

Acute options for mental health care insights paper

August 2024



Insights Paper on Acute Options for Mental Health Care

A paper issued by Te Hiringa Mahara—the New Zealand Mental Health and Wellbeing Commission (Te Hiringa Mahara).

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Te Hiringa Mahara—the New Zealand Mental Health and Wellbeing Commission—was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website: www.mhwc.govt.nz

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We are also incredibly grateful to the services who provided us with information about their service and the mahi they do. Thank you for allowing us to share these examples and highlight existing options that are providing successful alternatives to inpatient care as part of the acute continuum of care. We look forward to spotlighting more examples of such alternatives over years to come.



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Whakamōhiotanga whānui |

Overall summary

A high-quality acute continuum of mental health care can provide a safety net for anyone who needs it, anywhere, and at any time. It provides clear pathways to culturally appropriate assessment, treatment, and social support, in line with people's needs and preferences.

There is an ongoing need to expand acute options to ensure acute mental health services are accessible, acceptable, and effective. This insights paper explores possibilities and opportunities to grow and develop the acute continuum and highlights a range of possible alternatives to acute inpatient care. Good evidence shows alternative approaches are effective both internationally and in Aotearoa New Zealand.

This paper highlights peer-led, community-based, and Kaupapa Māori services as these types of services show positive outcomes and are well received by people who need acute care. Alternative options have some key features that resonate with those with lived experience. Tāngata whaiora¹ felt supported and accepted by peer-led services, which managed decisions about risk and safety in collaboration with them. These services provided a gateway to other services when required and were most effective when they had strong relationships with local clinical services and crisis teams.

Increasing the range of acute services to include options such as the ones highlighted in this paper can relieve some of the pressure that acute inpatient services are under. Having options that vary in their staffing requirements allows for a more diverse workforce and provides the opportunity to strengthen the peer specialist workforce while enabling more efficient use of the clinical specialist workforce, who play a critical role in supporting these services.

We have heard from lived experience communities that they want a wider range of acute options and more choice, so people can be supported in ways that work best for them and their whānau. Greater investment in a wider range of community-based acute options can support people through the acute phase while staying closer to home in their local community.

¹ Tāngata whaiora are people of any age or ethnicity seeking wellbeing or support, including people who have recent or current experience of distress, harm from substance use, or harm from gambling (or a combination of these). Tāngata whaiora include people who have accessed or are accessing supports and services. They also include people who want mental health or addiction support but are not accessing supports or services.



Kupu arataki | *Introduction*

Te Hiringa Mahara—the Mental Health and Wellbeing Commission (Te Hiringa Mahara) has the mandated function to assess and report publicly on the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing; monitor mental health and addiction services; and advocate for improvements to those services.²

We are committed to achieving better and equitable mental health and wellbeing outcomes for Māori and being grounded in Te Tiriti o Waitangi, as we express in [Te Tauāki ki Te Tiriti o Waitangi | Te Tiriti o Waitangi Position Statement](#). We prioritise the voices and interests of people with lived experience in our work, as captured in our [Lived Experience Position Statement](#).

The purpose of this insights paper is to highlight the range of options that could and (in some cases) do make up the acute continuum of care. These options increase the choices available to tāngata whaiora³ when they need acute care. This paper highlights some peer-led, community-led, and kaupapa Māori examples of alternative services that are already offered in some areas of Aotearoa and summarises a broader range of models, some of which are not currently available in Aotearoa. It also advocates for the ongoing need to expand acute options to ensure acute mental health services are accessible, acceptable, and effective.⁴

Acute options for mental health care

It has been six years since **He Ara Oranga**, the landmark inquiry into mental health and addiction services, was published (Government Inquiry into Mental Health and Addiction, 2018). One of the areas that the report highlighted was the need to increase choice of services and broaden the types of mental health and addiction services available (Recommendation five, p.16). One of the strong themes to come out of the inquiry was that people want support, including crisis support and acute care, in the community (p.9).

In June 2022, Te Hiringa Mahara published [He Ara Āwhina \(Pathways to Support\) framework](#) following a wide co-development phase with the mental health and

² These roles are mandated under the [Mental Health and Wellbeing Commission Act 2020](#).

³ Tāngata whaiora are people of any age or ethnicity seeking wellbeing or support, including people who have recent or current experience of distress, harm from substance use, or harm from gambling (or a combination of these). Tāngata whaiora include people who have accessed or are accessing supports and services. They also include people who want mental health or addiction support but are not accessing supports or services.

⁴ The focus of this report is on adult mental health services. We acknowledge that some people accessing mental health services may also be receiving support for an addiction issue.

addiction sector and lived experience communities. He Ara Āwhina describes 12 domains that express what an ideal mental health and addiction system looks like from a Te Ao Māori perspective and a shared perspective. One of the domains of He Ara Āwhina—Access and Options—states that:

We have the right to choose support and services, when and where we need them, that respond to our experiences, needs and aspirations, and believe in our capacity to thrive.

