclusion and physical, mechanical, and chemical restraints. These practices have been shown to be harmful to people's mental, emotional and physical health, sometimes leading to death *(1-3).*

This technical package showcases a selection of crisis services that provide effective care and support without resorting to the use of force or coercion, and that respect the right to legal capacity and other human rights. Such services can be delivered in various ways. Some assist people to overcome their crisis at home with support from a multi-disciplinary team. Others deliver care and support in respite centres or houses. These provide community-based, temporary accommodation designed to allow for short-term breaks from people's usual daily lives.

All services presented in this technical package take a holistic, person-centred approach to care and support. They acknowledge that there is no consensus on what constitutes a crisis, and that what a person may experience as a crisis may not be viewed as such by someone else. Therefore, each service showcased approaches crisis as a very personal experience that is unique and subjective, requiring different levels of support for an individual to overcome.

Based on a human rights-based and recovery approach, services showcased in this technical package pay particular attention to power asymmetries within the service. Many also focus on meaningful peer involvement and the provision of a safe space and comfortable environment in which to overcome the crisis. All insist on the importance of communication and dialogue with the people experiencing the crisis and understand that the people themselves are experts when it comes to their own care and support needs.

People receiving support from crisis response services featured in this technical package are never removed from community life. Many services actively include families and close friends in the care and support of individuals, with their agreement. Additionally, these crisis response services are well connected to other resources available in the community. They are able to connect individuals with and help them navigate the system outside, so that they are supported beyond the crisis period.

Overall, the success of these services demonstrates that crisis response does not necessitate the use of force or coercion. Instead, communication and dialogue, informed consent, peer involvement, flexibility in the support provided, and respect for the individual's legal capacity are shown to achieve quality care and support that is responsive to people's needs.

The services described in this technical package were chosen following an extensive search and screening of services identified through literature reviews, a comprehensive internet search, an e-consultation and with input from existing WHO networks and collaborators. A detailed description of the methodology is provided in the annex of *Guidance on community mental health services: Promoting person-centred and rights-based approaches.* The selection process was based on the five human rights and recovery criteria, namely: respect for legal capacity, non-coercive practices, participation, community inclusion, and the recovery approach. Services from low-income contexts and under-represented geographical regions were prioritized where possible and/or appropriate, as well as services with evaluation data. One of the key challenges identified in reviewing the services was the lack of robust evaluation data. This challenge was encountered across all service categories. The need for greater investment in evaluating

services is one of the recommendations made in the section on guidance and action steps in *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. The services described in this technical package are not intended to be interpreted as best practice, but rather to illustrate what can be done and to demonstrate the wider potential of community-based mental health services that promote a person-centred, rights-based, recovery approach.

Providing community-based mental health services that adhere to human rights principles represents considerable shifts in practice for all countries and sets very high standards in contexts where insufficient human and financial resources are being invested in mental health. Some low-income countries may assume that the examples from high-income countries are not appropriate or useful, and equally, for high-income countries looking at the examples showcased from low-income countries. New types of services and practices may also generate a range of questions, challenges, and concerns from different stakeholders, be it policy makers, professionals, families and carers or individuals who use mental health services. The intention of this guidance is not to suggest that these services be replicated in their entirety, but rather to take and learn from those principles and practices that are relevant and transferrable to one's own context in providing community-based mental health services that are person-centred and promote human rights and recovery.

2.

Good practice mental health crisis services – description and analysis

2.1

Afiya House

Massachusetts, United States of America

Primary classification: Crisis service

Other classifications:

- [ ] Community mental health centre
- [ ] Community outreach
- [x] Peer support
- [ ] Crisis service
- [ ] Hospital-based service
- [ ] Supported living service

Availability in different locations:

- [ ] Yes
- [x] No

Evidence:

- [ ] Published literature
- [x] Grey literature
- [ ] None

Financing:

- [x] State health sector
- [ ] State social sector
- [ ] Health insurance
- [ ] Donor funding
- [ ] Out-of-pocket payment

Context

Afiya House is located in Northampton, Western Massachusetts, in the United States of America. It is run by the Wildflower Alliance, a broad community of people working within a peer-to-peer framework; all Wildflower Alliance's staff identify as having faced life-interrupting challenges such as psychiatric diagnoses, trauma, homelessness, problems with substance use, and other issues. Formerly known as the Western Mass Learning Community (RLC), which launched in 2007, the group rebranded in 2020 to better reflect its community-building mission and international training and advocacy work *(4)*. The Guiding Council of Western Massachusetts (GCOW) serves as an advisory board to the Alliance. It too is comprised primarily of individuals with lived experience and its members represent all the counties of Western Massachusetts. The council meets every month to guide the development of the Alliance and oversee its activities.

The Wildflower Alliance operates resource centres in Holyoke, Pittsfield, Greenfield and Springfield; it has also developed groups, workshops and events in a variety of settings in the community. Four types of activity are on offer: alternative healing practices, such as yoga; education in creative activities, such as writing books, making films, and providing training events nationally and internationally, as well as access to resources such as computers, a lending library and peer-support information; advocacy; and peer support, offered by telephone or in person. The Wildflower Alliance employs community bridgers, people who offer support to individuals preparing to leave hospital and transition back to the community *(4)*. Bridgers are also employed to support people in prison.

Afiya House is one of the Wildflower Alliance's peer-support initiatives. It was opened in 2012 and is located in an urban residential neighbourhood that is easily accessible by public transport *(5)*. It is the only peer respite in Massachusetts and one of about three dozen respites across the US. People who stay in Afiya House are automatically connected with all the other activities provided by the Wildflower Alliance, and those who work at Afiya House are considered employees of the Alliance.

Description of the service

Afiya House is a peer-run respite which aims to support people in distress. The aim is to turn a crisis into a learning and growth opportunity. The respite is open to anyone, 18 years old and over, experiencing significant emotional or mental distress and who believes they would benefit from a peer-supported environment. Lack of housing cannot be the sole reason for staying at the respite. People staying at Afiya must abide by the values and expectations of the house or may be asked to leave. In such cases, the individual will have a meeting with two members of the team to discuss the situation, as well as follow-up communication pertaining to potential future stays. The maximum stay at Afiya is seven nights; most people stay for this length of time.

No medical clearance is required to a stay at Afiya, but individuals who need hands-on personal care, such as assistance in the bathroom or to administer medication, are not eligible to stay unless accompanied by someone who can assist them as required *(6)*.

Afiya's physical structure includes three bedrooms, two bathrooms, one kitchen, a living room, and other community spaces including a furnished basement and TV room. There are one or two paid peer support team members present at any time.

Employees are asked to complete four core training courses; Intentional Peer Support (IPS) *(7)*, Alternatives to Suicide *(8)*, Hearing Voices facilitator training, and anti-oppression training. Other training opportunities are offered when possible and if applicable. With diverse interests and experiences, employees are willing to be flexible and participate in activities residents of the house might find useful. These include meditation, practicing yoga, going for a walk or hike, or gardening, as weather, resources and interests permit.

Three people can stay at the house at any one time. While resident at Afiya, individuals have access to peer support 24 hours a day for up to seven nights. Everyone is assigned a private room. However, they also have access to communal rooms including a kitchen with basic food items and a variety of resources such as books, art supplies, musical instruments, and yoga mats. People are supported to set up a specific plan, if they feel that this would be useful, but there is no expectation that people keep to any pre-determined schedule (such as sleep and wake times or mandatory activities). Peer supporters regularly check on people during their stay; they may invite the individual to connect or help identify activities the individual might like assistance with. Peer supporters are available for one-to-one peer support, but group support can also be organized if everyone in the house agrees. In fact, the space is most effective when support takes place between the people who are staying, and not simply between paid team members and individuals in the house.

People staying at Afiya are free to enter and leave the property to continue their regular schedule, if this is desired or thought useful. For instance, they may continue with school, work, community obligations, or appointments; individuals can even include a practice night at home as a part of a transition plan towards the end of their stay. However, if a person leaves for more than 24 hours without notice, they will forfeit their place *(6)*.

Other activities offered during a stay may include:

- learning how to develop a wellness plan or advance directive;
- exploring written and online resources such as the Harm Reduction Guide to Coming Off Psychiatric Drugs or the Inner Compass Initiative Withdrawal Project, a web-based online platform which provides opportunities for like-minded people to find each other *(9, 10)*;
- re-evaluating or making new plans for moving forward, after their stay at Afiya House;
- learning about new ideas and community resources, such as the Hearing Voices Network and Alternatives to Suicide *(6)*; and
- taking walks, gardening, and other outdoor activities.

Any written documentation is limited and the purpose of each document is clearly explained. When people first enter the house, they must sign a document that explains what they can expect, what is offered and not offered within the house, and the responsibilities of residents. If someone staying at the house does not want to complete any other forms, they will not be coerced into doing so. Some forms, such as one where an individual can share ideas about how they want to be supported if their situation deteriorates, are considered the property of the individual and can be taken away or destroyed at the end of their stay. Team members are strongly discouraged from reading any previous paperwork remaining on site if someone returns for a second stay. This approach to paperwork helps to reduce the power imbalances that often exist in mental health services.

Those interested in staying at Afiya must first have a conversation with a team member from the service. This can be done in person or by telephone depending on the individual's location and ability to meet face-to-face. Standard systems language such as "intake" is intentionally avoided. During this first meeting, a team member offers information about the house and asks questions to learn more about the individual's circumstances, and why they think Afiya might be a good fit for them. The final decision as to whether a person should stay is made by the individual, the first team member they spoke to, and a second team member, who ensures no other pertinent information is missed. The process is kept as flexible as possible. For example, should a person find speaking at length too arduous, based on their current distress, other options are offered, such as text messaging. A three-person waiting list is also maintained.

Afiya does not offer any clinical services, but people staying at the house are welcome to maintain existing clinical relationships in the community as desired. Team members can also support individuals to identify whether they wish to make changes to their clinical services and can explore options with them. However, transportation support is limited by the number of team members available at any one time to cover the house while supporting someone in the community.

Team members are unable to assist with the administration of psychotropic drugs or any medical treatments, to avoid all interactions historically rooted in power imbalances and coercion. Individuals are provided with a locked box in their room where they may store their own medication or valuables. They can have visitors if assistance is desired or required.

Afiya operates under the assumption that people are responsible for themselves. If an individual treats another person staying or working at the house with disregard, that individual is considered responsible for their actions and expected either to repair the relationship or leave the house. This rule, however, does not detract from people's freedom to experience and express a full range of emotions, including anger, within the house.

