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Defining Acuity in Community Mental Health: An Evolutionary Concept Analysis

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ABSTRACT

The term 'acuity' is used in community mental health in clinical decision-making related to risk and access to services. It has consequences for people who use services, as it has impacts on how resources are allocated. However, the meaning of 'acuity' is obtuse, as it lacks consensus or definition in community mental health practice. To examine the concept of acuity in community mental health, Rodgers' evolutionary approach was used to analyse critical attributes, antecedents and consequences from 19 studies selected for review. Thematic analysis identified attributes, antecedents and consequences. Six attributes of acuity in community mental health were identified: clinical presentation, risk, complexity, urgency, need and perception. Two categories of antecedents were identified: clinician-perceived vulnerabilities and organisational factors. Four consequences were also identified: treatment, prioritisation, access and workload. This paper presents these findings and a definition to reflect current understandings of acuity in the community mental health practice context.

A Note About Language

The authors have used language consistent with the papers that are reported here and note that it is not always consistent with a recovery or lived-experience approach. The authors adopt a critical stance on the provision of mental health services, with a commitment to giving a voice to those often marginalised and minimised, such as service users and the lived experience voice, and identifying social injustices, such as the overuse of coercive approaches and power imbalances. The searches undertaken for this review sought to include lived experience perspectives. Critical engagement with these views will be offered in the discussion. This research is part of a larger study which examines the operationalisation of acuity in community mental health and includes the perspectives of people with lived experience to inform how acuity is used in their experiences of accessing mental health support.

1 | Introduction

Acuity in general healthcare is presented [1] as "the severity of a person's illness and the level of attention or service they may need from professional healthcare and support workers" (p. 2). This definition may be adequate where acuity is predicably related to a stage of illness or corresponds to identifiable stages of illness or recovery. Within mental health service provision, the concept of acuity has been more closely associated with inpatient settings. In these contexts, definitions tend to focus on the person's level of unwellness [2–4]. For example, the New Zealand Ministry of Health [3] describes a condition as becoming acute within inpatient services "when over brief periods of time a person's symptoms worsen and their capacity to perform everyday tasks of living deteriorates" (p. 9). Similarly, the National Institute for Health and Care Excellence (NICE) [4] defines acuity as "how ill the person is" (p. 4). Levels of acuity are used as

criteria to inform safe staff-to-service user ratios in policy and guidance documents [2–4].

In 2007, Baker and Munro [2] identified that no consistent definition of acuity existed within inpatient mental health services. They identified a range of factors contributing to acuity, including reason for admission, service user characteristics, use of the Mental Health Act, risks associated with violence and aggression, substance misuse, occupancy rates, and length of stay. The ambiguous use of the term has been noted to disempower staff, reinforce negative attitudes, and increase the perception that the prevalence of mental illness has worsened [2]. Subsequent literature examining triage and prioritisation continues to demonstrate variability in how these factors are interpreted and applied in practice [5]. The concept of acuity has been adopted in community mental health practice without a critical appraisal of its suitability for this context, further adding to the ambiguity of its use in practice.

Understanding how the concept of acuity came to be used in community settings requires an awareness of the evolution of mental health services in Aotearoa New Zealand. Mental health services in Aotearoa New Zealand, as in other countries, have evolved through a gradual shift from containment to biomedical treatment, and subsequently toward community-based recovery and rights-focused care. Early responses framed mental distress as a matter of public order, with people detained under the Lunatics Ordinance Act 1846 [6] and later housed in large asylums prioritising segregation over recovery [7, 8]. Throughout the twentieth century, legislation, including the Lunatics Act 1882 [9], the Mental Defectives Act 1911 [10], and the Mental Health Act 1969 [11], progressively expanded state oversight and increased voluntary care options [12]. The psychological effects of the world wars and the reframing of asylums as psychiatric hospitals signalled an incremental movement toward therapeutic and rights-based care [13, 14].

From the 1970s, deinstitutionalisation accelerated, with all patients assessed for community placements [7] and major hospitals closing through the 1980s and 1990s, including the final closure of Kingseat Hospital in 1999 [15]. The Mental Health (Compulsory Assessment and Treatment) Act 1992 enabled compulsory care in the community [16], and successive health reforms created regional variation in capacity and models of care [17, 18]. Community services expanded rapidly, managing increasing levels of illness outside hospitals, yet reviews continued to highlight persistent gaps in access, choice, innovation, and the locality of care [16, 19]. Critics also described the persistence of institutional and risk-averse practices within community settings [19]. The unexamined transfer of the concept of acuity may be one mechanism through which these practices persist.

In all settings, acuity is associated with risk and safety, with direct implications for safe staffing. Unsafe staffing increases the risk of harm, decreases the quality of care and outcomes, and reinforces outdated models of care [20]. Despite this, international reports [19, 21–24] identify that community mental health staffing is unsystematic and continues to be shaped by budget constraints or historical practice. For example, caseloads are often based on ratios, budgets, or average numbers rather than on the presenting issues or needs of individual service users. Unsafe staffing affects staff morale, well-being, productivity, and retention [20], while safe staffing frameworks typically emphasise having sufficient staff and skill mix to meet service user needs [20, 25–28], with some extending to encompass staff values [29], organisational structures [30, 31], and service user outcomes [32].