This domain was the focus of our 2024 mental health and addiction service monitoring report, [Kua Tīmata Te Haerenga | The Journey Has Begun](#). A key finding of this report is that access to specialist services has decreased over the last five years, largely due to increased pressure on these services and workforce shortages (Te Hiringa Mahara, 2024b).

People told us that they want to see increased access and more options, particularly when they are in crisis. We heard about the increased pressure on specialist services and significant workforce shortages and high vacancy rates. We highlighted these findings in our accompanying [Voices Report](#) (Te Hiringa Mahara, 2024c).

This insights report focuses on acute options that can provide an alternative to acute inpatient care and help relieve some of the pressure on these services. Increasing the range of acute options provides people with viable and welcome alternatives that allow them to stay safe and supported in their local community.



Horopaki | *Context*

Defining mental health crises

The World Health Organization (2021) finds that there is no consensus on what constitutes an acute episode or a mental health crisis. It recognises that one person's crisis is a personal and unique experience that someone else may not see in the same way.

From a clinical perspective, crises tend to have certain elements in common. Specifically, they are temporary states that overwhelm someone to the point where that person:

- is unable to take care of themselves
- is unable to function
- is unable to use their usual personal resources or natural supports
- needs external or expert assistance to regain a sense of equilibrium (Hoff, 2001).

From a lived experience perspective, crises are deeply personal so different people experience them in different ways. Sometimes a person's experience of a crisis can be that they are unable to carry out the functions of everyday life. At other times, crisis can occur while a person continues to go about their usual life—and it can be particularly challenging and invalidating to try to access support at these times.

Historically, mental health crisis has been framed as a 'medical emergency'. Such framing has led to urgent medical responses that have not always upheld people's rights or provided choice of support (Minkowitz, 2021). In seeking alternative approaches, lived experience communities have advocated for support options that are non-coercive and respond to crisis with compassion and intensive support.

While people who have been diagnosed with a mental health condition can experience mental health crises, others can have such experiences too. A mental health crisis can be triggered by a range of biological, psychological, or social factors (or a combination), including for people who have not been diagnosed with a mental health condition or substance use disorder.

Defining adult acute services

In this paper, we define 'acute services' as those dedicated services that are designed to respond to the needs of people who are experiencing a crisis related to mental health and/or substance harm. The focus of this paper is on adult mental health services.

Acute mental health and addiction services can be defined as a subset of specialist services. Specialist services (also called secondary services) are designed to respond to needs of tāngata whaiora with the most severe and/or complex needs. They require a referral or assessment for entry. They are publicly funded services provided by Health New Zealand | Te Whatu Ora or non-governmental organisations (NGOs). Specialist services include a range of services that are delivered in both inpatient and community settings (Te Hiringa Mahara, 2024b).

Acute services are usually 24-hour care and treatment services provided to people who are experiencing severe acute symptoms and need intensive input for a short period. The primary goal is to achieve a short-term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a mental illness (Health New Zealand, 2024b).

Aotearoa has a range of acute and inpatient services. Table 1 outlines the definitions for these services according to the current national service specifications for adult mental health services (Health New Zealand, 2024a). These specifications are part of the National Service Framework, which provides the overarching framework for a range of effective, evidence-based service types (Ministry of Health, 2016). While these definitions are standardised and form the basis of services funded through Health New Zealand, local services may vary so these definitions do not always accurately reflect the services being delivered on the ground.

Table 1: Types of acute and inpatient services in Aotearoa

Service	Definition
Adult acute home-based treatment	A service to provide acute responsive services that are highly mobile and available in the service user’s home setting as an appropriate alternative to a service in an acute inpatient hospital-based setting.
Adult acute in-patient services	A service that provides inpatient care within a hospital setting for people in the acute stage of mental illness, who are in need of a period of close observation and/or intensive investigation, support and/or intervention, where this is unable to be safely provided within a community setting or less acute inpatient service. The service will be provided by a multidisciplinary team of people trained in mental health intervention, treatment and support.
Adult acute package of care	A service to provide individually tailored packages of care/treatment for adults who are experiencing

	an acute episode of a serious mental illness/mental health problem.
Adult crisis respite	A service that is home-based or residential as an option for people who would otherwise require admission to acute inpatient mental health services.
Adult intensive care in-patient beds	A service that provides the most intensive level of clinical care and skilled observation for acutely ill service users who present an immediate risk of harm to themselves or others within the context of acute inpatient services, in a hospital setting.
Crisis intervention service	A service that provides rapid assessment and intervention for people experiencing a mental health crisis. The services are highly mobile and available in the setting and at the time that the crisis is occurring.
General hospital liaison service	A service to provide recovery-oriented specialist assessment, intervention and advice regarding the needs of people who are receiving treatment from a general hospital and who have concurrent physical and mental health or addiction needs.
Sub-acute/extended care in-patient	An inpatient recovery-oriented service that enhances the skills and functional independence of service users. The service is for people who are assessed as requiring care in a more structured environment because of diagnostic and treatment complexity, or insufficient response to treatment, and have a continuing need for a high level of ongoing supervision and support.

