Mental Health Emergency Departments – Rapid Evidence Review

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Key messages

- There is a clear national direction of travel to develop Mental Health Emergency Departments, but no formal evaluation is currently available to guide local decision making.
- Existing Mental Health Emergency services vary greatly in scope, workforce, location, and physical health capability, making a clear picture of the landscape hard to ascertain and a “lift and shift” approach unrealistic.
- Early reports show potential benefits, but outcomes are inconsistent and difficult to compare due to data limitations and variation in service configuration.
- Evidence suggests that local service design will require clear definition of purpose, strong integration within existing mental and physical health pathways, and robust evaluation from the outset to provide the best opportunity to impact Norfolk and Suffolk.

1. Introduction

1.1 Background

The Evidence and Evaluation Hub at the Norfolk and Waveney ICB have been asked to produce a briefing describing the available evidence for Mental Health Emergency Department (MHED) style services to inform commissioning decisions moving forwards. Initial scoping found very limited evidence addressing the impacts of MHEDs directly. There has not yet been a systematic evaluation of the existing services from which to draw conclusions. However, national policy indicates a clear ambition to expand MHED type models across England. The Urgent Emergency Care Plan 25/26 outlines investment in new mental health crisis assessment centres with aims to reduce ED (Emergency Department) overburdening, improve patient experience, and shift urgent mental health care to more appropriate settings.

Evidence was identified which relates to service users with mental health needs presenting in a traditional ED environment, crisis support alternatives, system pressures, and integrating mental health support staff into existing ED pathways.

1.2 Aims and objectives

The purpose of this evidence brief is to provide a rapid review of the available evidence base concerning Mental Health Emergency Departments and similar services. The evidence and suggestions in this review are intended to support discussion and considerations during the exploration of establishing a similar service across Norfolk and Suffolk.

This brief will aim to:

- Describe the evidence base on dedicated MHED or mental health urgent care centre models in England.
- Clarify the extent to which the existing literature may be used to answer service design questions.
- Identify gaps in the evidence base.
- Inform discussions regarding next steps for local planning.

2. Method

2.1 Data collection and analysis

This briefing considers a range of published and grey literature. The academic search strategy is described below. Grey literature sources included NHS England documentation, national policy and guidance, NIHR (National Institute for Health and Care Research) pages, outputs from the NIHR-funded Mental Health Policy Research Unit, NHS Futures workspaces, and wider resources.

However, with the exception of a few resources, there does not appear to be much by way of an evidence base relating directly to the development, operation, or impacts of mental health emergency departments currently. A potential explanation for this lack of existing evidence may be the relative novelty of these services, many of which were established during or in the aftermath of the COVID-19 pandemic.

Academic sources	Google Scholar, OpenAthens
Grey literature sources	NHSE policy, NHS Futures, NIHR evidence and NIHR Mental Health Policy, ICS/ ICB documentation
Search terms	“mental health emergency department”, “MHED”, mental health ED”, “psychiatric ED”, “mental health urgent care”, “mental health emergency alternatives” “mental health emergency pathways”
Inclusion criteria	English language Published after 2016 England (extended if appropriate)

3. Findings

3.1 Current landscape

National policy direction in England appears to be moving towards the development of dedicated mental health emergency pathways. This includes dedicated sites like Mental Health Emergency Departments and Crisis Assessment Centres as well as wider service changes to direct individuals undergoing mental health emergencies away from traditional EDs. The Urgent and Emergency Care Plan 2025/26 highlights mental health crisis care as a priority area, indicating that there is a need to reduce prolonged ED wait times, and to expand specialist crisis assessment centres to provide more appropriate alternatives to ED attendance. Investment in this policy direction has aimed to provide more care for service users in community and mental health settings, including the planned establishment of up to 15 new crisis assessment centres.

Despite this shift in strategic direction, no formal evaluation or evidence review is currently readily available that assesses MHEDs as a standalone clinical model. As a result, systems are being encouraged to plan MHED style services despite limited guidance on model design or expected outcomes. We have been informed by the National Clinical Director for Adult Mental Health that NHS England is in the process of collating learnings from early adopter sites and plans to publish a national overview of models to inform system planning. However, at present, there are resources that provide an initial understanding of the current operational models, similarities and differences between them, and early indications of impacts.

National and local ED activity also indicates that some mental health presentations come from inclusion groups and individuals with multiple unmet needs, often linked to inequalities, limited access to primary care, homelessness, or other forms of marginalisation. These wider system issues contribute to repeat attendance and highlight the importance of upstream community support alongside changes to emergency pathway models.