Not all peer respites are located within a broader and older peer-to-peer community like the Wildflower Alliance. This began five years before Afiya launched. Individuals do not need to be in crisis to access support; during and after their stay at Afiya, they can use resources the Wildflower Alliance has to offer as much or as little as they wish.

From 2019, Afiya employed a bridger for 15 hours per week to help ease the transition to and from the house. The bridger works with people on the waiting list to enter the house, as well as people who have been resident at Afiya but are preparing to leave. The bridger has a vehicle and can help individuals sign up to resources in the community if they wish; they support people to build or re-build connections with the community and to be successful after leaving the house. The extent to which individuals are supported depends on their own desires and self-identified needs.

Core principles and values underlying the service

Respect for legal capacity

People are free to do what they like during their stay. They are offered a variety of options including peer support, but no support or structure is imposed. People can have visitors and are also supported to refuse any unwanted visitors. The house will not disclose who is staying if there are telephone calls to inquire; this rule applies regardless of whether callers identify themselves as a provider.

Afiya emphasizes prioritizing choice and self-determination by providing trauma-informed peer support (6). Emergency mental health crisis services are never called, regardless of how much a person is struggling, unless the individual specifically wants them. All potential options are discussed as needed, including the pros and cons of any particular option and what to expect from it. The police or ambulance are only contacted without someone's express consent during a medical emergency (such as a heart attack, drug overdose or if they are found unconscious, for example), or if there is a serious threat to, or violence towards, the house or someone in it. If emergency services are engaged without the expressed consent of the person involved, and even if the decision is thought to have been justifiable, team members are expected to document the incident and engage in a full review and debriefing process to explore what might have been handled differently before or during the situation.

Although optional, people staying at Afiya may choose to fill out a form called a Preferred Contact and Support Sheet, detailing emergency contacts, important medical information (such as allergies or medical conditions), and how they wish to be supported during difficulties, crisis situations or medical emergencies. This form is considered the property of the person completing it and can be taken or destroyed at the end of their stay. If requested, team members can attend doctors' appointments as an advocate, or help the individual prepare what they want to say to the doctor. When they enter the respite, people are briefed on human rights issues; they are also made aware of Afiya's human rights officer as well as third parties to contact if they believe they are being mistreated in any way while at the house (6).

Emotional distress, suicidal thoughts or even a plan to kill oneself, are not regarded as medical emergencies and the staff at Afiya are trained to support people in these situations; all staff receive training on supported decision-making, Intentional Peer Support (IPS) and the Alternatives to Suicide approach, a form of peer-support groups modelled on the way Hearing Voices groups operate *(7, 8)*. Developed in 2008 by the Western Massachusetts Recovery Community (RLC), Alternatives to Suicide evolved from a realization that traditional approaches to suicide prevention were actually counter-productive and often led to coercive interventions. Over time, the approach has been developed into stages called, Validation, Curiosity, Vulnerability, Community (VCVC).

Non-coercive practices

A period of residence at Afiya House is completely voluntary. It can only be initiated by the person who wishes to stay and not by family, friends or service providers. Bedrooms cannot be locked from the outside but can be locked from inside if the person staying there chooses to do so. Afiya House is not against medication. However, support and resources on withdrawing from psychotropic drugs can be provided if a person wishes it *(6)*. The nature of a peer respite, which involves neither medication administration nor holding a person's money while they stay, and staff who are not clinically trained, minimizes asymmetric power dynamics between the individuals staying and those working at the house. This reduces the potential for even an unintentional drift towards coercive interactions.

There are processes and protocols in place to respond to crisis situations and to document and learn from any incidents that result in involuntary actions in relation to medical emergencies, such as overdoses, uncontrollable bleeding following self-harm, chest pain, and collapse. In these circumstances, staff are encouraged to contact emergency services without delay *(6)*. After any incident when force is used, as a result of calling emergency services for example, an internal review takes place.

Approaches such as IPS, Alternatives to Suicide, and Hearing Voices all offer useful means for being present with someone, including those in anger. Afiya House believes that it is important for people to express their anger while simultaneously avoiding violence and considering the impact on the environment and others. The service does not offer team members any specific de-escalation training or protocol beyond VCVC *(8)*.

Community Inclusion

Afiya House recognizes community inclusion as a key component in offering respite; people staying at the house are supported to go out and explore local resources. That they can come and go freely from the house, according to their wishes, also helps to maintain or initiate important ties and responsibilities in their community, including work, education and other activities *(6)*. People staying at the respite are supported to keep or become connected with any family, friends, providers or supporters they wish to. On occasion, Afiya team members have also helped to facilitate healing dialogues between people staying at the house and their friends or families.

Community is recognized as being found in spiritual, sports, educational communities and beyond. Staff at Afiya House share information about resources they are aware of and may partner with the individual to learn about resources. Furthermore, Afiya House partners with other elements of the Wildflower Alliance as needed. The Alliance's Community Supports Coordinator does a great deal of work around housing and homelessness, for example.

Participation

Afiya House was created by people who have experienced psychiatric diagnosis, trauma, homelessness, problems with substances and a variety of other life-interrupting challenges. Consistent with Afiya's peer respite charter *(6)*, Afiya continues to maintain a team of people who identify in this way, including the entire leadership.

Everyone staying at Afiya is requested to complete a satisfaction survey to evaluate their experience, so that the respite can respond to any concerns and continually improve services. The survey evaluates whether the values of Afiya were upheld, if available support met the person's needs, and the impact that the person's stay at Afiya had on different aspects of their life, including health, relationships, work, personal goals, and their connection with the community. To compare with previous experiences of mental health services, people are also asked to rate clinical services they may have used in the past using the same scales.

Recovery Approach

Afiya House does not require individuals to create a recovery plan. It simply asks individuals to complete a "Hopes for Stay" form that briefly outlines what they would like to achieve during their time at Afiya. Hopes may include something as simple as re-regulating a sleep schedule, but can also be more detailed such as developing a wellness plan or finding new housing. The form can also be refused, and team members do not insist on its completion in such instances. If they want, individuals may complete a Preferred Contact and Support Sheet that identifies wishes, preferences, vulnerabilities, and ways they would like to be supported if they are not able to communicate at any stage. Plans are the property of the person, which they can choose to take, leave, or destroy upon leaving *(6)*. A few days before their departure, a team member will invite a person staying at the house to discuss anything that they wish to put in place before they go. This is also a time when the person can share verbal feedback about their experience at the house.

Service Evaluation

Afiya House produced a report in 2017 *(5)* that displayed aggregate data on usage, as well as results from anonymous and voluntary satisfaction surveys, taken both at the end of and six months after a stay. Surveys are always voluntary. A total of 124 responses, an 84% response rate, was received for the end-of-stay surveys.

This report *(5)* stated that people stayed at Afiya 174 stays at Afiya House between 1 July 2016 and 30 June 2017; 107 (61%) people stayed once, 29 stayed twice and 38 stayed three times or more. Seventy-five (43%) individuals had never stayed at the house before. Before their stay at Afiya House, 51% of respondents reported a prior experience at a traditional respite programme, 57% reported using other mental health services, and 16% reported never having used any mental health services. In addition, 1344 people who contacted the service did not result in a stay at Afiya House; 74% of these were due to a lack of space available, and the remainder did not stay because they were ineligible, perhaps because of medical needs or age requirements.

After their stay, 70% of service users went home, 7% went to friends or family, 5% went to conventional respite, 1% went to a psychiatric hospital and 0.5% went to a hotel; 17% went to unknown places *(6)*. The report looked at responses to individuals' Hopes for Stay forms; 86% of respondents said that they met at least one hope for their stay. Qualitatively, people reported that Afiya had a positive impact on their lives. Compared to hospitals and other clinical, rather than peer respites, individuals scored Afiya House higher across multiple variables. People felt more welcome at Afiya and that information about the support was communicated more transparently to them. They also thought Afiya used more recovery-oriented language and had more non-judgmental team members who were engaged and made them feel listened to. People also preferred Afiya, in terms of being able to connect and engage in mutual support with others *(6)*.

Respondents also noted the following were helpful during their time at Afiya House: engaging with staff members who really cared, feeling connected to staff and other service users, managing to accomplish goals, and the freedom to do whatever they needed to do, including to seek support. Long-term service users reported better emotional health and relationships, fewer hospitalizations, better coping skills, and improved housing *(6)*. Importantly, respondents also thought there should be more support to plan for what to do after they leave the respite, often due to the lack of available resources in the community they returned to. In response to this feedback, a bridger was employed to support people transitioning to their home environment, to link up with available community resources.

In this 2017 report *(5),* Afiya House notes that it is difficult to fulfill one of its primary goals of hospital diversion because Afiya only has a three-person capacity and is often full, whereas there are nine psychiatric units in the region. It is also challenging to meet the demands of the number of people in the community struggling with housing; this is a system-wide issue which is difficult for any one group to address.

In 2015, it was projected that individuals responsible for 125 of 250 separate stays at Afiya, would probably have been hospitalized had peer respite not been available (based on self-reporting and past history of hospitalization) *(6)*.

Costs and cost comparisons

Afiya House is completely free of charge for anyone who stays, and no insurance is required. The respite is fully funded through the Massachusetts Department of Health and has been secured until at least 2027. The total annual running cost for Afiya in 2019 was US$ 443,928, of which personnel expenditure comprises the largest component. In 2015, the estimated the average cost per person per day in Afiya was US$ 1,460 compared with US$ 2,695 per person per day in hospital *(6)*.

Challenges and solutions

Building staff confidence

A major challenge was the lack of confidence felt by team members to try new and different methods of working. Many were not confident enough to vocalize their own personal limits in the work they carried out. Applying Intentional Peer Support and other newly acquired skills was difficult, especially in situations where people in the service were talking about frightening things, such as hurting themselves or someone else.

Team members were offered a great deal of training on providing peer support, and a whole month was dedicated to building connections between team members before the respite opened.

Overcoming resistance to the Afiya approach

Mainstream service providers' opinions and practices meant they found accepting the way staff at Afiya House responded to crisis situations challenging. Many did not believe the support on offer could be taken seriously. Providers often saw themselves as doing all the real crisis work; Afiya House was a place to send people who were not in crisis, but wanted some extra support. In addition, mainstream providers believed that once consent for the sharing of information was received from a service user, all personal information could be freely shared among service providers. In contrast, Afiya House views this practice as contributing to the loss of power of people staying in the house.

To remedy the situation, the service organized ongoing outreach to providers. It provided specific examples of how the team at Afiya supported people in crisis situations. Importantly, the staff highlighted the successes; residents who had been in crisis but improved. Additionally, the service organized "information share" meetings with mainstream service providers, both at Afiya house and by telephone, to promote a better understanding of each other's job demands and expectations. This included acknowledging that providers require certain kinds of information and are under pressure to keep track of people. At the same time, the service shared the values and reasoning behind restrictions in data sharing.