Data used in this report

Voices of people with lived experience and whānau

This paper reflects the voices of tāngata whaiora as well as whānau, family, and supporters. Two lived experience advisory groups supported the early stages of this project: a Māori roopu, and a lived experience and whānau group.

We also selected relevant tāngata whaiora quotes from other qualitative data we have gathered, including data from:

- the [consultation for He Ara Āwhina \(Pathways to Support\) framework](#)
- a report covering the [first three years of the Access and Choice programme](#) (Te Hiringa Mahara, 2022)
- two of our focus reports for Te Huringa Tuarua 2023 about:
 - [Kaupapa Māori services](#) (Te Hiringa Mahara, 2023b)
 - [the admission of young people to adult inpatient mental health services](#) (Te Hiringa Mahara, 2023c)
- a report about the [peer support workforce](#) (Te Hiringa Mahara, 2023a)
- the [Voices Report](#) (Te Hiringa Mahara, 2024c), which accompanies [Kua Timata Te Haerenga | The Journey Has Begun](#) (Te Hiringa Mahara, 2024b, our 2024 mental health and addiction service monitoring report).

Where relevant, we have also included a few quotes from staff from the Voices Report.

Example services

Three of the four service providers that this paper highlights as examples of acute care alternative services (Te Whare Matatini Hauora, Te Puna Wai, and Taranaki retreat) directly provided data. The Tupu Ake evaluation is available publicly on the [Te Pou website](#).

Literature

Our literature search on the effectiveness of acute and crisis options focused on systematic reviews, national-level reports, and evaluations of acute mental health services (published in English, from 2013). This process identified 70 relevant articles and reports. We found that lived experience and peer perspectives were more likely to be represented in the ‘grey literature’⁵ so our search approach may under-represent the peer and lived experience perspectives that have been published more widely.

Identifying inpatient beds in Aotearoa

Health New Zealand provided the data used in the map on page 16, which shows acute mental health inpatient beds by district.

⁵ Grey literature is any information that is not published commercially or indexed by major databases. not been published commercially; therefore, it is not necessarily searchable via the standard databases and search engines.

Pūtake | *Background*

Learning from the past

Since 2000, several reports have examined the mental health and addiction acute services available in Aotearoa. In 2001, the then Mental Health Commission published **Open All Hours? A review of crisis mental health services in New Zealand** (Mental Health Commission, 2001). This review highlighted the strengths, shortcomings, and service delivery issues associated with responding to mental health and addiction crises. Some of those issues continue in the current system.

Then in 2006, the Mental Health Commission published another report on adult acute services: **The Acute Crisis: Towards a recovery plan for acute mental health services in New Zealand** (O'Hagan, 2006). The author, Mary O'Hagan, found that progress with deinstitutionalisation was slower for acute services than for other mental health services. She identified the urgent need to develop a wider range of community- and home-based acute services. O'Hagan also highlighted the lack of international literature on acute services for indigenous people and ethnic minorities, and stated that Māori should be resourced to design, develop, and deliver their own acute solutions. She concluded with suggestions about how to improve the suite of acute services as part of a larger plan for the mental health system.

Similarly, **He Ara Oranga** noted the lack of acute options available and called for early, easily accessible support for people in crisis, during which they could maintain their connections to family and whānau, homes, schools, workplaces, friends, and communities (Government Inquiry into Mental Health and Addiction, 2018, p.93).

Increasing need for acute support

As we heard during our qualitative data collection for [Kua Timata Te Haerenga](#), which was highlighted further in our [Voices Report](#), specialist mental health services over the last couple years have been under increasing pressure, largely due to workforce shortages. As a result, wait times have grown longer, and tāngata whaiora and people working for primary care and NGO services consider that thresholds for specialist services have increased (Te Hiringa Mahara, 2024b, 2024c).

Acute inpatient services are particularly pressured, as they deal with high demand and ongoing high occupancy rates (Association of Salaried Medical Specialists, 2021; Ellingham, 2024). People have told us about challenges with accessing support for tāngata whaiora who are acutely distressed or unwell and/or experiencing a crisis.

Inpatient service was accessible only once my daughter was so sick that she could be admitted through ED [the emergency

department]. Criteria and waiting list for outpatient service made that inaccessible.