3.2 Description of existing models

While there are a range of MHED and dedicated mental health urgent care centres in operation, there is no standardised model across England. Service provision differs based on local context, crisis pathways, and workforce capacity. There appears to be two major presentations of MHED service provision in the early adopter sites.

Dedicated Mental Health Emergency Departments operating outside of acute (physical health) EDs but with strong links. These sites benefit service users by providing a potentially more appropriate location for treatment of mental health emergencies, but also rely on having dedicated premises, effective physical health capacity, and high staffing requirements. Typically, these standalone services focus primarily on mental health care provision and rely on traditional ED settings for physical health assessment and treatment.

- Hertfordshire Mental Health Urgent Care Centre
  - Provides rapid triage, assessment, and short-term stabilisation within a dedicated mental health environment.
  - Flexible stay length, generally 24-48 hours, to support safe de-escalation.
  - Accessed via 111 referrals, ED referrals, or ambulance conveyances.
  - Early reported benefits include reduced acute mental health admissions and reduced mental health wait times in ED.

- Lincolnshire Mental Health Urgent Assessment Centre
  - Opened in 2023, located near the acute hospital but operating independently.
  - Accepts patients via ambulance conveyance, ED diversion, or community referral.
  - Service is also open to children via ambulance referrals and/or diversions from ED.
  - Early performance data shows relatively stable mental health A&E attendance levels.

- Leicestershire Mental Health Urgent Care Hub

- Centralised crisis assessment and short stay model.
- Staffed by mental health practitioners able to treat all ages.
- Aims to assess within two hours.

Mental health units adjacent to or seated within existing EDs designed for rapid diversion of service users with additional mental health requirements away from acute beds. Typically, these are focussed on reducing ED congestions, providing faster treatment for mental health conditions, and integration with primary care. High capability to deal with physical health issues is also maintained in this presentation, due to location in or adjacent to a traditional ED environment.

- North London Crisis Assessment Service
  - Originally established as walk-in crisis services located within acute hospitals.
  - Sites have been trialled in multiple locations within the region, the suggestion is that this is reflective of high mental health attendance to EDs across London and the need to divert to appropriate care settings.
  - Flexible access routes depending on the site: self-referral, ambulance conveyance, police referrals, ED referrals.

- Sheffield Health and Social Care NHS FT
  - Operates a crisis assessment centre located near ED with strong integration with triage nursing teams.
  - Workforce includes 24/7 psychiatry liaison and rotating mental health staff.

- Basildon Mental Health Urgent Care Department
  - 24/7 model offering assessment, stabilisation, and onward referrals to appropriate services.
  - Adjacent to ED allowing “warm handovers” and rapid physical health escalation.
  - Adult only service provision.

3.3 Early impacts

There is not, at present, any formal evaluation of the pilot sites available. However, some indirect evidence has been reported to demonstrate early effectiveness of MHEDs. This data has been gathered largely through local performance dashboards, service reports, and qualitative learning from national reports (GIRFT). While causation may not be determined from these data sources, it may be useful to reflect some of the emerging insights when developing any similar service.

Some areas have suggested that MHEDs and similar services may contribute to system improvements including reductions in mental health A&E attendances, decreases in prolonged wait times for those undergoing mental health crises, and improvements in patient experience. However, these impacts are not consistent in services across England, suggesting regional variation in service setup and local system pressures may affect success. There have been reported reductions in mental health A&E attendances for some early implementer sites including Mid and South Essex (46% reduction) and Hertfordshire and West Essex (19% reduction). Within other sites, reductions are not as clearly presented or may not be visible at all.

Early qualitative insights from the existing sites reported that service users valued calmer, non-clinical environments, and the opportunity for access to faster assessment and potentially treatment compared to a normal ED experience. Staff feedback indicates that these services provide a more appropriate setting for service users but there were inconsistencies in the perceived safety of the services. Similarly, several early implementer sites noted that varying physical health capability could add further complication, particularly where services did not have diagnostic capability or were unable to accept individuals with unresolved physical health concerns. These differences may have been the results of variation in opening hours, physical health capability, local ED pressures, staffing levels, and differences in service access routes. For many of the sites, difficulty was also expressed when measuring outcomes, potentially as a result of low data quality and comparability between sites. Overall, early findings indicate potential benefits but also considerable variation in impact across sites.

3.4 Evidence gaps

At present, no study directly evaluates MHEDs as standalone clinical models, meaning the instigation and implementation of new services is reliant on local experience, strategic mandates, and surface learning from similar models already in operation. Decisions are, therefore, being made without the benefit of robust evidence. Part of the difficulty in making comparisons between services and gathering an appropriate evidence base may be a result of the lack of clear, national direction regarding what these services should look like. Early implementer sites differ substantially in scope, operating hours, workforce capacity, access routes, physical health capability, and the extent of integration with existing crisis pathways. As a result, there is currently no consistent service model, and significant variability exists between areas.