Advocating for change in the wider mental health system

That Afiya house is limited to a three-person capacity makes it extremely difficult to act as a diversion, given the number of psychiatric beds in the area. In addition, struggles experienced by individuals are so often related to deep structural problems. A key challenge for the service was how to effectively address someone's distress in a week, when that may be intrinsically linked to a person's lack of housing, for example.

The service spent time building relationships with local legislators, local thought leaders and people in important and respected positions. It continually raised the issue of limited access to services of this kind and the implications for the present as well as future sustainability and efficacy, within every annual report, at every presentation, and in every conversation with funders and legislators. Additionally, data collected through systematic evaluations has provided the evidence required for funders to continue financing the service.

Securing sufficient pay for the peer workforce

Lack of funding has made it difficult to pay enough to keep the best employees. Peer support is not treated with the respect it deserves; finding someone with first-hand experience, who is willing to talk openly about their lives and good at supporting others, is particularly challenging. The salary paid must be sufficient to keep those employees truly able to do this difficult work well. To overcome this obstacle, the service uses a small percentage of any extra funding offered to Afiya House to boost salaries of people working in the house whenever possible.

Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- engaging people with lived experience in the design and implementation of research to develop more relevant, appropriate and meaningful research. This helps avoid the mistrust people have in the research;

- maintaining the integrity of the support that the service provides rather than adjusting the support to fit research constraints

- recognizing that it is easier to build a service with a new vision from scratch rather than to break down existing structures and processes, especially where there are entrenched vested interests;

- looking for staff in mainstream services who can help the organization examine and challenge its existing knowledge and beliefs, and become aware of other possibilities;

- ensuring the service is a part of a larger peer-to-peer community that has a strong leadership and first-hand experience of mental health conditions and psychosocial disabilities; and

- focusing advocacy towards stakeholders, from funders to local government institutions, to ensure a consistent stream of finance.

Additional information and resources

Website:
https://wildfloweralliance.org/

Videos:
Afiya House (full version)
https://www.youtube.com/watch?v=9x8h3LvEB04

Contact:
Sera Davidow, Director, the Wildflower Alliance, USA
Email: sera@westernmassrlc.org or sera@wildfloweralliance.org

Link House

Bristol, United Kingdom of Great Britain and Northern Ireland

Primary classification: **Crisis service**

Other classifications:

☐ Community mental health centre ☐ Community outreach ☐ Peer support

☐ Crisis service ☐ Hospital-based service ☑ Supported living service

Availability in different locations:

☑ Yes ☐ No

Evidence:

☐ Published literature ☑ Grey literature ☐ None

Financing:

☑ State health sector ☐ State social sector ☐ Health insurance

☐ Donor funding ☐ Out-of-pocket payment

Context

Bristol is a city located in the west of England. A major innovation in mental health services occurred in 2014 when eighteen public and voluntary sector organizations from the city came together to form Bristol Mental Health, unifying the delivery of care. Fully funded by the state through the National Health Service (NHS), each constituent organization contributes expertise in different aspects of mental health care.

One of these eighteen organizations is Missing Link, which since 1982 has supported women who are homeless or are unable to live in their current homes due to mental health issues. Missing Link is the largest provider of women-only services in Bristol. Between 2017 and 2018, the organization helped 864 women find services and housing in their community, of which 150 used one of its services, Link House, a residential crisis centre *(11)*.

While this service description focuses on Link House, it should be noted that Missing Link, which is registered under the Co-operative and Community Benefit Societies Act (2014), offers many other services including counselling, outreach for those at risk of losing their housing, shared housing, and resettlement support. It also provides accommodation for homeless women with complex needs, support for people subject to domestic abuse and forced marriage; and emotional and practical support to women, children and men who are victims of rape and sexual assault *(12, 13)*.

Description of the service

Link House is a residential crisis centre for women aged 18 years old and older, who are going through a mental health crisis and need time away from their home environment. Link House has existed since 2010 with the primary aim to divert women in crisis away from psychiatric admission. The service helps women to cope with the immediate crisis and to build a social network and resilience for the future. Link House emphasizes that its support is not medical but is instead comprised of conversation and activities; it is informed by a social model of care *(12)*.

An alternative to inpatient care, the house has space for 10 women at a time; each can stay a maximum of four weeks. The service accepts all women, including those subject to the provisions of a Community Treatment Order, the terms of which mean they must accept medication and therapy, as a condition for being able to live in the community rather than being detained in an inpatient setting. Women detained in the local psychiatric hospital under the Mental Health Act can be 'discharged' into Link house as part of a facilitated early discharge. However, any stay at Link House is always done so on a voluntary basis. Women with intellectual, cognitive, and physical disabilities are also welcomed into Link House if they can take care of their own personal care needs; there is a disability suite at the house that is regularly used.

With a major emphasis on providing a non-clinical environment, the house features a large sitting room and shared kitchen where people bring their own food. In addition, there is a laundry, dining room and garden. House rules include respectful behaviour to others, ensuring safety and wellbeing within the household, and no smoking or drinking alcohol.

Staff are available 24 hours a day, seven days a week. Three members work during the day and two at night. People staying at Link House have their own support worker. In addition, support is also offered through a programme of group activities, such as mindfulness sessions. There are no medical staff. Some staff members, recruited from the local community, have had personal experience of mental health conditions. No formal qualifications are required for people to work at Link House. Staff receive core training in safeguarding, equality and diversity, suicide awareness, self-harm minimization and mental health first aid. There is also training in alternative coping strategies and de-escalation.

Individuals wanting to join Link House can self-refer by phoning in. They do not require a referral from mental health services. Referrals are also received from care coordinators, recovery navigators, the crisis team, support workers or general practitioners within the Avon and Wiltshire Trust, NHS health services offered throughout the counties of Avon and Wiltshire, including the city of Bristol.

After referral, members of staff speak to the person interested in using the service to decide whether Link House is suitable. They may arrange to assess the individual in person, to examine how they can offer support *(14)*. People with psychosis or suicidal thoughts are accepted into the house, as well as those with alcohol and substance use problems, if they are making good progress towards recovery. A decision to refer someone elsewhere rather than to support them at Link House may be made if staff members feel they cannot support the person appropriately; such a decision may also depend on the care and support needs of women currently staying in the house and the capacity of the service at that time.

To avoid waiting lists during emergency situations, Link House piloted a project in 2017–2018. Here an emergency bed was made available that could be directly accessed by crisis teams at the hospital *(15)*. If a woman experiencing a mental health crisis is homeless and there is no room available at Link House, it may be possible to find a place for her at one of the other Missing Link services.

When a woman comes to stay at Link House, she is supported to identify an area of her life she would like to improve, and the staff creates a programme tailored to this goal *(16)*. Each woman is allocated a staff member for one hour per day to work on the area identified. The members of staff also try to build support services around each individual and assist them in skills related to self-care, managing money, cooking, domestic skills, time management, relationships, employment, and parenting *(14)*. Link House offers a group recovery programme two or three times a week and many daily activities (including holistic recovery methods). The women staying at Link House can also benefit from the other programmes run by Missing Link. They can have visitors and are free to leave the house with visitors or on their own. Visits to the house are limited to certain times of the day and an hour's duration only, because of limited space. The women agree between themselves who is going to visit and when.

Core principles and values underlying the service

Respect for Legal capacity

Listening to the person using the service and respecting self-determination are essential elements of the philosophy behind Link House. All its activities are guided by the core values of respect, listening, understanding, valuing and responding to what service users say. All actions are taken in line with service user preferences. If a woman is unwell and unsure of what she wants, staff will sit with her – if she does not object – but will not press her to make decisions or talk.

Overall, service users continue their lives, with Link House in the background as a safety net *(16)*. Activities are tailored to help the women articulate their own goals and wishes; for example, staff can help service users to find an advocate to join them during a doctor's appointment *.*

If service users are dissatisfied with Link House, Missing Link has a complaints procedure. Here, a service user (or a third party if preferred) can report any complaints regarding the service or its workers. Missing Link has indicated complaints are dealt with promptly *(17)*.

Link House encourages and supports women to develop an advance plan, stating their wishes and preferences, as part of their overall recovery plan. This is in recognition of the fact that some women experience several crises.

Non-coercive practices

Access to Link House is always voluntary; during the initial assessment care is taken to ensure that women requiring the service are genuinely happy to stay at the house. Although encouraged to follow a routine during their stay, service users are not forced to do this, and restrictive practices are not used. Service users said the centre felt safe and homely, and that they appreciated the non-medical, women-only, positive and supportive approach by staff *(18)*.

Women staying at Link House are responsible for their own medication; staff members are not involved with the monitoring or administration of medication. If a woman decides not to take prescribed medication, this does not affect her stay at Link House. If a woman's mental health situation deteriorates to the extent that it is making her, or other people, feel unsafe, she is referred to the NHS crisis team or inpatient services.

Community inclusion

There is an emphasis on providing an inclusive environment; women using the service are encouraged to interact and cook together and there are group sessions organized 2–3 times a week. Link House actively links people to different community services based on their preferences and wishes. For example, residents may wish to connect with Missing Link's employment support services. They are encouraged to consider what they would like to do in the future, helped to examine their training needs and to prepare a CV if appropriate. Importantly, Link House encourages the them to continue regular activities in the community for the duration of their stay (16).

Participation

Link House is co-produced, and people with lived experience are involved at every level of the organization.

At a managerial level, Link House created The Crisis House User Reference Group (CHURG), composed of past service users. It aims to increase co-production and acts as a peer-support group for those who attend. The group meets every six weeks and is well-attended. CHURG members have been consulted on house rules, policy, literature, and activities.

Residents of Link House have an important say in the day-to-day management of the house and activities provided. In the service evaluation, 98% of service users were satisfied with their levels of participation in running the house (18). When Missing Link issues an appeal for volunteers, it aims to hire people with lived experience, and at least 20% of those engaged are peers (15). Focus groups are also conducted with women using the service to feed into further service development and improvement efforts.

Recovery Approach

This service uses a social care model of recovery rather than a biomedical model. It has adopted a strengths-based approach, which values lived experience and self-determination; it focuses on equality and cultural sensitivity; takes a holistic view, provides flexible support depending on individual needs, and helps individuals reconnect with their lives. All staff are trained and supported with reflective practice and using trauma-informed approaches.