While safe staffing frameworks emphasise service capacity, acuity is fundamentally a characteristic of the individual presentation. Acuity reflects the immediacy, severity, and complexity of a person's needs, including their level of psychological distress, risk, co-occurring illness, and the extent to which these fluctuate over time [2, 33]. In community settings, acuity is dynamic and often shaped by factors in the person's lived environment, such as instability at home, social pressures, and reduced containment compared with inpatient care [34]. Acuity, therefore, relates to the person's presentation, whereas staffing and service configuration are system responses rather than determinants of acuity. High acuity presentations in community mental health services may involve acute distress, rapid deterioration, suicidality, or complex co-existing conditions that demand timely and skilled intervention [33, 34]. Mental health triage literature reinforces urgency, risk, and anticipated deterioration as core dimensions of acuity, all relating to the service user rather than the service context [5]. Recognising acuity as an individual and situational attribute helps prevent its use as a shorthand that obscures the depth and complexity of a person's experience [2], particularly in ongoing debates about risk, coercion, and the persistence of institutional concepts in community practice.

Decisions about acuity have significant ramifications as a determinant of service provision. Although the literature outlines typologies and criteria, there is no uniformity or consensus [2, 35]. With different understandings and limited shared knowledge, it is unclear on what basis clinicians determine the appropriate level of care for service users [36, 37]. This lack of transparency prevents service users from challenging decisions associated with acuity levels. There is also a risk that acuity becomes a reductive label which oversimplifies complex presentations and potentially invalidates the lived experience of marginalised or culturally diverse populations [35–37].

Greater clarity is needed regarding how the term acuity is used in community mental health settings. If acuity influences someone's treatment, the level of care, and consequently access to services, it is crucial to understand how it is conceptualised and operationalised. With this quest for clarity in mind, the following concept analysis explores the literature related to acuity in the context of community mental health.

2 | Methods

2.1 | Concept Analysis Framework

A scoping review was undertaken using Rodgers' evolutionary concept analysis approach [38] to explore understandings of acuity in community mental health services. Rodgers' method assumes that concepts are dynamic, socially produced, and continually shaped by their contexts. The method structures concept analysis using six components: (1) identifying the concept and its surrogate or related terms, (2) selecting the setting and sample for data collection, (3) analysing attributes, (4)

exploring antecedents, (5) consequences and (6) related concepts. This inductive and cyclical orientation is suited to concepts that are complex, multifactorial, or insufficiently defined, as it supports the interpretation of how meaning evolves within specific social and cultural contexts [39, 40]. Given that acuity appears to be inconsistently used and poorly delineated within mental health services, the evolutionary approach provides the most appropriate foundation for clarifying how acuity is understood and applied in contemporary community mental health practice.

2.2 | Literature Retrieval and Analysis

2.2.1 | Search Strategy

Following Rodgers' [38] evolutionary approach, a review of databases was undertaken to identify any literature that defines or describes acuity within the context of community mental health. Searches were undertaken in August 2024, including in CINAHL, MEDLINE (via OVID, EBSCO and PubMed), PsycINFO, Cochrane, Tuwhera Open Access Theses and Dissertation, and Joanna Briggs Institute (JBI). No date or country limit was included but an English-language restriction was applied. The following search terms were used: 'acuity' AND ('community' OR 'out#patient'1) AND ('mental health' OR 'psychiatr*'2). Given the large volume of irrelevant results returned in initial scoping, search terms were limited to titles and abstracts (where the database permitted) to increase specificity and avoid cross-contamination of search terms. This approach was intentionally adopted to identify literature in which acuity was explicitly defined or described, consistent with the aims of concept analysis to examine how a concept is used and constructed, rather than to exhaustively retrieve all related literature. This deliberately simple and targeted search strategy aligns with Rodgers' evolutionary concept analysis, which seeks to map the use and meaning of a concept across the literature rather than undertake comprehensive evidence synthesis [35, 38].

2.2.2 | Inclusion and Exclusion Criteria

The aim was to identify sources that discussed acuity in community mental health. The inclusion criteria were sources that (1) the primary setting was community mental health, (2) used the word acuity, (3) were a primary or secondary study and (4) were available in English. Given international variation in terminology, both community and outpatient services were included, as the distinction between clinicians going to service users versus service users attending clinics is not consistently applied. Exclusion criteria included research that focused on inpatient or forensic mental health settings or was not set in a community setting.

Aligned with Rodgers' evolutionary concept analysis, formal quality appraisal of included studies was not undertaken. The purpose of this analysis was to explore how acuity is defined and conceptualised across the literature, rather than to evaluate the methodological quality or strength of evidence. Literature was treated as data, reflecting the use and meaning of the concept, with inclusion based on conceptual relevance rather than methodological hierarchy.

2.2.3 | Research Article Selection

Figure 1 shows the PRISMA flowchart and selection process for identifying papers to include within the review. A total of 541 papers were identified from electronic database searches. The title and abstracts of these 541 papers were screened, and 522 papers, including duplicate results, were excluded. Of the remaining 19 papers, the full text was reviewed. All 19 papers were included.