Whānau, family, and supporters online form

We have also heard from clinicians and service providers about how challenging it is for current services to meet the needs of people who are acutely distressed or unwell and/or experiencing a crisis.⁶

I think specialist services have increased their threshold ... they're down on psychiatrists, they're down on frontline staff, so they've got to do what they've got to do. So, it is hard.

Primary care provider

As we highlighted in our 2023 insights paper, growing and developing the peer support workforce has the potential to offer additional options for tāngata whaiora in need of acute care. The peer support workforce has been shown to improve hope, psychosocial outcomes, and quality of life for tāngata whaiora. There is also huge potential to further develop the Māori lived experience workforce, who bring a Te Ao Māori perspective, which incorporates mātauranga Māori, tikanga, and kawa (Te Hiringa Mahara, 2023a).

In the Budget 2022 announcements, the Government acknowledged the need for more and better crisis response services. It announced a \$27 million investment (over four years) into community-based crisis services (Little, 2022; Te Hiringa Mahara, 2024a).⁷

Tāngata whaiora views

One of the most common ways in which tāngata whaiora feel let down by the mental health and addiction system is that they find it difficult to get help when they most need it. Another common concern is how long they must wait for help, assessment, or treatment from the mental health and addiction system after they first contact someone.

Tāngata whaiora have reported that the hospital acute inpatient units often exacerbated their mental distress rather than alleviated it. While acknowledging some positive attributes of acute inpatient care, people have shared with us that during this care they felt culturally alienated, found the environment unwelcoming, and felt very unsafe (especially women on mixed-gender wards). We have also heard that people felt bored because of a lack of activities on the ward and wanted access to peer

⁶ For more information, please see our [Voices Report](#) (Te Hiringa Mahara, 2024c).

⁷ For more information, please see our upcoming report, [Budget 2019 to Budget 2022 investment into mental health and addiction](#) (Te Hiringa Mahara, 2024).

support and more whānau support (including through having the option of whānau staying overnight with them).

More services and a wider range of alternatives to inpatient care

During our engagements, tāngata whaiora have raised the need for an increase in the services available and a wider range of alternatives to mental health inpatient services, including respite care and community treatment.

More funding and support for those who suffer immediately and the family/support people of sufferers is an absolute essential. Services being available to help keep sufferers in their community with support and not having to be moved to special locations.

Person with lived experience

More holistic wellbeing services, more alternative services like respite care and day programs, peer support work, all of those options.

Young person commenting on the admission of young people to adult inpatient mental health services

Kaupapa Māori services

We have heard from tāngata whaiora Māori that they want services that reflect Te Ao Māori. Kaupapa Māori services can provide that worldview.⁸

It's a reflection, bro, of who we are as a people in this community. And it should look exactly the same, like a mirror reflecting back on us. And if it doesn't, it means it doesn't reflect who we are, and it needs to.

Tāngata whaiora Māori commenting on Kaupapa Māori services

More Māori staff and less tauwi staff, as they are not in alignment with our cultural needs and therefore, we are often misunderstood and discriminated [against] and not treated correctly. A Te Ao Māori approach would be more beneficial.

Lived experience advisory group

Finding the right person that will be non-judgemental and hold space for culture and talanoa. If we are intending to make safer space for our people ... there needs to be a much better system, that acknowledged Te Ao Māori concepts and mātauranga, as well as

⁸ For more information, including definitions, see our [Kaupapa Māori services report](#) (Te Hiringa Mahara, 2023b).

Pacific, those brothers and sisters need to receive real time care, as and when needed.

Lived experience online form—Māori

Peer-led services

Throughout our projects, tāngata whaiora have told us of the benefits of peer support.⁹ Tāngata whaiora have also told us that peer-led services need to be more accessible and to be seen as equivalent to specialist services.

Peer support, group therapy rather than this plodding individualistic approach, more options in services.

Lived experience online form

I could have been provided with other community services or peer support avenues to explore on the triage phone call instead of being told I didn't meet severity criteria.

Lived experience online form—Māori

... we need peer led services, we need these roles right across existing services whether they're clinical or not clinical.

Person with lived experience commenting on the peer workforce

The acute continuum

The acute continuum of mental health care for adults can be made up of a number of services, including:

- crisis community mental health teams
- acute inpatient services, sub-acute services
- acute alternative services
- crisis respite services
- home-based treatment teams
- assertive community outreach teams
- acute/intensive package of care teams
- crisis cafés.

Across Aotearoa, some districts have a wider range of services than others. Areas can also differ in the names they use for these teams and services.

Acute inpatient beds are provided by Health New Zealand in a hospital setting. Some districts also provide sub-acute services, in some cases through NGO providers.

⁹ For more information, please see our paper on the [peer support workforce](#) (Te Hiringa Mahara, 2023a).

Acute alternative and crisis respite services are another part of the acute continuum and are usually provided by NGOs or community providers that hold a contract with Health New Zealand to deliver these services.

