**Community alternatives to inpatient admissions in psychiatry**

The aim of treating people experiencing a mental health crisis in settings other than hospital inpatient wards is not new[1]. A system of family foster care for people with mental health problems at times of need was established in Geel, Belgium 700 years ago. In the 1930s, A. Querido set up a home treatment admission-diversion system in Amsterdam, the Netherlands. In the 1970s, P. Polak developed in Colorado a network of crisis services including family placements, crisis beds, an acute day unit and treatment by mobile mental health teams. The first recognizable modern multi-disciplinary crisis resolution home treatment team was founded by L. Stein in Colorado in the 1970s.

The attractions of averting hospital admission where possible are obvious. Inpatient care is very costly. Potential harms to patients from hospital admission include: institutionalization and dependency; distress from enforced social proximity to others, or from separation from friends and family; harm from other patients or staff; loss of employment or housing tenure; the development of unhelpful coping strategies; stigma[2]. Some of these harms may be mitigated by alternative residential crisis provision. Treatment at home during a crisis offers positive opportunities: to identify and modify social and environmental precipitants of crisis, enlist family support, develop coping skills applicable to people's normal social context, and offer a more equal basis for collaborative relationships between staff and patients.

Patients tend to strongly advocate alternatives to admission being available. The provision of a range of crisis services, from which patients and staff could collaboratively choose the best option, appears evidently desirable. A number of community service models now have trial evidence as viable alternatives to inpatient admission for many patients. Acute day hospitals may be able to treat as many as one in five patients who would otherwise be admitted to acute wards, with comparable outcomes[3]. Crisis resolution teams can reduce inpatient admissions and increase satisfaction with acute care[4]. Residential crisis houses may have greater patient satisfaction and lower costs than inpatient admission, with comparable effectiveness[5].

Despite this promising evidence, community crisis alternatives have struggled to become fully embedded in national acute care systems. Crisis resolution teams are probably the most widely adopted model, but have only been implemented nationally in England and Norway. Community crisis models, even where they do act effectively as an alternative to admission, risk being labelled as a luxury and vulnerable to cuts. Community alternatives are unlikely ever to replace psychiatric hospitals completely: some patients may always be unwilling to accept treatment, or pose such a high risk that secure accommodation is required. No crisis alternative has demonstrated any impact on rates of compulsory hospital admission.

Four challenges can be identified for community crisis alternatives to thrive in modern mental health systems, as detailed below.

*Rapid response.* In many countries, lack of bed availability can lead to delays in admissions, or patients being admitted far from home. In principle, though, referral routes to inpatient wards are clear and new patients can be accepted rapidly at any time. Community alternatives, in order to provide a genuine crisis service, must seek to match this. Yet in England, for example, crisis resolution teams' response time targets for initial assessment of patients referred in crisis vary from one hour to one week[6].

*Managing acuity.* While community alternatives must set responsible limits on levels of risk which can be safely managed, an ability to accept acutely ill and distressed patients, even where some risks are present, is essential. Referral processes, staffing levels and skill mix, the physical environment, and organizational culture have been identified as modifiable barriers to successful management of acuity in community crisis services[7].

*Role clarity.* Community alternatives may offer either comparable treatment to inpatient wards in an alternative setting, or distinctly different care from psychiatric hospital. Crisis

resolution teams typically emphasize the former, providing clinical treatment from a multi-disciplinary team to all those for whom hospital admission might be averted. Residential crisis houses may seek a more niche role, to provide different, innovative and potentially more appropriate care for a specific demographic or clinical group. The Soteria model of crisis houses provides the best known example of this. Developed in California in the 1970s, Soteria houses offer a minimum medication-use, non-hierarchical residential treatment setting for people with first-onset psychosis in crisis[8]. Being perceived by local commissioners and service planners as having a clearly defined role is a key factor influencing the sustainability and survival of crisis alternatives[7].

*Implementation.* Community crisis alternatives face the common challenge of replicating the benefits observed from early adopters and initial evaluations, when scaled up. The English experience of implementing crisis resolution teams nationally exemplifies this. Reductions in inpatient admissions anticipated from trials have not been consistently reproduced[9] and implementation of national policy guidelines has only been partial[6]. High model specification, rigorous assessment of adherence, and programmes to support implementation may be required to maximize the benefits of crisis alternatives.

Potential unintended consequences of crisis alternatives should also be considered. Outcomes for rare adverse events, such as suicides, are poorly evaluated by individual studies. Community alternatives may attract skilled staff away from inpatient wards and, by accepting the more compliant, less high-risk patients, may raise the overall levels of disturbance and acuity on acute wards. Increasing the complexity of local acute care systems presents challenges to maintaining continuity of care. Overall length of stay in acute care could be increased, if crisis alternatives were commonly used as a "step down" provision from inpatient wards.

Community crisis alternatives, which offer a cheaper alternative to inpatient admission, as well as a potentially less frightening, stigmatizing and socially dislocating experience, have a positive role to play in sustaining deinstitutionalization. Yet, there is little consensus within or across countries about optimal acute service configurations. The next challenge for researchers is to move beyond evaluating individual service models to system level evaluation, which can identify service components and configurations which provide the best outcomes for patients within mental health acute care systems.

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