3 | Results

The reviewed studies are detailed in Table 1. Publication dates ranged from 1990 to 2023. The 19 papers included original

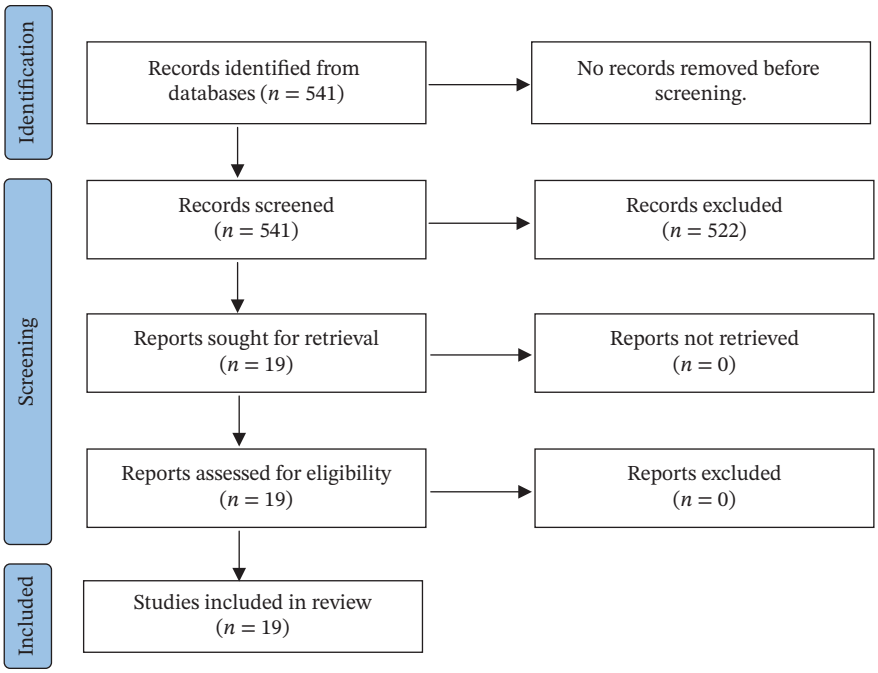

FIGURE 1 | Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement [11].

TABLE 1 | Included studies and key findings.

Study	Country	Focus of study	Method	Potentially related words
Albutt et al. [32]	UK	Mental health professionals' perceptions of patient safety issues.	Framework analysis of qualitative interviews of 14 mental health professionals across community and inpatient settings.	Illness, safety, access, workload, level, perception, observation, co-morbidity, sicker, risk, crisis, suicidal
Barker et al. [41]	Canada	Likelihood of receiving outpatient mental health care after psychiatric ED visits.	Quantitative analysis of deidentified health administrative data available via a not-for--profit research institute.	Presentation, substance use, level, crisis
Belcher and Munjas [42]	USA	Management concerns of mental health head nurses.	Open-ended question interviews of four head nurses working in various mental health settings across the U.S.A.	Chronicity, delayed treatment
Berry et al. [43]	USA	Effectiveness of an intensive outpatient program for LGBTQIA + youth with high-acuity depression, anxiety, and suicidality.	Data of 551 LGBTQIA + patients were collected from intake and discharge outcome surveys measuring depression, suicidality, and non-suicidal self-injury.	Depression, anxiety, self-harm, daily functioning, psychological well-being, behavioural issues, sexuality, intensive services, treatment outcomes, restrictive care
Cawthorpe et al. [44]	Canada	Usefulness and validity of the children's mental health priority criteria score	Statistical analysis of priority criteria scores against clinical criteria of 497 clients.	Urgency, maximum acceptable waiting times, triage
Evans-Chase et al. [45]	USA	Unrecognised treatment needs of adolescents and young adults attending an intensive outpatient programme.	Thematic analysis of 200 journal entries of youth treatment experiences.	Restrictive care, treatment frequency, complex needs, multiple or persistent psychiatric disorders, substance use, trauma, daily functioning, youth, clinical symptoms
Evans-Chase et al. [46]	USA	Changes in depression between intake and discharge among youth and young adults in an outpatient programme.	Quantitative analysis of Patient Health Questionnaire Adolescent scores of 1022 adolescents and young adults at the start and end of a remote intensive outreach programme.	Health disparity, higher health needs, complex needs, depression, diagnosis, intensive outpatient programmes, hospitalisation, stable, treatment
Gabet et al. [47]	Canada	Characteristics of patients that predict out-patient follow-up within 30 days of presenting to emergency departments.	Data on clinical and sociodemographic characteristics, and service use were extracted for 9514 patients who attended an emergency department for mental health reasons. Hierarchical logistic regression was used to investigate predictors for prompt follow-up.	Illness, emergency, urgent care, suicidal ideation, suicide attempt, violence, social issues, priority, severe and acute conditions, adjustment disorders, bipolar disorder, higher physician care, more psychosocial intervention
Gliske et al. [48]		Factors related to engagement outcomes for clients in complex developmental periods with co-occurring conditions.	A latent profile analysis of 2924 clients was conducted using indicators of clinical acuity at entry and assessed for associations with demographic factors and treatment engagement outcomes.	Engagement, anxiety, depression, self-harm, age, gender, transgender, sexuality, youth, trauma, behavioural issues, self-injury, daily functioning
Karcher et al. [49]	USA	Early identification of youths who are experiencing mental health concerns.	Synthesis of virtual meetings with mental health researchers, clinicians, and stakeholders. It was unclear how they synthesised.	Symptoms, assessment, level of care, safety concerns, suicide risk, abuse, neglect, danger to self or others

(Continues)

TABLE 1 | (Continued)