A further challenge in interpreting the emerging evidence relates to this inconsistency in how these services are named and operated nationally. Early implementer sites are using a wide range of terminology including, but not limited to: “Mental Health Emergency Department”, “Crisis Assessment Centre”, “Urgent Care Hub”, “Crisis Hub”, “Mental Health Assessment Centre”, and “Psychiatric Decision Unit”. The different nomenclature reflects variation in the function, clinical scope, and physical health treatment capacity within the early implementer sites.

The current evidence base highlights both some of the emerging promise of MHEDs as well as the uncertainty around their implementation and impacts. These gaps underline the need for careful local planning and clear problem definition before progressing to implementation. It will, therefore, be critical to explore current mental health service provision across primary and secondary care in Norfolk and Suffolk to identify where additional urgent mental health support pathways may have the most impact for service users.

4. Considerations for a Norfolk and Suffolk service

As advised in correspondence with the National Clinical Director for Adult Mental Health, any MHED type service should be considered as a component of the wider urgent and emergency care pathway, rather than a standalone unit. A whole system approach incorporating existing mental and emergency physical health services will be critical to ensuring any new MHED service integrates effectively. Based on the evidence currently accessible, key implications for a Norfolk and Suffolk service that need to be considered are:

Scoping of existing service provision: to ascertain where a new service is likely to support the most service users.
Defining the problem the MHED is intended to solve: is the intention for the service to improve service provision for people with mental health needs, alleviate strain on conventional EDs, or a combination of both?
Location of the service: will the service be a team co-located with existing ED sites, a separate clinical space with potentially different operating hours, linked to primary care, able to refer in and out depending on physical health needs.
Defining physical health capability: physical health assessment poses a significant operational challenge. Clear decisions are required regarding whether the service will undertake physical health assessment and treatment or accept only individuals who are medically fit. Workforce availability will also influence the level of physical health capability that can be provided, particularly if extended hours or a 24/7 model is being considered.
Evaluation: with a lack of existing evaluation to draw on, embedding effective, appropriate, and realistic evaluation from the outset will be key in ensuring the service is agile enough to make changes where necessary.
Use national learning: where possible, engagement with early adopter sites to gather information on best practice and learning so far will be instrumental for effective service design. Given the lack of national standards and the substantial variation across early implementer sites, it may be sensible to await the publication of the NHS England review and accompanying guidance before progressing with service design discussions. This could help to ensure local planning aligns with national expectations and can reflect the learning from the early adopter sites.

5. Resources for consideration

The following represent some of the resources used within this report and may provide additional strategic context to support discussions considering a Mental Health Emergency Department model in Norfolk and Suffolk.

NHS England – Urgent and Emergency Care Plan 2025/26
Sets out national priorities for improving urgent and emergency care, including the commitment to expand mental health crisis assessment provision. Provides helpful context on why MHED services are being developed and how they are expected to relieve pressure on traditional EDs.
https://www.england.nhs.uk/long-read/urgent-and-emergency-care-plan-2025-26/

GIRFT Mental Health: Crisis & Urgent Care Deep Dive (2024/25)
Offers insight into how the different MHED and crisis assessment models are operating across the country. Highlights the variation in scope, physical health capability, and workforce.

Postorivo et al. (2024) – Review of Crisis Alternatives
A broad review that looks at services such as crisis cafes, hubs, and assessment centres. Useful context for understanding what individuals receiving treatment value, the conditions in which alternatives to EDs might be works, and the wider background in which MHED services sit.

Nuffield Trust – The Changing Terrain of Mental Health in A&E
Helps to frame the wider system pressures that MHED services are being established to alleviate. Looks at national trends in mental health presentations to EDs.
The changing terrain of mental health in A&E: specialised care or the same old bottlenecks? | Nuffield Trust

Centre for Mental Health – Crisis and Acute Mental Health Care
Explores evidence relating to acute and crisis mental health care in hospitals and the community. Makes recommendations on actions the NHS could take to improve service provision.
CentreforMH_Briefing64_CrisisAndAcuteCare.pdf

NHS England - 24/7 Neighbourhood Mental Health Centres
Overview of the rapid learning, emerging practice, and shared principles to support ICS system readiness for Neighbourhood Mental Health Centres.
247 Neighbourhood Mental Health Centres Interim Guide - Mental Health, Learning Disabilities and Autism Quality Transformation Programme (MHLDAQT) - Futures