Among all those who use specialist mental health and addiction services, relatively few people will require admission to an acute inpatient service. In 2022/23, 4.8 per cent of people using specialist services were admitted to an inpatient unit once or more in the year (Te Hiringa Mahara, 2024b). Given inpatient services are only one part of the acute continuum of mental health and addiction services, the range of services available in the community (both acute and non-acute) has a large impact on the level of pressure on and demand for inpatient services.

Regional variation

Tāngata whaiora and lived experience communities continue to call for an increase in the range of options for acute care. Further work is needed to explore effective options that could be added to the acute continuum in Aotearoa.

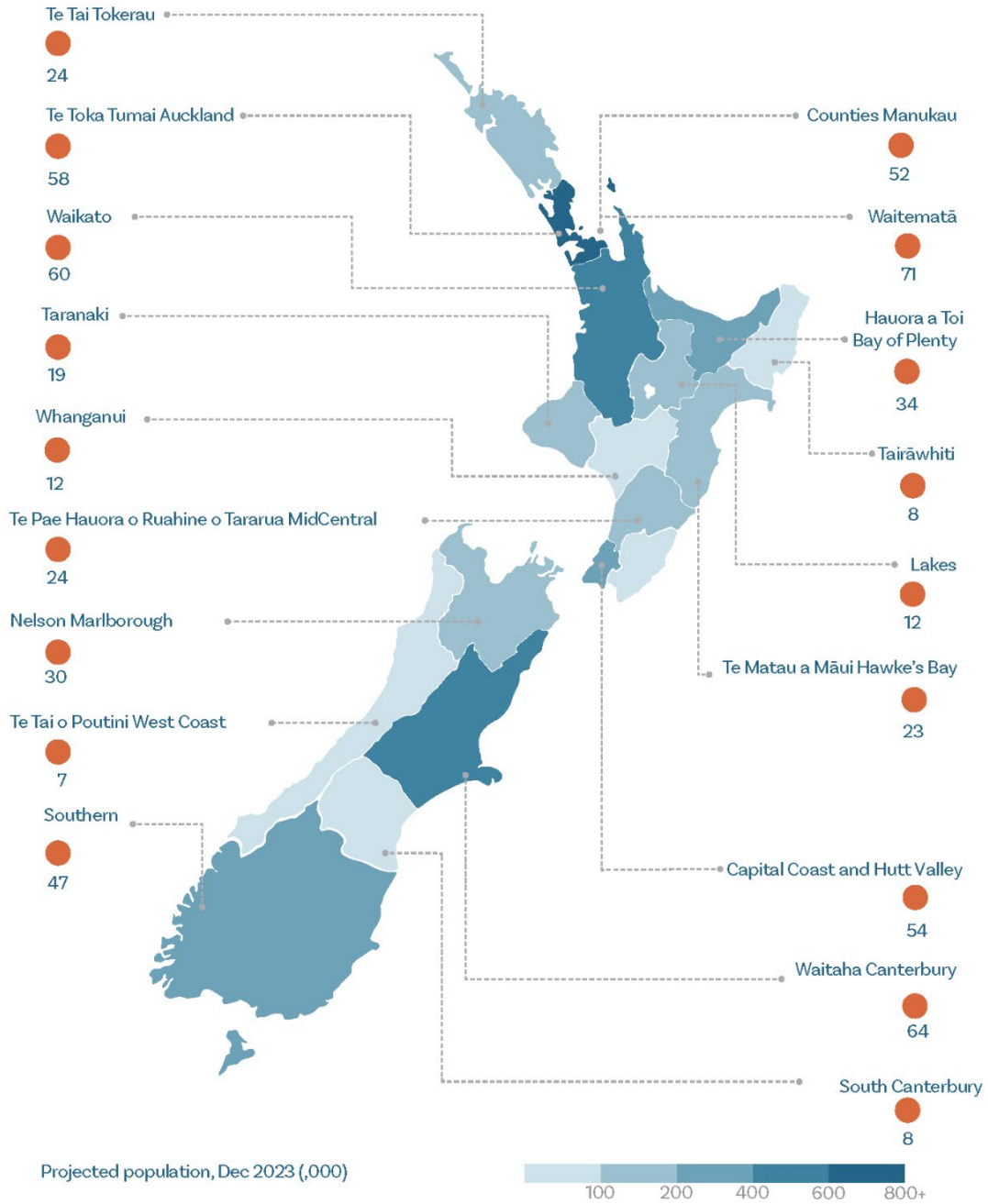
Which acute services are available varies widely across Aotearoa. While some areas have invested in a range of acute community options, other areas have limited or no options available. We heard from clinical leaders that more sub-acute (and other community-based) options are needed in many parts of the country where they are simply not available.