Study	Country	Focus of study	Method	Potentially related words
McGarvey et al. [50]	USA	Predictors of initiating involuntary commitment of individuals experiencing a mental health crisis.	Qualitative coding-based analysis of crisis interactions with 2624 clients underwent statistical analysis of various factors to determine significance.	Risk of self-harm, risk of harm to others, severity of the crisis, drug abuse, drug dependence, severity of symptoms
Nichols et al. [34]	USA	Factors that impact caseload and case acuity in outpatient mental health and family maltreatment.	Focus groups with American military family advocacy and mental health staff. It was unclear how many people participated in focus groups. Inductive thematic coding was used to analyse the data.	Caseload, environmental factors, individual factors, needs, assessment, treatment, clinic context, mental state, symptoms, safety, intense case, level, triage
Prabhakar et al. [51]	USA	Factors associated with the prescribing of first-line, second-generation antipsychotics associated with weight gain.	Statistical analyses of 340 retrospective patients' medical records in the U.S.A (304 were in the control group) were completed.	Mental status, symptoms, illness, psychotic symptoms, manic symptoms
Sabbioni et al. [52]	Australia	Effectiveness of a culturally sensitive mental health model for people ages 13–24 years of age.	Mixed methods study, including a regression analysis of rating scales from 40 Aboriginal clients.	Clinical, baseline, predictor, covariate
Siskind et al. [53]	Australia	Predictors of mental-health-related acute service utilisation and treatment costs in the year following an acute psychiatric admission.	Dataset of 1757 patients containing administrative and outcome data for 1 year before and after an acute psychiatric admission was analysed using multivariate regression models to identify patient- and treatment-related predictors of service utilisation or cost.	Inpatient admission, illness, mental illness, acute, poorer functional ability, involuntary status, living conditions, self-harm, substance abuse, severity of symptoms, highest HoNOS, psychotic disorders, high service use
Sullivan et al. [54]	USA	Supports and challenges affecting mental health service provision at school-based health centres during the COVID-19 pandemic.	Qualitative data collected from School-Based Health Centres to examine supports and challenges affecting mental health services provision during the COVID-19 pandemic, changes in this provision, and priorities for assessing and supporting student mental health.	Mental health problems, more immediate and complex mental health challenges, greater co-morbidities, increased demand for services, crisis, mental health concerns
Szmukler [55]	United Kingdom	Ethics in community mental health.	Reviewed the literature and shared own observations as a medical director of ethical challenges in community mental health.	Severely mentally ill, community fears, consequences of care
Uscher-Pines et al. [56]	USA	Health centres use of tele-mental health in conjunction with in-person care.	Semi-structured interviews with 20 USA health centre leaders were analysed using inductive, deductive, and matrix approaches.	Wait times, preference to see in person, complex histories, high-risk, suicidal ideation, homicidal ideation
Willis et al. [57]	Australia	Staffing methodology tool designed to equalise the workload of community mental health teams.	Workload tool for community mental health and community nurses was developed, trialled, and evaluated. Evaluation occurred using qualitative and quantitative data.	Intensified work of community nurses, workload, complexity, quality of care

research (18) and literature reviews (1). Journal editorials were read for policy and research direction. The methods used in the original research varied, including tool evaluations, population-based studies, implementation studies and service evaluations. Each paper is considered equal in standing rather than critiqued for the approach and methodology. However, the literature identified and reviewed did not include lived experience perspectives. Their absence reflects how knowledge of acuity is produced within the field and highlights important limitations in its conceptualisation. The findings, including surrogate terms, related terms, antecedents, attributes, examples and consequences of acuity, are outlined in Table 2 and detailed below. Figure 2 presents the antecedents, attribute and consequences of acuity in community mental health practice.

3.1 | Antecedents of Acuity in Community Mental Health Practice

Antecedents are the factors that precede the occurrence of the concept of interest [38]. Antecedents to perceived acuity in community mental health were not well defined in the literature, yet several recurring factors appeared to shape whether a presentation was judged as higher or lower acuity. These influences fell broadly into two domains: clinician-perceived vulnerabilities related to the person, and organisational conditions shaping how services operate. Across studies, what counted as vulnerability was highly variable and largely inferred rather than explicitly defined, raising questions about subjectivity and bias in clinicians' judgements [2, 43, 52, 53]. Characteristics such as gender, ethnicity, indigeneity, sexuality, recent hospital or Emergency

TABLE 2 | Elements of acuity in community mental health from the literature.