Women are supported to develop coping strategies and strengths that can support them in their journeys to recovery. Women going through the service create individual Wellness Recovery Action Plans (WRAPs), a prevention and wellness process used around the world (19). Indeed, 88% of service users found WRAPs helpful, and staff tailor activities around each service user's goals. Service users' current care providers are also integrated into this recovery plan. With a member of staff, women using the service are also supported to develop a Recovery Starchart, an outcomes measure which enables people using services to measure their own recovery progress (20). Developed by the UK Association of Mental Health Providers, the chart covers 10 domains of the person's life including living skills, relationships, work and identity, and self-esteem. When they leave Link House, women can revisit this chart to see the progress they have made in each domain.

Service evaluation

Service users reported using hospitals less and for shorter periods, when admitted to Link House. All those using Link House, who were referred from mental health services, were assessed as needing a hospital bed. Thus, it can be inferred that the use of the house by these women directly reduces hospital admissions *(21)*. In 2017–2018, Link House supported 150 women. Of the 122 women surveyed, 99% found their stay a helpful experience, 99% said the support was responsive to their needs, 94% said they felt their mental health had improved, 100% found the activities and group sessions helpful, and would recommend it to a friend.

One service user described their stay at Link House. She said, "Four weeks here have been entirely life-affirming. I am nervous leaving but excited and hopeful for the future for the first time in ages. Thanks for helping me [to] find the strength to turn things around." *(22)*

Each time a service user leaves, they complete an Exit Feedback Survey. The 2015-2016 exit survey *(18)*, with 131 responses from women who stayed that year, had positive overall feedback. All respondents said that their Link House stay was a helpful experience, 81% liked the Star Recovery Chart, 88% said that their mental health had improved, 93% said they felt safe, and 98% found the activities they attended useful. However, many said that they wanted more activities.

Service users said they would like more follow-up support after they leave the house. Individuals are often transitioning from a situation where they have round-the-clock support to one with little or no support. They expressed a desire for the staff to be more active in managing this change *(18)*.

Costs and cost comparisons

The service costs £467,000 (approximately US$ 650,450[b]) per year to deliver, and covers rental and property costs, utilities (£75,000), staff (£337,000) and overheads, including cleaning, central office costs, publicity, audit costs, IT and security (£55,000). This equates to £127 (approximately US$ 171[b]) per person per bed per night. A hospital bed costs approximately three times more than a Link House bed *(23)*. The service is funded by the Clinical Commissioning Group and there is no cost to the people using the service.

Challenges and solutions

Persuading others of the social model

The proposal to set up Link House was seen as radical; it was considered a risk to commission an NGO to provide the service in place of a government agency. Negative attitudes towards a social model of mental health persisted. In addition, using the knowledge and expertise of people with lived experience within the proposed service caused resistance from some professional staff.

It took 18 months of persistent work to convince commissioners of the potential value of the project. The service worked with local organizations of people with lived experience to push the agenda forward. Engaging champions ready to promote the service, also helped. Today, both the social model and the recovery approach have become more accepted and are no longer seen as radical. Many professionals now support this way of working. Wherever possible, efforts were made to collaborate with government-run services, while continuing to maintain independence; such collaborations were often a delicate balance.

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b Conversion as of March 2021.

Making the case for women-only services

Opening a woman-only service was a challenge because only because there was little local evidence that women did poorly in mixed inpatient units. The value of women-only services continued to be questioned, particularly during periods of national austerity and in the context of efforts to achieve greater equality between men and women.

The service worked with local peer groups to conduct a survey of women who had used inpatient services. This showed an overwhelming preference for a woman-only unit based in the community and not in a psychiatric hospital. The case for the right of women to receive care in a non-threatening setting was made on a continuous basis. This meant continuing work to promote the service.

Securing financing

Funding the project was a major challenge. No new money was available, so commissioners were being asked to redirect funds from existing services. Ongoing funding, after the initial start-up injection, remained an issue. Inflation and rising costs were not built into the financial allocation received when contracts were renewed. This means that, effectively, each year the service had less to spend. There is ongoing pressure too from government-run services to take over mental health beds as hospital wards shut and the demand for mental health services grew. That Link House provides 24-hour support seemed staff-intensive and costly to those assessing different services to fund.

Finance for the project was supplemented by grants from small funding bodies; fundraising events also brought in extra money. In addition, the service sought to keep overheads to a minimum. Importantly, Link House produced evidence of positive outcomes and that it was less expensive than the use of a hospital bed.

Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- maintaining the self-determination of service users as a driving factor for the service;

- monitoring and evaluating the service internally on an ongoing basis;

- undertaking independent evaluations every three years; funding for evaluations should be incorporated into the overall budget;

- co-producing evaluations with people who have lived experience;

- having a larger organization to provide back-up, other services to refer to, and managerial support;

- considering the availability of community housing and other accommodation options on which to build the service; and

- providing follow-up support after users leave the house, especially if they are transitioning to a less supported environment.

Additional information and resources:

Website:
https://missinglinkhousing.co.uk/services-we-offer/link-house-for-women-in-mental-health-crisis

Videos:
Link House -
https://missinglinkhousing.co.uk/link-house-film

Sara Gray, staff member, Link House
https://www.youtube.com/watch?v=GMSofLVJMcY&feature=youtu.be

Contacts:
Sarah O'Leary, Chief Executive Officer, Missing Link Mental Health Services, Bristol, United Kingdom
Email: Sarah.OLeary@nextlinkhousing.co.uk

Carol Metters, past Chief Executive Officer, Missing Link Mental Health Services Bristol, United Kingdom
Email: Carol.metters@missinglinkhousing.co.uk

2.3

Open Dialogue

Lapland, Finland

Primary classification: **Crisis service**

Other classifications:

☐ Community mental health centre ☑ Community outreach ☐ Peer support

☐ Crisis service ☐ Hospital-based service ☐ Supported living service

Availability in different locations:

☑ Yes ☐ No

Evidence:

☑ Published literature ☑ Grey literature ☐ None

Financing:

☑ State health sector ☐ State social sector ☑ Health insurance

☐ Donor funding ☐ Out-of-pocket payment

Context

Open Dialogue is a specific technique for working psychotherapeutically and dialogically with individuals and families dealing with a mental health condition. It was developed in Western Lapland, Finland but many mental health professionals are now being trained in Open Dialogue in parts of Scandinavia, Germany, the Netherlands, Austria, UK, USA, Australia, Japan and Ireland *(24, 25)*.

Western Lapland has six municipalities and a population of approximately 65 000. The Open Dialogue approach informs all elements of the mental health service in Western Lapland. However, this section outlines the operation of a crisis/home outreach service coordinated by the Keropudas Outpatient Clinic, an on-call clinic based at Keropudas Hospital, in the city of Tornio (population of 21 900).

This crisis service serves the whole region of Western Lapland and coordinates with other outpatient clinics and services based in the other municipalities of Western Lapland. Keropudas Hospital is focused only on mental health and aside from the outpatient clinic, it also provides inpatient care for all municipalities in Western Lapland with a 22-bed psychiatric unit. The unit is staffed by a head nurse; an assistant head nurse; 17 nurses (each with a bachelor's degree); 13 primary nurses (with a foundation degree); two doctors; a psychologist; a social worker; as well as a secretary.

There is also a separate outpatient clinic in Tornio which provides mental health interventions in the city and municipality of Tornio. This clinic has an assistant head nurse, six nurses, a psychiatrist, a psychologist, a social worker, an occupational therapist, and a secretary.

The city and municipality of Kemi, with a population of 21 000, also has an outpatient service. Smaller teams provide outpatient services in the municipalities of Simo, Tervola, Keminmaa and Ylitomio. The crisis team in Kerapudas works closely with outpatient services in Tornio and Kemi to support the crisis work in these settings.

A general mental health team is based next to Länsi-Pohja Central Hospital in Kemi, a general hospital which serves the whole of Western Lapland. The mental health liaison team, comprising two nurses, a psychologist and a part-time psychiatrist, takes referrals from the Emergency Department and medical wards. An important part of the team's work includes terminal care and care for people who have self-harmed. It actively liaises with the outpatient teams in the different municipalities to provide follow-up care.

Two clinics for children and adolescents with mental health conditions, working with Open Dialogue principles, are based in Kemi and Tornio and serve the whole region.

Description of the Service

The Open Dialogue crisis service administered from the Keropudas Outpatient Clinic aims to provide a psychotherapy-based intervention for individuals who present with a mental health crisis, including those with psychotic symptoms. The team is made up of a head nurse, an assistant head nurse, 14 nurses, a social worker, psychiatrist, psychologist, occupational therapist and a secretary. Trainee doctors also participate in the work. Peer-workers who act as consultants to the service can also provide input, but this usually takes place towards the end of the intervention.

Staff have offices at Keropudas Hospital but most of their work is carried out in the community. Staff members are available 24 hours a day, seven days a week. They provide the single contact point for crisis situations in Western Lapland. People get in touch with the service by telephone, text, email or simply by turning up. Over one 4-week period in 2018, 724 calls were taken. These included requests for support in crisis, for treatment and information. Sometimes calls are received from people directly seeking support and at other times from the police, youth workers and GPs; physicians may call to talk specifically about a patient but often ring to discuss general issues concerning their work.

In 2019, approximately 100 first meetings were arranged with individuals, families and networks every month. There is no set limit to the numbers that can be cared for; however, other services are sometimes considered more appropriate for an individual and their family, and people are referred to these accordingly.

Once contact is made with the crisis clinic, the person who receives a request for help organizes a case-specific team, which works with the person in crisis and their family or network throughout the time they are needed. Anyone working in the mental health service can be asked to join a case-specific team including crisis service staff or the inpatient unit. At times, other services can be involved, such as social workers from the municipalities' social work teams *(26)*. If the person is admitted to the inpatient unit at any point during a crisis, this team will remain involved throughout.

The service aims to respond to each referral as quickly as possible and, during severe crisis, within 24 hours, unless the person involved specifically requests a delay. Meetings with the person, their family and network can take place at home or the team offices, wherever the person prefers. The primary goal is to provide support to avoid hospitalization, although this is not always possible. Occasionally people are admitted to the inpatient unit from the General Hospital in Kemi, effectively bypassing the Keropudas crisis service. This situation is usually the result of temporary staff at the hospital not knowing the system.

Staff members have a wide range of skills and many have been trained in various forms of psychotherapy, including group psychotherapy, art therapy, Cognitive Behavioural Therapy (CBT), and trauma therapy. People using the service can receive input from individual practitioners throughout their involvement with the team, depending on their needs and wishes. In addition, people can participate in organized weekly activities, such as swimming, golf and other forms of physical exercise.