The map on the following page shows the number of inpatient acute beds relative to the population in each district. We recognise this map shows only part of the acute continuum and it is important not to look at inpatient beds in isolation as some areas have a lower number of inpatient beds relative to the number of people in their population but have a wider range of acute options in the community. However, reliable data on acute options delivered in the community are unavailable.

Further work is required to gain a detailed list of the range of acute services available, which will help us understand how acute options vary across Aotearoa. We also need to better understand which acute options work best for whom, and under what circumstances. Finally, we need a plan to eliminate the differences in availability, access, and quality of care for tāngata whaiora who need these types of services in different parts of the country—especially in smaller rural areas.

Acute mental health inpatient beds by district

● Inpatient





Matawhānui mō ngā tautiakitanga wawe | *Vision for acute care*

A high-quality acute mental health system provides a safety net for anyone who needs it, anywhere, and at any time, and provides clear pathways to culturally appropriate assessment, treatment, and social support in accordance with people's needs and preferences.

He Ara Oranga (Government Inquiry into Mental Health and Addiction, 2018) outlines a vision for mental health and addiction services as a continuum of care that is underpinned by a set of core principles. It also sets out expectations for accessible, acceptable, and effective acute mental health and addiction services. These expectations include that:

- support is easily accessible for people in crisis, and while accessing this support they can maintain their connections to family and whānau, homes, schools, workplaces, friends, and communities
- services, which are led by caring, competent, and skilled health, peer, and cultural workers, provide an immediate response
- an immediate response service is able to effectively de-escalate situations and support people into appropriate assessment and respite services, community hubs, or inpatient services.

The **Oranga Hinengaro System and Service Framework** states that 'a number of critical shifts ... need to occur across the health system to improve outcomes'. The following are among these critical shifts (Ministry of Health, 2023).

- Part of the shift to 'build lived experience-led transformation' includes having 'a greater range of lived experience led services, in particular peer support, across the service landscape, including acute services'.
- The shift to 'promoting wellbeing and responding early when distress arises' will involve developing 'a strong continuum of community-based acute mental health and addiction responses in all parts of the country, including pathways into hospital-based services when needed'.
- Making the shift to 'actively deliver on Te Tiriti o Waitangi' means that 'all services that are predominantly accessed by Māori or serving a high Māori population will be radically re-designed (by and with Māori) to reflect Te Ao Māori values and practices and utilise mātauranga Māori and pūrākau to

support oranga hinengaro while ensuring ongoing access to needed clinical services’.

Voices of lived experience


The core elements of an effective crisis system from the perspective of tāngata whaiora are that the system offers:

- someone they can call
- a safe and welcoming place to go
- immediate access to help, hope, and healing
- a compassionate and culturally appropriate response.

Tāngata whaiora have told us that they want acute mental health and addiction services to offer them genuine choice. That includes more accessible community-based acute options, such as Kaupapa Māori services, youth-oriented services, and peer-led services, all of which include holistic supports.

Tāngata whaiora Māori have told us that they want acute options that are culturally, spiritually, and physically safe for them. They want to see:

- an increase in acute mental health and addiction responses that recognise the mental distress and safety concerns of tāngata whaiora Māori
- options that recognise whānau and significant others are central to their wellbeing
- a choice of Māori approaches and Māori healing practices
- a greater understanding of, and an increase in responses to, acute mental distress from a Te Ao Māori perspective and within the context of Māori models of health.



He taunakitanga o ngā putanga whai hua | *Evidence of what works*

Overview

Much of the research on the effectiveness of acute services comes from the United Kingdom and North America. The findings coming from both regions are similar, suggesting that this evidence may be broadly applicable to Aotearoa.

A few Aotearoa-based evaluations of acute mental health services are available (Butler and Kongs-Taylor, 2017; Every-Palmer et al., 2022; Magill, 2021a; Tipene-Leach et al., 2019). While some research has examined Māori experiences of acute mental health care, we found no published evaluations of culturally specific acute mental health services.

While only limited research is available on the effectiveness of community-based residential alternatives relative to hospital inpatient care, existing evidence supports the use of intensive home treatment services, acute day units, and community crisis services. Research on peer support models has demonstrated the approach is cost-effective, leads to improved outcomes for tāngata whaiora, and is seen as an important component of acute mental health care (Substance Abuse and Mental Health Services Administration, 2022).

Internationally, countries and regions vary in the descriptive terms and service models they use for different acute options. This inconsistency makes international comparisons difficult for both researchers and commissioners and presents a challenge when assessing the effectiveness of the different types of acute options. Such difficulties have prompted calls for the development of a standardised methodology (taxonomy) for classifying mental health and addiction services (McPherson et al., 2018).

While service models vary across the world, the research evidence can be broadly categorised into the following four service types:

1. community-based non-residential
2. community-based residential
3. mental health and addiction partnerships with police and/or ambulance
4. hospital-based.

The following table summarises the evidence for the effectiveness of services within each of these service types.