Elements	References
Antecedents of Acuity	
Clinician-Perceived Vulnerabilities	Albutt et al. [32]; Barker et al. [41]; Belcher & Munjas [42]; Berry et al. [43]; Cawthorpe et al. [12]; Evan-Chase et al. [58]; Evans-Chase et al. [30]; Gabet et al. [46]; Gliske et al. [35]; Karcher et al. [23]; Nichols et al. [10]; Prabhakar et al. [3]; Sabbioni et al. [28]; Siskind et al. [34]; Sullivan et al. [51]
Organisational Factors	Albutt et al. [32]; Belcher & Munjas [42]; Berry et al. [43]; Evans-Chase et al. [30]; Gabet et al. [46]; Gliske et al. [35]; Karcher et al. [23]; McGarvey et al. [49]; Nichols et al. [10]; Sullivan et al. [51]; Szmukler [59]; Uscher-Pines et al. [31]; Willis et al. [52]
Attributes of Acuity	
Clinical Presentation	Albutt et al. [32]; Barker et al. [41]; Belcher & Munjas [42]; Berry et al. [43]; Evan-Chase et al. [58]; Evans-Chase et al. [30]; Gabet et al. [46]; Gliske et al. [35]; Karcher et al. [23]; McGarvey et al. [49]; Nichols et al. [10]; Prabhakar et al. [3]; Sabbioni et al. [28]; Siskind et al. [34]; Sullivan et al. [51]; Szmukler [59]; Uscher-Pines et al. [31]
Risk	Albutt et al. [32]; Berry et al. [43]; Evan-Chase et al. [58]; Evans-Chase et al. [30]; Gabet et al. [46]; Gliske et al. [35]; Karcher et al. [23]; McGarvey et al. [49]; Nichols et al. [10]; Siskind et al. [34]; Szmukler [59]; Uscher-Pines et al. [31]
Complexity	Albutt et al. [32]; Berry et al. [43]; Evan-Chase et al. [58]; Evans-Chase et al. [30]; Gabet et al. [46]; Gliske et al. [35]; Nichols et al. [10]; Sabbioni et al. [28]; Sullivan et al. [51]; Uscher-Pines et al. [31]; Willis et al. [52]
Urgency	Albutt et al. [32]; Barker et al. [41]; Belcher & Munjas [42]; Cawthorpe et al. [12]; Gabet et al. [46]; McGarvey et al. [49]; Nichols et al. [10]; Sullivan et al. [51]
Need	Berry et al. [43]; Evan-Chase et al. [58]; Evans-Chase et al. [30]; Gliske et al. [35]; Karcher et al. [23]; Nichols et al. [10]
Perception	Albutt et al. [32]; Gliske et al. [35]; Nichols et al. [10]
Consequences of Acuity	
Prioritisation	Belcher & Munjas [42]; Berry et al. [43]; Cawthorpe et al. [12]; Evan-Chase et al. [58]; Evans-Chase et al. [30]; Gliske et al. [35]; Karcher et al. [23]; Nichols et al. [10]; Prabhakar et al. [3]; Sabbioni et al. [28]; Siskind et al. [34]; Uscher-Pines et al. [31]; Willis et al. [52]
Access	Albutt et al. [32]; Barker et al. [41]; Belcher & Munjas [42]; Cawthorpe et al. [12]; Gabet et al. [46]; Nichols et al. [10]; Sullivan et al. [51]; Uscher-Pines et al. [31]
Treatment	Albutt et al. [32]; Berry et al. [43]; Evan-Chase et al. [58]; Evans-Chase et al. [30]; Gabet et al. [46]; Gliske et al. [35]; Karcher et al. [23]; Nichols et al. [10]; Szmukler [59]; Uscher-Pines et al. [31]
Workload	Nichols et al. [10]; Willis et al. [52]

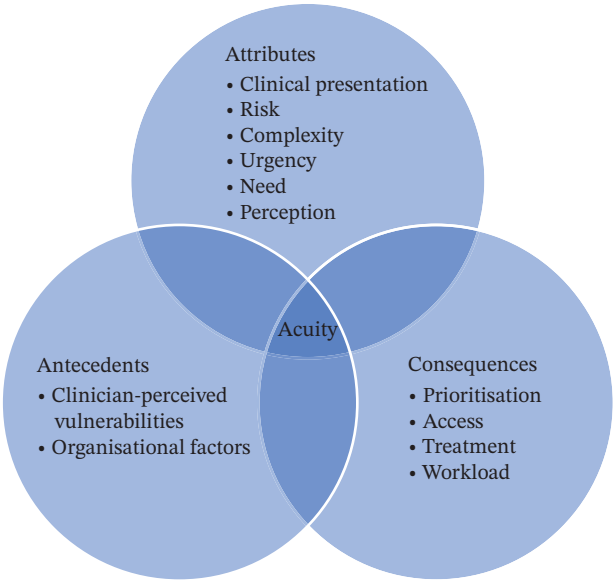

FIGURE 2 | Conceptual model of acuity in community mental health practice.

Department use, and social or environmental disadvantage were all associated with higher acuity ratings [34, 47, 52, 53], despite inconsistent evidence of their predictive value. These attributions risk reflecting structural inequalities rather than clinical need, particularly when factors such as unsanitary living conditions, limited supports, unemployment or compulsory legal status are treated as intrinsic markers of acuity rather than consequences of broader social determinants [34, 47, 53]. The strength of the therapeutic relationship [32, 52], patterns of engagement with services [34, 53] and clinicians' perceptions of risk [32] exert considerable influence on acuity assessments, yet these constructs were rarely defined explicitly and, in most cases, lacked clear or consistent evaluation frameworks. One broader structural antecedent was also noted, where societal fear of services failing people who are mentally unwell, amplified by media attention, influenced clinical responses and contributed to increased compulsory admissions following high-profile events [55].

A substantial proportion of antecedents related not to the person but to how services were configured and resourced. Limited service availability, delays in accessing care, pressures for early discharge, and constrained service capacity all contributed to higher perceived acuity [42, 49, 55]. Organisational factors such as model of care, team functioning, staff availability, clinician skill or confidence, workforce training, continuity of care and overall service design were also described as influencing acuity determinations [32, 42, 47, 50, 54, 57]. When previous health records were inaccessible, the absence of information itself increased perceived acuity [32], illustrating how assessments were shaped by service limitations rather than clinical presentation. These findings highlight that perceptions of acuity, at times, reflect organisational constraints rather than the individual's characteristics. This conflation is analytically important, as it blurs the boundary between a person's needs and a service's ability to meet them and risks producing acuity decisions that are contingent, context-dependent, and influenced by systemic pressures rather than grounded in a consistent set of clinical criteria.