Meetings are held regularly, often daily at first. There is no fixed time-limit for meetings, which usually run from 45 minutes to two hours. If acceptable to the individual, the team actively includes family and their social network. The service is flexible – able to adapt easily to individual needs and preferences, and mobile – working with clients in settings both in or out of hospital, and provides continuity of care. The service works to minimize the use of medication where possible, and maintain consistency in the members of the support team. The service seeks to be fully transparent, and all discussions and decisions involve the person using the service and their family and care group. The team uses the term dialogism to indicate that their primary focus is the promotion of dialogue and the building of a new understanding between participants, in the language of the person, family and network. The staff is trained to tolerate uncertainty.

Open Dialogue seeks to be, "a non-institutional and non-medicalizing form of intervention". It attempts to foster, "local and context-bound forms of knowledge and practice" and deliberately uses a network approach to facilitate, "a contextual and relational understanding of mental well-being"*(24)*.

Open Dialogue is based on a set of "fidelity criteria for dialogic practice" *(27)*. These involve seven, "structural principles" that include immediate help; a social network perspective; flexibility and mobility; responsibility; psychological continuity; tolerance of uncertainty; and dialogue (and polyphony[c]). It also incorporates 12 "therapeutic principles": there must be two or more therapists in the team meeting, the family and network should participate and open-ended questions are used. In addition, therapists must also respond to clients' utterances; emphasize the present moment; elicit multiple viewpoints using a relational focus in the dialogue; respond in a matter-of-fact style and be attentive to meanings; emphasize the clients' own words and stories, not symptoms; converse with other professionals (reflections) in treatment meetings; be transparent; and tolerate uncertainty.

Core principles and values underlying the service

Respect for legal capacity

The service aims to promote the dignity of the person and respect for their legal capacity by creating the conditions for real dialogue with them, their family and network. Therapeutic care plans emerge from this dialogue. The team members do not impose their professional language and work to create a situation where all voices are heard and no one voice is favoured or allowed to be dominant. If the person does not want family involvement, for whatever reason, this requirement is not imposed. In meetings, everyone is treated equally. In other words, "the therapists' primary task is to be open and largely responsive, rather than instructive or interpretive"*(24)*. Open Dialogue training emphasizes the need to create conditions where less dominant voices can be heard and acknowledged.

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c In Open Dialogue, the term polyphony is used to indicate a situation where validity is given to all the voices heard in a narrative.

Thus, a central tenet of Open Dialogue is to hear and be directed by the views and wishes of the person who is using the service. Diagnostic terms are not considered necessary and the team seeks to use the ordinary language of the family. Thus, the whole intervention aims to promote respect for the decisions, values and priorities of the person involved. For example, decisions about the locations and timings of meetings are left to the person using the service. The idea is that the treatment team is at their disposal, and treatment decisions are determined only by the person. Open Dialogue attempts to promote, "the client's potential for self-exploration, self-explanation, and self-determination". Sometimes this can be difficult if the person is experiencing a psychotic crisis; however, the focus of Open Dialogue on, "meaning-making" enables the person to be understood. The involvement of family and network can also help to elucidate the will and preferences of the person having difficulties, but only with their consent.

The values of Open Dialogue include consensus, participation, autonomy, dialogue, communication, the fostering of safe spaces for mutual understanding, and engagement. There is also an attempt to develop a, "shared form of risk management," that works with the social network around the person using the service *(24).* When someone is brought to hospital by the team, the social network chosen by the person is encouraged to remain involved and help the person articulate their views and wishes.

The Open Dialogue team aims to be sensitive to the power differentials involved at times of crisis. These can have the effect of undermining the ability of those using the service to articulate their needs and preferences. The service addresses the issue of power, and how to manage its imbalances, in training and supervision, and works to minimize these.

Non-coercive practices

The crisis service works to avoid coercive interventions by seeking to de-escalate tense situations. People who refuse to take medication are not threatened with hospital admission. There is always considerable negotiation to find a safe solution to these situations. The service staff is trained in Management of Actual or Potential Aggression (MAPA), a de-escalation intervention *(28).* However, force is used at times and people are admitted and treated against their will at the inpatient unit of Keropudas Hospital when no other option appears available. This situation arises most often when there are concerns about violent behaviour and safety. Restraint and seclusion are sometimes used in the inpatient unit in these circumstances.

Community Inclusion

The person's family and social network are actively encouraged to participate in therapeutic meetings, but decisions about who to invite to meetings are made by the person using the service, in conjunction with the treating team. The service works closely with schools, training institutes and workplaces as well as with other organizations that might provide support. The network meetings may therefore involve stakeholders from various fields including family members and other kin, neighbours and friends, teachers, social workers, employers, and traditional healers *(24).*

Participation

There are no recognized positions for peers in the Finnish mental health system. However, in Western Lapland, four peer workers with yearly contracts are employed by the service on a consultancy basis. They are mainly engaged in training and management work but also organize and facilitate support group meetings. They may be involved in work with individual users of the service and can participate

in the Open Dialogue crisis work, but are not yet included as full members of the case-specific teams. Since 2014, the mental health service has been engaging professionals and peers to co-produce a new form of training, seen as a vehicle through which the peer point-of-view can be heard.

A systematic approach is used to gather feedback directly from people using the service through annual anonymous surveys on the treatment received and general reactions.

Recovery Approach

Open Dialogue's focus on the centrality of relationships, values and meanings, is consistent with the recovery approach. In particular, the service promotes connectedness through encouraging family and network involvement in therapeutic meetings. It works to empower the person using the service by avoiding the use of technical professional language and instead seeks to normalize and develop meaning from the person's experiences. Open Dialogue also encourages individuals to be actively involved in deciding how problems should be discussed and engaged with.

Service Evaluation

The Open Dialogue approach in Western Lapland has received academic support for its evaluation over several decades from the University of Jyväskylä. This has been important in sustaining the high level of research produced *(29)*. Additionally, research has become a part of the practice of the professionals working with the service.

Research relevant to the crisis service has focused on the treatment of first episode psychosis and has included people who received some, or even all, of their care in hospital. These studies are best understood as a form of what is termed action research *(30)* and reflect the complexity of service evaluation in the real world. In addition, there are some controlled comparisons between Open Dialogue and treatment-as-usual in the literature. One of these was a register-based cohort study that compared the long-term outcomes of people who had undergone the Open Dialogue approach with a large Finland-wide control group. Members of these cohorts had attended mental health services for the first time after an episode of psychosis and were followed up over a period of approximately 19 years. The Open Dialogue cohort experienced significantly lower durations of hospital care, disability allowances and the need for neuroleptic medication than the control group *(31)*. Importantly, while almost everyone in the control group (97.3%) received neuroleptics at some point in their treatment, 46% of the Open Dialogue cohort completed their treatment without the use of these drugs. People undergoing the Open Dialogue approach are also reported to have better employment outcomes compared with those treated more conventionally *(26)*.

In a national comparison, independent support for these findings is provided by another cohort study with a 5-year follow-up, which found that the Western Lapland catchment area had the lowest figures in Finland for durations of hospital treatment and disability pensions *(32)*.

Qualitative studies have generally found that Open Dialogue is acceptable to people using services, as well as their families and the professionals involved *(33)*. In a US study of people using a mobile crisis service, it was found that participants and family members appreciated the openness and transparency of the approach, as well as the time spent with the team, their involvement with decision-making, and that the intervention was not simply about medication *(34)*. Staff satisfaction was also reported as high.

Most Open Dialogue research has focused on issues such as the use of neuroleptic medication, disability allowances and durations of hospital stay. There is less evidence about its impact on the use of coercion. However the 19-year follow-up study mentioned above *(31)* found that 50% of admissions were involuntary in the Finland-wide cohort, compared to just 26% of those in Western Lapland. This suggests that Open Dialogue had a significant impact on the level of involuntary treatments. No data is currently available on the number of people supported by the crisis team who end up being admitted and treated involuntarily.

An extensive review of the existing quantitative and qualitative research on Open Dialogue services in Finland, Norway and the United States *(35)* highlighted that research is complicated by the many different variants of Open Dialogue; variations from the original model implemented in Lapland as well as the different contexts of implementation. The authors argued for further studies in real-world settings to explore how and why Open Dialogue works. Such studies are now underway in different countries *(29)*. In the UK, the Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness (ODDESSI) study is the largest-ever randomized controlled trial of Open Dialogue, with more than 600 service users over a 3-year period *(36)*. In 2019, the Italian National Research Council received a grant to set up the international HOPEnDialogue project. Linked with the UK ODDESSI trial, this seeks to investigate the effectiveness of Open Dialogue in different contexts and aims to connect and support an Open Dialogue Learning Community across the world *(37)*.

Costs and cost comparisons

As a state-funded service via the health sector, finance comes through taxation from local municipalities. National health insurance also covers the costs of some medication and private psychotherapy. Neuroleptic drugs are provided free of charge *(38)*. The crisis service is free to those using it, however. It has been estimated that one dialogical network meeting of 60-120 minutes costs €130-400 (approximately US$ 158-482[d]) *(38, 39)*; this includes the active engagement of a multi-professional team which can span social work, helping with housing and finances, medication prescriptions and sick leave, trauma interventions, occupational therapy, art therapy, and peer-consultation: ([Kurtti M], [Western-Lapland Health Care District], personal communication, [2021]).

The service in West Lapland is helped by the localized way in which health-service funding is organized in Finland, enabling a significant investment in staff training.

Challenges and Solutions

Working within a fragmented organizational structure

Over 40 years ago, when the service started, the local psychiatric hospital was managed by a different organization. Setting up a comprehensive crisis intervention in the community meant confronting many organizational challenges.

The service sought active engagement with stakeholders to overcome these problems: staff, management and political representatives at a regional level. Clear goals were identified and agreed for the service. Staff were better prepared to participate in the reorganization of the service to fit in with the changing environment.

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d   Conversion as of March 2021.

Changing the dominant mental health culture

Staff within the mental health service were cynical about what could be achieved by a different way of working and were reluctant to engage. To overcome this obstacle, there was a strong focus on training; which was open to all and relevant to the work people carried out on a day-to-day basis.

Encouraging reflection under pressure

There have been significant challenges in managing time and resource pressures on a daily basis. Staff have limited time to reflect on the service and the work they do. In addition, regular changes to the way services have been organized and managed has added to pressures and disrupted the functioning of the service.

Active efforts were made to set aside time for the team to sit, talk together and reflect on the work. By creating a culture where research was valued, staff were given the incentive, time and opportunity to reflect on what they do. Similarly, people using the service were given the chance to feedback their experiences; this was used as an important opportunity to assess the effectiveness of the service.