Summary of the evidence for the effectiveness of acute services

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
Community-based non-residential			
Peer-run warm line	Peer-run alternative to a crisis line	Yes	Users report broadly positive experiences and a reduction in the use of other crisis services (Dalgin et al., 2011; McClellan et al., 2022).
24-hour crisis call centre	Telephone, text, or chat lines to reduce distress and link to other supports	Yes	Consistently positive outcomes across multiple digital modalities for help-seekers' emotional state, satisfaction, and referral plans (Hvidt et al., 2016; Mazzer et al., 2021). Limited evidence for newer contact modalities, e.g., texts.
Acute day unit	Alternative to hospital admission; focus on crisis resolution and recovery	Yes	Good-quality evidence that acute day units are as clinically effective as inpatient treatment, and they are associated with greater service user satisfaction (Paton et al., 2016). Unclear how acute day unit care fits with other types of acute home-based or community services that are more effective at reducing admission rates. Further data needed on the cost-effectiveness of acute day units (Marshall et al., 2011).
Community-based mobile crisis resolution teams	Mobile team of mental health and addiction professionals who assess and resolve/refer	Yes	Overall, mixed-quality evidence indicates these services—when implemented well—are clinically effective and cost-effective. Benefits include reductions in the probability of hospital admission and greater service user satisfaction compared with inpatient services. There is no or poor

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
			evidence for many other outcomes of interest. How this approach is implemented varies greatly (Carpenter et al., 2013; Holgersen et al., 2022; Johnson, 2013; Murphy et al., 2015; Paton et al., 2016). Including peer workers on mobile crisis teams reduces subsequent use of crisis and emergency services (Bassuk et al., 2016).
Crisis cafés	Offer a welcoming, drop-in, support space	Yes	A key theme reported by tāngata whaiora has been the need to have a place to go for respite, safety, and emotional or other support (DeLeo et al., 2022). However, there is no empirical evidence for the effectiveness of crisis cafés, and no information about specific service models or the key components of these services (Molodynski et al., 2020).
Distress brief intervention (Scotland)	Trained front-line police and health staff help ease distress; further community-based support is available	No	Evaluation of the pilot in Scotland was sufficiently positive to recommend national roll-out. Having a central agency to coordinate services is an essential component (Duncan et al., 2022).
Home-based treatment	Short-term, intensive community mental health and addiction support and treatment	Yes	Reduces inpatient bed usage including readmissions and is less expensive. Relative impact on safety and reducing coercive care is unclear. Limited evidence for clinical measures and effects on caregivers and staff. Probably improves patient experience (Johnson et al., 2022; Paton et al., 2016; Towicz et al., 2021).

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
Living Room (Chicago, USA)	Peer-led service offers an alternative to obtaining mental health and addiction services in an emergency department (ED)	No	Outcomes from the first year of operation suggested that this service was more cost-effective than traditional EDs and was effective in helping people to alleviate a crisis without the use of EDs (Heyland et al., 2013).
Open Dialogue outreach (Tornio, Finland)	Psychotherapy-based, social network approach for those in crisis, available via phone, text, or email, or on a walk-in basis; staffed by a multidisciplinary team	To be developed	Evaluation found that duration of hospital care, disability allowances, and the need for neuroleptic medication remained significantly lower for the Open Dialogue cohort. Participants also had better employment outcomes than those treated conventionally. People using the service were positive about it, as were families and professionals (World Health Organization, 2021).
Community-based residential			
Crisis stabilisation centres	Comprehensive mental health and addiction services like those provided in an acute hospital setting, but in a more home-like environment; mixed staff	No	Effective at assessing and treating people whose acute needs cannot be met by other community acute mental health and addiction services (Mukherjee and Saxon, 2019). Experience data lacking.
23-hour crisis stabilisation units	Time-limited (usually up to 23 hours), medically supervised unit providing	No	A single evaluation found the service was effective in reducing inpatient admissions, reducing health care costs,

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
	a therapeutic environment in which to de-escalate the crisis severity		and improving tāngata whaiora outcomes (Braitberg et al., 2018).
Crisis respite	Time-limited, community residential service	Yes	Although evidence is inconclusive, research suggests a greater level of satisfaction, greater autonomy, an increase in therapeutic alliances, and few differences in outcomes compared with inpatient treatment (Substance Abuse and Mental Health Services Administration, 2014). However, crisis houses and acute wards may not cater for service users with similar clinical needs (Smithson, 2022). Some evidence indicates that peer-staffed crisis respites reduce hospital admissions and are cost-effective (Bouchery et al., 2018).
Peer-led acute alternative to admission	Peer-led, community-based residential services that provide brief, acute-level mental health support as an alternative to admission to a mental health and addiction acute inpatient service	Yes	Limited research; positive results from evaluations of two New Zealand services (Butler and Kongs-Taylor, 2017; Connect Supporting Recovery and Waitematā District Health Board, 2016).
Short-term residential step-up	Residential treatment and rehabilitation to minimise the need for hospitalisation and to	Yes	Associated with improved quality of life, lower health care costs, and lower non-health care costs (Farhall et al., 2021). However, services may serve a consumer group that