3.2 | Attributes of Acuity in Community Mental Health Practice

Attributes are the components or features that define a concept [38]. Six defining attributes emerged from the literature. These were clinical presentation, risk, complexity, urgency, need, and perception. Attributes of acuity were varied and broad, encompassing both the service user presentation and the interpretation of that presentation. Interpretations of clinical presentation were often used to determine service access and response, and there appeared to be a relationship between attributes. For example, a strong link was evident between someone having higher risk ratings and being considered more complex. Each attribute is described below in order of prevalence, with a breakdown also provided in Table 2. It is important to note that without any consensus of meaning, prevalence is not necessarily indicative of importance.

3.2.1 | Clinical Presentation

All but two papers [44, 57] discussed clinical presentation in the context of acuity. Relevant aspects of clinical presentation included the severity or chronicity of a service user's symptoms, as well as the presence of specific symptoms such as alcohol/drug use, personality-related symptoms and suicidality. Psychotic illness and mood-related disorders were identified as specific diagnoses associated with high acuity. Mental health history was also identified as relevant to acuity, including the complexity and history of trauma [34, 56].

Across the literature, these factors were treated largely as isolated indicators rather than as interacting components, undermining the ability to understand acuity as a multidimensional construct. For example, personality-related symptoms simultaneously elevate perceived acuity [34] yet reduce access to services [53], highlighting an unresolved tension within clinical decision-making. This tension suggests that assessments of acuity reflect implicit hierarchies of risk, unpredictability and treatability rather than the person's needs. In practice, this means acuity functions not only as a marker of clinical severity but also as a gatekeeping mechanism that can either facilitate or restrict care. Such patterns illustrate that the relationship between clinical presentation and acuity is neither linear nor consistently applied, highlighting a need for greater conceptual clarity and transparency in how clinical features are weighted in community mental health settings.

3.2.2 | Risk

Twelve of the papers [32, 34, 43, 45–50, 53, 55, 56] referred to risk, particularly safety concerns in relation to acuity. Enough papers explicitly referenced this area for it to be considered a separate, albeit relevant component of clinical presentation. Risk was described in various ways, including as an increased likelihood of developing an illness, the context of actions that suggest an intent to harm oneself or others, as a factor that impacts safety, and as something that can be managed, often through restrictive care settings [43, 45]. Albut et al. [32] suggested that a focus on risk and safety is present in community services but not discussed as overtly as in inpatient services, with staff in community services being more likely to use phrases such as relapse indicators or early warning signs. It seems the issue of control is relevant despite the community context, in that clinicians may feel less

able to mitigate the risks associated with a person in uncontrolled community environments. The consideration of risk focuses on risk from service users to others or themselves and without consideration of risk from others or how service users perceive risk related to themselves [60]. The use of the word risk reflects the narrow view on physical harm, which fails to encompass the broader aspects of a person's safety needs [58].

3.2.3 | Complexity

Eleven papers [32, 34, 43, 45–48, 52, 54, 56, 57] described the complexity of a person's situation as a factor related to acuity. Complexity in these papers encompassed multiple factors, both current and historical. These factors included complex history, such as trauma, and someone's current presentation, which included co-existing conditions and social factors. Complexity is a reductionist term used to describe dynamic factors at play, where varied priorities may rise and fall in quick succession. The papers identified historical and current factors as predictors of acuity but gave little attention to the currency and validity of these assumptions, indicating a need to further unpack causal relationships that may evolve over time. Complexity is an appropriate term to use to represent the multiple interactions that occur across and within the various domains of a person's being, including psychological, social, environmental and spiritual [61]. However, the shorthand use of the term 'complex' in acuity assessment, absent a holistic analysis of the interplay between historical and dynamic factors, may produce inaccurate assumptions about service user capacities, risks, and needs. This, in turn, may privilege historical factors over current context.

3.2.4 | Urgency

Eight papers referred to urgency as a temporal factor related to acuity [32, 34, 41, 42, 44, 47, 50, 54], where experiencing a crisis was associated with greater acuity and the need for a timely response. However, none defined what constituted a crisis, and references were largely in the context of delays in treatment or barriers to early intervention, which were described as leading to crisis presentation [34]. These delays were attributed solely to service users delaying help-seeking, with no corresponding discussion on delays arising from limited resources, workforce shortages or service configuration. This asymmetry suggests that urgency may reflect assumptions about engagement or compliance rather than access.

Crises were also a factor in determining priority and acceptable waiting times, implying that the perception of urgency directly shaped acuity decisions [44]. However, the absence of details about what constitutes an acceptable waiting time or the criteria underpinning prioritisation indicates that these judgments rely heavily on subjective interpretation rather than objective or standardised assessment. A further aspect of time was highlighted by Nichols et al. [34], who identified the amount of time required for a case or caseload as a factor in acuity assessment. This may also lead to conceptual inconsistency if the amount of time spent with a service user is determined by service availability and responsiveness, rather than a reflection of the person's support needs.

3.2.5 | Need

Six papers [34, 43, 45, 46, 48, 49] highlighted a person's need(s) in relation to their acuity but separate from other related factors, such as risk or treatment. Of these, two papers [43, 45] discussed need as an individual descriptor of care that a person might require. Need was not defined across the papers, but all used the term in the context of individual need(s) that care providers were required to meet. This is not a new phenomenon; need is not well defined and is broadly used in mental health to encompass varied reasons for seeking support, from domestic discord and socially unacceptable behaviour to risk factors related to illness and symptoms [59, 62–64]. However, even when viewed through this broad lens, the relationship between need and acuity remains unclear. The papers did not articulate whether particular needs increased perceived acuity more than others, nor whether need operates independently or through other components such as risk, access barriers or complexity. This lack of clarity likely contributes to ambiguity in acuity assessments.