Expanding the pool of trained staff

Reductions in the available staff has presented further challenges. Changes to national regulations in Finland, led the number of trained family therapists among the staff in Western Lapland, especially trained in the Open Dialogue technique, to fall from 70% in the 1990s to 30% in 2019.

To tackle this problem, a local in-house training programme began with its own qualification. The curriculum, lasting 3.5 years, was co-produced by professionals and people with lived experience, incorporating guidelines from the National Family Therapy Association. The association performs some training and, while dialogical practice is an important focus, there is also an emphasis on making the peer-voice more prominent generally.

Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- evaluating what works and what doesn't work, from different perspectives;
- determining which outcome measures should be used so that it reflects what is important for a person using the service;
- prioritizing training in Open Dialogue techniques to create a pool of trained professionals;
- emphasizing the peer point-of-view in training and within crisis teams, whenever possible;
- implementing an integrated system of service delivery to maximize collaboration between the crisis team, inpatient staff, and local municipality-based outpatient services;
- ensuring general hospital staff – even temporary or part-time staff – are aware of the crisis team so that referrals are not missed; and
- seeking academic support from universities to sustain research and create international interest in the service.

Additional information and resources

Website:
http://developingopendialogue.com/

Videos:
Open Dialogue, An Alternative, Finnish approach to Healing Psychosis
http://wildtruth.net/films-english/opendialogue/

Jaakko Seikkula - Challenges in Developing Open Dialogue Practice
https://www.youtube.com/watch?v=VQoRGfskKUA

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Tupu Ake

South Auckland, New Zealand

Primary classification: Crisis service

Other classifications:

- [ ] Community mental health centre
- [ ] Community outreach
- [x] Peer support
- [ ] Crisis service
- [ ] Hospital-based service
- [ ] Supported living service

Availability in different locations:

- [x] Yes
- [ ] No

Evidence:

- [ ] Published literature
- [x] Grey literature
- [ ] None

Financing:

- [x] State health sector
- [ ] State social sector
- [ ] Health insurance
- [ ] Donor funding
- [ ] Out-of-pocket payment

Context

New Zealand is high-income country that recently earmarked a record budget for mental health services *(40)* as the result of a 2018 government review, which highlighted the shortcomings of the existing mental health system. *(41)*.

The mental health system in New Zealand comprises publicly-funded specialist mental health services provided by District Health Boards (DHBs) working in conjunction with non-governmental organizations (NGOs) *(42)*. Minority communities, such as Māori, the indigenous population of New Zealand, who make up 15% of the population, face major challenges such as high levels of economic and social deprivation, cultural alienation, and intergenerational and societal trauma that increase the prevalence of mental health issues *(43)*. Māori also face differential treatment in the health system, being subjected to much a greater use of compulsory treatment and seclusion *(44)*.

Tupu Ake is a peer-led, acute, alternative admission service located in Papatoetoe, a suburb of South Auckland and within the catchment of the Counties Manukau District Health Board (CMDHB), which serves a mostly urban region. The CMDHB covers a 512 000-strong population with a higher proportion of Maori and Pacifica people than other parts of New Zealand and higher levels of social deprivation.

Mental health services, both acute inpatient and community clinical support services, are delivered by both CMDHB and community-based NGO providers. These services include long-term residential housing, employment support services, community support work, services assisting people to live independently in the community and short-term respite care services. Tupu Ake was set up initially as a pilot recovery house service in 2008 by the NGO Pathways, a major national provider of community-based mental health, addiction and wellbeing services in New Zealand (it supports 6000 people to, "live well" in their own communities per year) *(45)*. Today, this NGO service is provided by Pathways in partnership with CMDHB and several peer-led NGOs, which have all been involved in the co-design process.

Another service modelled on Tupu Ake, located in Christchurch is also funded by the local DHB and Pathways. Te Ao Marama has seven beds and also offers a day programme. A DHB in the Waikato region is in the process establishing another service based on Tupu Ake, following co-design principles, with a Māori health provider. It is funded to deliver support to 10 people. Peer-led crisis respites, similar to Tupu Ake, are operating along the same principles in the USA and UK too *(46)*.

Description of the Service

Tupu Ake offers short stays of up to one week for a maximum of 10 people, as well as a day support programme for up to five. People who use the service usually have stable housing to return to. If not, they are supported to access community support providers to find suitable housing. The service aims to provide people experiencing mental health problems with brief crisis support. Tupu Ake was one of the first mental health and wellness services in the country to provide a real alternative to hospital admission.

The service usually runs at an occupancy rate of approximately 80%. Entry to the service is only allowed through community crisis teams delivered by the DHB. Therefore, a person will not be referred by a crisis team if it believes that the person cannot be safely supported within the open community setting, due to levels of distress and suicidality. Although people cannot self-refer to Tupu Ake, an increasing number of advance directives cite Tupu Ake as the preferred place of care, rather than hospital. People can stay in Tupu Ake regardless of their diagnosis. In the 2015 and 2016, 42% of people who stayed had a diagnosis of psychosis and 42% a diagnosis of depression/anxiety *(47)*. Most people who stay at Tupu Ake are aged between 21–50 years old. People using the service were 32% New Zealand Europeans, 29% Maori and 20% Pacific Islanders; 53% were female and 47% male.

The vision for the service is underpinned by a "peer competencies" framework, developed in 2014 by Midlands District Health Board, the Northern Regional Alliance and Te Pou o te Whakaaro Nui (Te Pou), a national centre for evidence-based workforce development for the mental health, addiction and disability sectors in New Zealand, and funded by the Ministry of Health *(48)*. The national centre works with a range of organizations from DHB and NGOs, to train and educate providers, researchers and international experts, to improve their services.

The peer competencies framework used at Tupu Ake comprises six core values:

- **mutuality** – the sharing of similar experiences between two peers and the subsequent natural bond that forms between them**;**

- **experiential knowledge** – the knowledge that comes from hearing life stories of peers with mental health or addiction problems. This new knowledge can help people see things from a different perspective;

- **self-determination** – the right of guests to make free choices about their life and support. The service reports that guests should be experiencing support without coercion. People actively consent to stay in Tupu Ake and cannot be compelled to stay for compulsory treatment under the Mental Health Act;

- **participation** – the active participation of peers in the co-design of activities and support they receive. Tupu Ake reports that instead of structured 15-minute checks on the guest that would occur in an inpatient unit, they "check-in" with people and explore how the guest is doing and their plans for the day. A peer-to-peer system allows a peer support specialist to accompany guests to community activities, home visits or other activities if needed;

- **equity** – treatment as equals irrespective of the diagnosis. The service employs and trains people with lived experience of mental health conditions. The focus of the service is also to ensure responsiveness to Māori and Pacific populations and to achieving equity of outcomes; and

- **recovery and hope** – the service maintains that a contributing factor to recovery is the support of the guest by someone with lived experience, as this can instil hope for recovery.

The service is staffed 24 hours a day from 07:00-11:00. The majority of staff at Tupu Ake are Peer support specialists (PSSs); they provide individualized support to people through the integration of peer values from the competency framework into their practice. The service consists of one team coach, who is a first-line manager, three senior PSSs, and registered nurse cover that amounts to 2.5 full-time equivalents (FTE). There are three peer support workers per shift, seven days per week. This provides a total of 16.2 FTE peers covering the service.

The team coach is a person with lived experience who has received recognized specialist peer support training including Intentional Peer Support (IPS), which has a focus on building relationships that are mutual, explorative, and conscious of power; and International Peer Employment Training, from an organization called Recovery Innovations, which provides a wide range of certified training for peer-support work, on an international basis *(49, 50)*. The team coach is responsible for the daily running of the service, the delivery of what Tupu Ake terms, "peer polish" or supervision, coaching of the senior PSSs, and responsiveness to family (*whanau*) and other key stakeholders.

Senior peer specialists are peers who have a greater degree of experience and have completed advanced peer training. They are leaders responsible for the staff on shift at any given time and for providing peer guidance and support to other peer workers.

The nurse reports to the team coach and is responsible for physical health monitoring and follow up, works in partnership with the peers when people have complex mental health or physical health needs, helps with health literacy, and supports people to achieve their goals for the duration of their stay. Some of the nursing staff identify themselves as having lived experience of mental health conditions.

People staying at Tupu Ake are referred to as guests to encourage a less hierarchical relationship with staff. The term guest derives from the Māori concept of *manākitanga*, translated as hospitality, respect, support, kindness, generosity and care for others when people are in another's home. Staff do not wear name tags; instead, there is a noticeboard with photos and names of staff members, their interests and working shifts.

The service integrates care with clinical crisis services provided by the CMDHB. Overall clinical responsibility is retained by the crisis team provided by the DHB, during stays at Tupu Ake, and guests attend regular meetings with their clinical team where their care plans are discussed. Consultation rooms and space for clinical assessment and interventions are made available in the house for this purpose.

The Tupu Ake villa is surrounded by landscaped gardens and entirely co-designed by peers, from the interior design to artworks by previous guests. Tupu Ake promotes immersion in nature as a helpful factor in a person's recovery, through activities such as walks, birdwatching, and horticulture in a small garden behind the house.

Self-soothing techniques based on sensory modulation, the use of sensory rooms, and the development of sensory plans, are used to help guests tolerate and recover from acute psychological distress. The interventions are delivered by the peer-support workers trained in these sensory techniques. The techniques are designed with the specific needs of the people using service in mind and their delivery is based on the individual's wishes and preferences.

The service also runs activities such as wellness classes, psychosocial interventions, cultural and physical wellbeing activities for guests. These activities include: cultural songs (*waiata*), prayer (*karakia*) and weaving (*harakeke*), "dealing with distress" programmes, art therapy, gardening, healthy eating, and mindfulness classes. Guests can create a Wellness Recovery Action Plan (WRAP), a tool used worldwide to manage the recovery process *(19)*.

Tupu Ake is a *whanau* or family-friendly space and family members are encouraged to participate in the service according to the wishes of the guest. There is a family room where guests can spend time with family and friends during visits. If family visits cause some disruption, this is discussed with the guest although it is often dependent upon other guests staying and the delivery of various activities at the same time.

Tupu Ake works closely with the person receiving services and their designated crisis team clinician provided by the DHB, to establish a personalized recovery plan that addresses the purpose of their stay in Tupu Ake. The clinical team visits frequently to review the progress of the plan and can alter it accordingly. The staff at Tupu Ake help guests learn coping strategies, reinforce behavioural and motivational techniques, support and assist with medication, and with feedback and progress reports to the clinical team.