3.2.6 | Perception

Three papers [32, 34, 48] discussed perception and acuity assessment, specifically in relation to clinicians' appraisal of safety and risk, suggesting a level of subjectivity in the process. Albutt et al. [32] noted that the perception of safety issues is under-researched and highlighted that this perception of safety issues is not just the clinicians' but also the views of service users and carers. This exposes a tension in practice where the perception of the various parties may not align and raises the question of whose view takes precedence and how such precedence can be justified if it rests on perception and subjective interpretation.

Nichols et al. [34] discussed the engagement of a person and their family as a factor that influences the time requirement of a case, suggesting a level of subjectivity in perceived levels of engagement. This foregrounds the power dynamics inherent in such assessments, where clinicians may interpret disengagement through their own worldview, including implicit expectations that are neither articulated nor mutually agreed upon. When perceptions of engagement are treated as objective indicators, they risk becoming unexamined determinants of acuity, raising concerns about whether these subjective judgements contribute to decisions that enable coercion or limit a person's rights.

3.3 | Consequences of Acuity in Community Mental Health Practice

Consequences are the results of applying acuity [38]. Across the literature, consequences of acuity were inconsistently defined and seldom discussed as interconnected components, reflecting broader conceptual ambiguity. Four themes emerged: prioritisation [32, 34, 41, 42, 44, 47, 54, 56], access [32, 34, 43, 45–49, 55, 56], treatment [34, 42–46, 48, 49, 51–53, 56, 57], and workload [34, 57].

Prioritisation was commonly framed as the immediate operational impact of high acuity, with higher-rated presentations receiving urgent response [42, 44, 47, 54, 56] or earlier placement on waiting lists [34, 44, 47]. However, the basis for these decisions was seldom transparent, often relying on undefined notions of

crisis and urgency [32, 41, 44, 54], making it difficult to determine whether prioritisation reflects need, service capacity constraints, or entrenched assumptions about priority. As prioritisation shapes subsequent access to care, these consequences function as a feedback loop, where being labelled high acuity both results from and reinforces differential access to timely intervention. However, higher prioritisation does not always result in greater access to services, where the consequences may include high prioritisation [34], but access to services may be comparatively lower [53].

Treatment consequences were similarly entangled with prioritisation and access, but the direction of influence was unclear. Acuity was positioned as a determinant of admission [46, 53], driver of treatment intensity [34, 43, 46, 48, 49, 52, 53, 56, 57], or outcome of treatment delays [42, 44], creating a circular logic in which acuity both prompts and is shaped by the treatment pathway available. The contribution of the therapeutic relationship to treatment outcomes [52] added another layer of complexity, underscoring that acuity does not operate in isolation from relational and contextual factors.

In contrast, workload consequences primarily impacted clinicians, with higher acuity cases reflecting increased frequency and length of contacts. However, the extent to which workload also shapes perceptions of acuity was not explored in the literature. It is plausible that if workload influences engagement and perceptions of urgency or risk, then it may shape acuity as much as acuity shapes workload. Taken together, these patterns suggest that consequences attributed to acuity reflect structural and organisational dynamics rather than intrinsic attributes of the person.

3.4 | Surrogate Terms for Acuity in Community Mental Health Practice

Surrogate terms are words or phrases that can be used interchangeably to represent the same concept [38]. In the case of acuity, however, no true surrogate terms were identified. Although the literature frequently uses related concepts such as severity, complexity and risk, alongside interchangeable use of workload or caseload [34], these refer only to particular aspects of acuity rather than its full meaning, and therefore cannot function as surrogate terms. Their presence in the literature reflects the ambiguity in how acuity is described. The inability to identify surrogate terms is a finding in itself, which demonstrates the lack of clarity surrounding acuity and supports the need for a concept analysis to understand how the term is being applied within community mental health.

3.5 | Related Terms to Acuity in Community Mental Health Practice

Related concepts possess commonalities with the concept but not the same characteristics [38]. Related terms were identified throughout the literature, with many forming attributes of acuity. Workload or caseload had a strong relationship with acuity. As mentioned earlier, it was incorrectly used interchangeably in some literature. Workload is also a consequence and to some extent an antecedent in terms of organisational factors. Safe staffing is a concept that has some commonality with acuity and is closely aligned to staffing levels, which was identified as an antecedent of acuity. Risk, albeit an attribute, was also incorrectly used in place of acuity in some literature [49, 56]. Risk is not a surrogate term but could be considered a related term.

3.6 | Examples of Acuity in Community Mental Health Practice

Examples can provide practical illustrations of a concept [38]. However, in the reviewed literature, there was no clear example of the concept 'acuity' as applied in practice. This is likely a result of the concept's relative immaturity and ambiguity on what constitutes or defines acuity in community mental health at this stage.

4 | Discussion

A range of theoretical perspectives emerged in the analysis, several of which are presented using deficit-framing language that positions individual characteristics as causal. Factors such as gender, ethnicity or indigeneity were seen to increase acuity ratings, with a distinct lack of strengths-based, asset-framing, or growth-mindset approaches. Such deficit framing risks misattributing inherent personal characteristics as increasing the risk of mental illness rather than relating to social determinants and structural conditions. As outlined in the note about language, this is not the perspective taken by the authors. These framings have been presented in their unfiltered form as part of the inductive process of evolutionary concept analysis, allowing mapping of literature as it currently exists rather than as it ought to be.