Tupu Ake works with a model that encourages self-determination; however, it is operating within a larger system that does not always do this. This tension is most apparent when the crisis team uses coercion or dominates the discussion about the guest's recovery plan. On these occasions skilled negotiation is required, and the key focus of Tupu Ake staff becomes advocacy and empowerment, so that the guest can assert their wishes and exercise self-determination.

Day Programme

Tupu Ake's day programme offers transitional support for guests while they settle back into their home environment. It is not available to those who have not used the residential services. Up to five guests can attend the day programme at any given time, for up to seven days; these days are not required to be consecutive. Activities include socialization, gardening, learning musical instruments, therapeutic art and other wellbeing-based activities, including the learning and use of sensory modulation and self-soothing techniques.

Core principles and values underlying the service

Respect for Legal capacity

Pathways is overtly committed to ensuring that people using its services are helped to make informed choices and give informed consent in every aspect of their lives, including: any support people receive from Pathways; the involvement of others in their support and recovery; the course of their recovery journey; the pursuit of dreams and attainment of personal goals; their living situation; employment opportunities; social and leisure activities; significant and meaningful relationships; and their health, happiness and wellbeing.

People are free to enter or leave Tupu Ake as they wish. They are informed of their rights and of the processes for reporting any concerns they may have, both while using the service and after they leave.

One of the six core values of Tupu Ake is self-determination, which the service defines as, "the right of guests to make free choices about their life and support". The aim is that guests should receive support without coercion or pressure from staff. The primarily peer-led nature of the staff and the peer support principles under which the service operates, reduce the power differential between staff and guests. Peer staff members support guests to make wellness plans with short and long-term goals, without imposing their own ideas on the service users. The staff also support guests to express their preferences and bring their own plans to clinical staff at clinical meetings. Advocacy is an important role assumed by Tupu Ake staff, to counter the power differential between people admitted under the Mental Health Act and their clinical providers.

Tupu Ake strives to ensure that options and choices are made available to guests whenever possible. In many situations involving legal capacity, peer staff serve as advocates for the guests; this may involve organizing urgent legal representation.

Non-coercive practices

Tupu Ake does not practice coercive treatment, seclusion or restraint; peer support specialists are trained to work without resorting to coercion or restrictive techniques. Instead, they are trained in de-escalation techniques, receiving non-violent crisis prevention training, and organizational training on trauma awareness and trauma-informed practices. Importantly PSSs are educated to, "sit with a level of discomfort in order to normalize the guests' experience while they are processing their distress," in order to help create a non-judgmental environment *(47)*.

There are well-defined processes for working with clinical crisis staff, including a space for voluntary assessments to be conducted on site. The conflict between the legal responsibility of crisis staff to enforce compulsory treatment orders and Tupu Ake's values is managed by clearly agreed, "processes and guidelines to ensure the process [of crisis staff working with Tupu Ake staff and guests is] respectful and maintain[s] the core values of a peer-led service". This includes taking a stand against compulsory treatment orders on site, ensuring service user choice whenever possible, peer representation at clinical review meetings and prior notice for guests before crisis staff visit *(47)*. In situations where a person does not want to take prescribed medication, Tupu Ake's staff members do not coerce them. Instead, they speak with the individual to understand the reasons and then work together to determine ways of engaging with the clinical team to resolve the issue. The staff aim to achieve resolution by, "walking alongside the person," and providing advocacy. Some people attend Tupu Ake with the intention of reducing their medications in a supportive and relaxing environment where they can be safely assisted to do so.

No aspect of the programmes delivered in the service is compulsory. Whilst people are encouraged to attend activities that might enhance their wellbeing, the service tries to ensure that everyone has a plan individually designed to meet their own defined needs.

Community Inclusion

Tupu Ake recognises the importance of family in people's lives because over 40% of their guests live with family. There is a room in the house for guests to spend time with family members or friends when they visit. Family members can stay overnight, if this is requested by the person using the service. This is rare, however. Visitors may stay only if there is space and their presence does not inconvenience other guests.

Many guests have significant social or cultural stressors in their home environments; Tupu Ake works with other community health and social service providers involved with an individual's care to address these. In particular, Tupu Ake ensures the person is connected to NGO-based community support workers (CSWs) if they have ongoing social support needs in the community. CSWs are trained workers skilled in supporting people to build their social networks, connect to community services and agencies, develop life skills, and engage with their family.

Guests are able to go for a walk, attend community activities, or visit local shops accompanied by a peer support worker if they wish. Depending on the care needs of individuals, most are also allowed to leave and return unaccompanied. However, this happens after discussion with the person, Tupu Ake staff and their clinician. To ensure the safety and wellbeing of all people using the service, it is expected that alcohol and drugs are not brought onto the property. Tupu Ake provides smoking cessation support and nicotine replacement therapy is readily available. Some of the peer support staff have had their own experiences of addiction and recovery. All staff are trained to work with people experiencing multiple problems and challenges.

The team at Tupu Ake works with guests to plan their exit from the house. This often involves connecting the person with the available community-based mobile support, part of New Zealand's mental health and addiction system. Through integrating with community support workers, Tupu Ake supports people to ensure their needs continue to be met outside the service.

Participation

Tupu Ake is a peer-led service that hires people with lived experience of mental health crisis. In addition, Pathways has a National Leadership Group, with a Peer Development Lead responsible for the development of its workforce of people with lived experience. Today, 34% of the Pathways workforce and all Tupu Ake's staff self-identify as having lived experiences of mental health conditions or psychosocial disabilities; these numbers are consistent throughout the leadership of the organization.

Peer co-production and involvement have been prioritized from the earliest stages of service development, from defining the language and vocabulary (for example, referring to service users as guests), to the design and renovation of the house itself.

People who use the service are routinely asked to share their experiences of service provision at Tupu Ake. They complete a User Experience questionnaire which asks them to rate the degree to which they felt: listened to and heard; respected; safe and comfortable; involved in decision-making and

care-planning; the support they received contributed to recovery; the meals were nourishing; and the activities were helpful. They are asked if they would recommend the service to family or friends with a similar need and for suggestions of how their stay could have been improved.

The leadership analyses the service user experience questionnaires and other measures of well-being and quality of life every three months. Lessons learned from listening to the voices of people who use services, are considered and included in the next 3-month planning and improvement cycle for the service.

Recovery Approach

Tupu Ake staff support guests to reflect on and clarify their own life goals and aspirations, as well as promote their sense of autonomy and control over their future. Great emphasis is placed on a tailored, recovery-focused and strengths-based plan (through approaches such as WRAP) for each person, to increase their resilience and ability to cope after returning to the community.

Peer workers share their own lived experience of mental health problems, which promotes connectedness and engagement, reduces stigma, and empowers the guests through instilling hope. Staff members encourage guests to be involved in, and to speak up about their own care, sometimes serving as advocates for guests in meetings with their clinical team.

Staff members view the person as a whole and offer holistic support by identifying factors that are causing or contributing to their distress. Supporting someone in this way allows the person to articulate their experiences without being pathologized or linked solely to a mental health diagnosis. That peer support specialists have hope and belief in their guests' own abilities, supports individuals to build resilience and maintain wellness in the community.

Peer to peer relationships can be transformative. Between the peer support specialist and the guest there is an understanding of recovery as the goal, but there are no rules or set pathways that must be followed to reach that destination. Instead, peer support specialists use their own experiences and knowledge to provide guests with choices and options they may find useful in their recovery. Peer support specialists believe in the guest's ability to lead their recovery using their own strengths and skills to enhance their wellness. They encourage guests to take positive risks to grow and realize their potential.

Service Evaluation

Since it launched in 2008, the number of people using the Tupu Ake service has increased. An independent evaluation of the service was conducted in 2017 *(47)*. A methodology called Most Significant Change (MSC), was used by researchers for the analysis of qualitative interviews with service users, allowing them to explore how the service works from the perspective of the people using it. Tupu Ake's six core values (mutuality, experiential knowledge, self-determination, participation, equity and recovery) were explored with 11 guests. Interviews were also undertaken with the other stakeholders including staff from Tupu Ake, Pathways and the DHB. Positive outcomes were experienced by individuals, in terms of self-determination and an increased ability to cope with their experiences. The guests reported higher levels of satisfaction with care and shorter average lengths of stay at Tupu Ake than comparable hospital inpatient units. The evaluation also highlighted the positive role Tupu Ake played in repairing relationships with family and bringing service users closer to social networks. There were also significant cost savings compared with a hospital admission.

During the period covered by the evaluation, 564 guests accessed the overnight service for one episode of care between January 2015 and December 2016. This was almost double the number using the service from 2008–2010. Less than 7% of guests were readmitted to Tupu Ake three or more times during this period (47). During 2018, a total of 339 people accessed overnight stays, and a further 35 accessed the day programme. As of December 2019, a further 303 people had accessed the overnight function and 30 individuals had used the day programme ([Phillips R], [Pathways], unpublished data, [2020]).

The day programme was underused in 2015 and 2016, as only 26 people accessed it. In addition, 17% used the service more than once in 28 days (47). Importantly, feedback from participants suggested it was helpful in reducing readmissions to acute services.

Of the 303 episodes of care in the service in 2019, 29 people (9.5%) required hospitalization when their support needs increased – a small number was admitted on an involuntary basis. Nine people left as they no longer wished to receive services. The remaining 88% left when their goals for the stay had been met. The average length of stay during 2019 was 7.7 days. This was significantly less than the average length of an admission at the local inpatient unit in Counties Manukau, which was 19.8 days. However, it is acknowledged that the profiles of the people using the two services can differ ([Phillips R], [Pathways], unpublished data, [2020]).

Many of the people using Tupe Ake for the first time actively assert a wish to use it again, rather than the inpatient unit, should the need arise in the community. People experience the service as respectful, rights-oriented and recovery-enhancing and so they actively choose to continue to receive support there.

One Tupu Ake evaluation author (47) said, "There are constant reminders throughout the house that the environment makes it different from other services delivering acute level support. It has the comforts of home and is not like an inpatient environment."

A guest of Tupu Ake (47) said, "I first came to Tupu Ake three or four years ago. Now I choose to come here instead of going to an inpatient unit because I know the peers, and I know how I am going to be treated, the environment is safe, and partly because it's peer led."

Another guest in a focus group, from Tupu Ake evaluation (47) said, "Coming to Tupu Ake has stopped me from going into the inpatient unit lots of times. I would get worse in an inpatient unit because of the environment. If you're in hospital you feel like you've gone backwards and think, 'Am I that bad?'"

Costs and cost comparisons

Tupu Ake is free to individuals using the service as it is fully funded by New Zealand's public health system. The service is contracted to deliver at capacity and is funded at NZ$ 297 (approximately US$ 190[e]) per bed per night. This covers all required staffing, facilities costs, programme consumables, food, information technologies and other associated costs of service provision. An inpatient hospital bed costs an average of NZ$ 1,000 per night (approximately US$ 650) ([Phillips R], [Pathways]. personal communication, [2020]).

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e Conversion as of June 2020.

Challenges and Solutions

Promoting the benefits of a peer-run service

The lack of knowledge and experience within the professional workforce about the role, function and capabilities of peer-support workers, was a challenge. Many were unaware of how people could use their lived experience to build positive relationships.

Significant time and effort were required to increase awareness of the benefits of a peer workforce among professionals. People with lived experience became champions in this regard. Leaders of mental health organizations were engaged and provided with specific training so that they could advocate, support and spread understanding of the values of peer work. Within advance directive requests, Tupu Ake's previous guests asked to return to the service rather than hospital inpatient care. This also convinced professionals of its potential. Most importantly there were ongoing open and regular efforts to address the different perspectives and priorities between the Tupu Ake service and the government-run mental health crisis team.

Building a sustainable peer workforce

The service required a substantial number of fully trained peer-workers. This proved to be a challenge, as the development of a peer-based workforce had only just begun in New Zealand. Staff recruitment and retention was difficult too because many people did not want the kind of shift work associated with a 24-hour service. There was a relatively high turnover of staff and this necessitated ongoing recruitment.

Initially, practical input received from an overseas partner organization helped with workforce development. Since then, the service connected with peer training programmes to inform participants about the service and work opportunities available. Interestingly, a number of people who have used the service were so inspired by both the peers and the recovery focus of the service, they trained in and then sought careers as peer workers at Tupu Ake.

Maintaining the quality and values of the service

Keeping the workforce connected to the values and philosophy underlying the programme has been a challenge, as has keeping track of outcomes and ensuring the service is properly evaluated.

One solution has been to ensure that all managers within the service are people with lived experience with training in peer-support. These peer supervisors provide active support on specific issues that emerge in this work. A 'peer polish' happens daily where peer staff collectively apply their understanding of peer values and connect these with their daily work. In addition, a measure of service user experiences and outcomes was developed and used routinely in the service; recovery stories and experiences were collected.

Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- budgeting for the evaluation of the service and including it within the funding proposal
- actively involving people with lived experience within the evaluation process;
- seeking official recognition and 'buy in' from existing health services;
- measuring the costs of the service to compare with mainstream provision;
- documenting whether people using the service would choose to use the same service again or an alternative within the mainstream; and
- investing to demonstrate the utility of peer support and the positive outcomes that can be achieved.

Additional information and resources:

Website:
https://www.pathways.co.nz/services/peer-services/

Videos:
Prime Minister visits Tupu Ake 31 May 2019
https://www.youtube.com/watch?v=SwQfaQ3BJVk

Contact:
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3.

Moving forward: from concept to good practice mental health crisis services

The purpose of this section is to provide readers with some key practical steps and recommendations that will facilitate the process of conceptualizing, planning and piloting a good practice mental health crisis service that aligns with human rights standards. It is not meant as a comprehensive and complete plan for setting up the service, since many context-specific factors, including socio-cultural, economic and political factors, play important roles in this process. Further detail on integrating the service into health and social sectors is provided in the guidance and action steps section in *Guidance on community mental health services: Promoting person-centred and rights-based approaches.*

Action steps for setting up or transforming a good practice crisis service:

- **Set up a group of different stakeholders** whose expertise is crucial for setting up or transforming the service in your social, political and economic context. These stakeholders can include but are not limited to:

  » policymakers and managers from health and social sectors, people with lived experience and their organizations, general health and mental health practitioners and associated organizations, legal experts, politicians, NGOs, OPDs, academic and research representatives and community gatekeepers such as local chiefs, traditional healers, leaders of faith-based organizations, carers and family members.

- **Provide the opportunity for all stakeholders to thoroughly review and discuss the good practice services** outlined in this document to get an in-depth understanding of the respective services. This is an opportunity to identify the values, principles and features of the good practice services that you would like to see incorporated into your country's services given the social, political and economic context.

- **Establish contact with the management or providers of the service(s)** that you are interested in to get information and advice on setting up or transforming a similar service in your context and to understand the nuances of the service. Ask specific questions about how these services operate keeping in mind the local context in which the services would be developed. This can be done via a site visit to the good practice service and/or video conference.

- **Provide training and education on mental health, human rights and recovery** to the groups who will be most relevant for setting up or transforming the service using WHO QualityRights face-to-face training materials (https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools) and e-training platform. Changing the attitudes and mindsets of key stakeholders is crucial to reduce potential resistance to change and to develop attitudes and practices in line with the human rights-based approach to mental health.

- **Research the administrative and legal regulations** concerning setting up or transforming the service.

Questions specific for setting up or transforming crisis services:

- Are you aiming to transform an existing or set up a new crisis service?

- Who will run the crisis service? Will it be run by peers, the government, NGOs, or co-run by people with lived experience alongside other professionals, or another group?

- Will your crisis service be a stand-alone service or part of a hospital, community mental health centre or other resource?

- Who are the beneficiaries of the service: will anyone be excluded? How will the service be accessed?

- Will your crisis service provide:
    » home outreach support through multi-disciplinary teams?
    » short-term, temporary respite accommodation in the community?

- What treatment and interventions are you planning to provide?
    » assessments of support needs and diagnosis if agreed by a person
    » trauma informed therapy
    » person-centred recovery planning
    » psychotherapy, e.g. Cognitive Behavioural Therapy
    » problem solving and behavioural activation/activity scheduling
    » individual and group based supportive counselling/therapy
    » psychotropic and other medication (including prescribing medication, as well as support for withdrawing safely from medication)
    » dialogue/meetings with families, friends and supporters (with the agreement of the person using the service)
    » transitional support for people returning to their home and community.
    » crisis hotline phone-in
    » peer support
    » other.

- How will your service assess, provide or refer people for any physical health conditions they may have?

- How will your service ensure coverage for 24 hours a day, seven days a week to respond to people in crisis?

- What will be the interrelationship between this service and other services, supports and resources in the community, including upward and downward referral systems?

- What human resources will be required (such as doctors – including psychiatrists, general practitioners and others, psychologists, nurses, social workers, peer support workers, occupational therapists, outreach workers, community/lay workers, administrative staff etc.) and what sort of skills and training will be required for them to provide quality and evidence-based services in line with human rights?

- What strategies and training are you planning to put in place to realize legal capacity, non-coercive practices, participation, community inclusion and recovery orientation[f] ?

■ Legal capacity

- How will the service ensure that mechanisms for supported decision-making are in place so that decisions are made based on the will and preference of the person?

- How will the service approach informed consent by service users in relation to treatment decisions?

- How will the service ensure that people are:

  » able to make informed decisions and choices among different options for their treatment and care; and

  » provided with all critical information relating to medication, including its efficacy and any potential negative effects?

- What process will the service put in place to systematically support people to develop advance plans?

- What kind of mechanisms will the service put in place to ensure that people can make a complaint if they need to?

- How will the service facilitate access to legal advice and legal representation by its users in need of this type of service (e.g. pro bono legal representation)?

■ Non-coercive practices

- How will the services ensure an open-door policy and a coercion-free culture to avoid both overt and subjective experiences of coercive practices?

- How will the service ensure the systematic training of all staff on non-coercive responses and de-escalation of tense and conflictual situations?

- How will the service support people to write individualized plans to explore and respond to sensitivities and signs of distress?

- How will the service create a "saying yes" and "can do" culture in which every effort is made to say "yes" rather than "no" in response to a request from people who are using the services?

- How will the service establish a supportive environment?

- Will the service have a comfort room?

■ Participation

- How will people with lived experience be an integral part of the service team as staff, volunteers or consultants?

- How will people with lived experience be represented in the high-level decision-making in your service?

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f   For more information see section 1.3 in *Guidance on community mental health services: Promoting person-centred and rights-based approaches.*

- How will the service systematically collect feedback from service users and integrate this into your service?

- How will the people using the service be linked with peer networks in the community?

■ Community inclusion

- How will the service support people to find work and income generation, for example through a transitional employment programme, supported employment programme and independent employment as appropriate?

- How will the service facilitate access to housing services?

- How will the service facilitate supported education and assistance in accessing community-based education opportunities and resources to continue education?

- How will the service facilitate access to social protection benefits?

- How will the service facilitate access to social and recreational programmes?

■ Recovery

- How will the service ensure that persons will be considered in the context of their entire life and experiences, and that care and support will not solely focus on treatment, diagnosis and symptom reduction?

- How will the service ensure that the five dimensions of recovery: (1) connectedness, (2) hope and optimism, (3) identity, (4) meaning and purpose and (5) self-empowerment are integral components of service provision?

- How will people be supported to develop recovery plans; that is to think through and document their hopes, goals, strategies for dealing with challenging situations, managing distress, strategies for keeping well, etc.?

- **Prepare a proposal/concept note** that covers process issues, detailing the steps for setting up the service, the vision and operation of the service network based on the full range of services that will be provided, covering the following:

  » human resource, training and supervision requirements;

  » how this service relates to other local mental health and social services;

  » strategies to ensure that human rights principles of legal capacity, non-coercive practices, community inclusion, and participation will be implemented, along with a recovery approach;

  » details about the monitoring and evaluation of the service; and

  » information on costs of the service and how this compares with the previous services in place.

- **Secure the required financial resources** to set up or transform the service, exploring all options including government health and social sectors, health insurance agencies, NGOS, private donors, etc.

- **Set up and provide the service** in accordance with administrative, financial and legal requirements.

- **Monitor and evaluate the service on a continual basis and publish research** using measures of service user satisfaction, quality of life, community inclusion criteria (employment, education, income generation, housing, social protection), recovery, symptom reduction, assessment of quality and human rights conditions (for example, by using the QualityRights assessment toolkit), and rates of coercive practices (involuntary treatment, mechanical, chemical and physical restraints).

- **Establish dialogue and ongoing communication with key stakeholders and members of the public** by holding public forums and hearings with these groups to allow people to openly express their views, ideas, and concerns about the service, and to address these concerns.

- **Advocate and promote the service** with all relevant stakeholder groups (politicians, policy makers, health insurance agencies, media, people with lived experience, families, NGOs, OPDs and the community at large). This also involves actively reaching out through both traditional and social media. Having the successes of the service highlighted publicly can be a good strategy to bring people on board.

- **Put in place the strategies and systems** required to ensure the sustainability of the service.

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