Evolutionary concept analysis provides a structured and inductive method for analysing concepts in their current state [65]. Given the limited and inconsistent literature, there remains considerable ambiguity surrounding the concept of acuity in community mental health. Applying Morse et al.'s [66] criteria for concept maturity, acuity remains an immature concept characterised by poorly defined attributes, antecedents and consequences, and blurred boundaries between these elements. This lack of conceptual clarity contributes to variability in how acuity is interpreted and applied in practice.

The analysis identified six defining attributes: clinical presentation, risk, complexity, urgency, need, and perception. While attributes, such as clinical presentation and urgency were consistently described, others, such as need or complexity, remained inconsistently defined, further indicating conceptual immaturity. However, a narrative review of international mental health triage tools [5] aligned well with the attributes of acuity, referencing clinical presentation, risk, need, urgency, and clinicians' perception. In the present concept analysis, four consequences were identified: treatment, prioritisation, access, and workload. Although the congruence across the literature varied considerably. Notably, consequences such as access and workload appeared to reflect service-level pressures as much as service user experiences. Agreement on antecedents was limited, with many described factors reflecting service architecture rather than service user characteristics, thereby reducing the ability to isolate predictors of acuity. Despite this, two categories emerged: clinician-perceived vulnerabilities, referring to attributes of people using services; and organisational factors, encompassing the structural, operational, and resource-related features of community mental health services.

Acuity is often conflated with related constructs such as risk, severity, complexity, and workload; however, the findings of this

analysis suggest that these constructs are better understood as conceptually distinct, though closely related. In particular, risk, complexity, urgency, need, clinical presentation, and perception are not synonymous with acuity but represent attributes through which acuity is interpreted in practice. In contrast, severity, referring to the intensity of clinical symptoms and a component of clinical presentation, in isolation does not necessarily account for contextual factors. Intensity, workload, or caseload reflects the implications arising from acuity rather than acuity itself. These distinctions highlight that acuity is not reducible to any single dimension but is a composite construct that emerges from the interaction of multiple attributes within specific clinical and organisational contexts.

Based on the findings from this concept analysis, this definition of acuity for community mental health was developed:

> Acuity is a sense of a person's presentation constructed through the clinical interpretation of the dynamic interplay between risk, urgency, need, clinical history, mental state and substance use assessment and psychosocial factors.

Providing this definition from the literature reflects the current conceptualisation for critique and further development. The review of the literature identified that conceptualisations of acuity are influenced by biomedical and neoliberal discourses that foreground individuality, illness, symptomology, diagnoses, deficits, restrictive practices, and clinical perspectives. More critical engagement is required to understand how this influences service provision and how particular knowledges are undermined, such as individual or family views of safety and needs. These priorities can shape service provision to support the status quo, meeting the needs of nonmarginalised communities, and further marginalising those whose needs are not met [19]. The adoption of acuity from inpatient service provision to community-based services has occurred without sufficient adaptation for context, including the social and structural factors that influence mental health and wellbeing [19]. The lack of lived experience and systemic perspectives in the literature related to acuity in community mental health contexts highlights a significant gap in research and practice.

4.1 | Future Enquiry

Future research will be crucial to further develop the concept of acuity in community mental health. The temporal aspects of the concept, identified as antecedents or consequences, are not well defined. Further longitudinal research may clarify these temporal aspects and the sequential nature of components identified as crossing domains in this review. A number of components of the concept were also identified in a small number of the included papers. Given the potentially subjective nature of acuity, these components would benefit from further investigation to understand their true relation to the concept.

The concept analysed here provides an initial conceptualisation of acuity in a clinical context. There is a need to understand the relationship between components of acuity further. Further enquiry is needed to expand the concept beyond a narrow clinical perspective and understand the antecedents, attributes, and consequences from a lived experience perspective, including people using services and their families. A greater focus is also needed on the context of acuity, including social determinants, psychosocial factors, and trauma responses, to understand the complex factors at play.

5 | Conclusion

This review identified that acuity in community mental health is poorly defined and operationalised. No explicit definitions were identified; however, each paper carries an inferred meaning, with some commonality across attributes, including clinical presentation, urgency, treatment, and risk. While this commonality exists, it is limited and variably interpreted. However, much of the difference is not disparate but adjacent in meaning; for example, need is not incompatible with risk but represents a related, yet distinct dimension.

These commonalities and differences have been used to propose a definition of acuity in community mental health. Acuity is therefore best understood as a composite construct shaped by multiple interacting factors rather than a singular measurable concept. Clarifying the meaning of acuity in community mental health is important, particularly given that the evidence suggests it is used to profile people to determine treatment, prioritise care, and determine access to services.

5.1 | Relevance to Clinical Practice

Concept analyses provide an opportunity to develop theory further. This is crucial as the link between theory and practice is inseparable. Acuity is used in various contexts, and this analysis identifies the defining characteristics of acuity in community mental health. This understanding should lead to greater transparency of workload, staff skill level required, decision-making, and access for service users, improving people's knowledge and ownership of their health, and improving equity of access to services.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Endnotes

[1]'#' represents a wild character adapted for each database. Where this was not available, outpatient, "out patient", and out-patient were used with an OR operator to capture spelling variation.

[2]'*' represents truncation adapted for each database. Where this was not available, psychiatry, psychiatric, and psychiatrist were used with an OR operator to capture variations in spelling.

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