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
and step-down sub-acute facilities	ease the transition from hospital back into the community		overlaps with but is distinguishably different from the group using inpatient psychiatric units (Sutherland et al., 2020).
Soteria houses	Psychosocially oriented community crisis houses	No	Outcomes relating to hospitalisation and readmission are positive compared with mental health hospitalisation (Cooper et al., 2020; Friedlander et al., 2022).
Mental health and addiction partnerships with police and/or ambulance¹⁰			
Crisis intervention teams	Uses trained police officers who have mental health training and are linked to specialist mental health and addiction services	No	Research suggests there may be a positive effect on police officers' interactions with people in crisis (Compton et al., 2008). There is little evidence of positive outcomes overall (Marcus and Stergiopoulos, 2022).
Co-response teams	Jointly deploys teams comprising staff from mental health services, paramedics, and police to respond to those in crisis	Yes	Descriptive research suggests co-response teams can contribute to better outcomes compared with police-only responses (e.g., reduced involuntary hospitalisation, shorter ED wait times, more—and more appropriate—community referrals), but outside of the UK may have little effect on arrests and use of force. However, the evidence is mixed: findings depend on the model implemented, the cases involved, and the outcome measures considered. Further

¹⁰ These partnerships exclude the now discredited Serenity Integrated Mentoring originally known as the Integrated Recovery Programme (UK). This involved staff from mental health services and the police working in a single team that developed and delivered a management plan to people identified as high-intensity users of services.

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
			<p>research is required to identify the key elements of co-response team programmes, the impact of those elements on outcomes of interest, and the impact on various populations (Blais and Brisebois, 2021; Every-Palmer et al., 2023; Ghelani et al., 2023; Heffernan et al., 2022; IACP/UC Center for Police Research and Policy, nd; Kirubarajan et al., 2018; Marcus and Stergiopoulos, 2022; Mulgrew, 2022; Puntis et al., 2018; Seo et al., 2021).</p>
Emergency medical/psychiatric team	Team comprises a specialist ambulance nurse and a specialist mental health nurse who jointly respond to 111 mental health and addiction crisis calls	No	No evidence relating to effectiveness. Experience evidence is positive but minimal (Lindström et al., 2020). More research is needed to identify effective ways of improving the delivery of care across organisational boundaries, particularly when there are limited community acute services available (Kerr et al., 2022).
Police watch-house nurse initiatives	Mental health and addiction nurses in police watch-houses to assist the police response	Yes	Evaluations of two single initiatives have found positive health outcomes for detainees, and benefits for both the police and the mental health system (Crilly et al., 2020; Howie, 2017).
Hospital-based			
Urgent psychiatric services	Hospital-based urgent psychiatric care located within a hospital's outpatient mental health		The amount and quality of published literature evaluating urgent psychiatric services is very limited. Developing an evidence base is hampered by lack of consistent definition and difficulty in achieving methodological rigour in

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
	service providing rapid access to multidisciplinary mental health care		evaluation. There is little consistency between programmes in terms of eligibility criteria, response times, appointment accessibility, and treatment offerings (Sunderji et al., 2015). Studies of individual psychiatric emergency service units, within or adjacent to EDs, have shown positive outcomes, e.g., reduction in wait times, reduction in physical restraint, and enhanced health care (Ledet and Chatmon, 2019).
Mental health and addiction consultations in EDs	Various models, including a multidisciplinary psychiatric liaison team, providing assessment, support, and triage to people in crisis presenting to a hospital's ED	Yes	Some (poor-quality) evidence shows that psychiatric liaison models in EDs are associated with reduced readmission rates, reduced waiting times, and improved service user satisfaction (Evans et al., 2019; Paton et al., 2016). Little evidence about the benefits of providing mental health training to ED staff (Paton et al., 2016). Early research suggests that the use of peer support in ED settings adds value to clinical services and decreases adverse outcomes that are secondary to the mental health and addiction crisis (Heyland et al., 2021).
Psychiatric assessment rooms in EDs	Dedicated rooms in EDs where psychiatric assessments can take place	No	No clinical outcome evidence. Some negative experiences have been reported including exacerbated symptoms, a perception of punishment, feelings of loneliness, and seclusion. Research highlights the importance of optimal design (Strike et al., 2008).
Short-stay mental health crisis units	Limited-duration, 24-hour specialist, multidisciplinary care for	No	Short-stay mental health crisis units are effective in reducing ED wait times and inpatient admissions. Further research should investigate the impact of units on patient

Acute service	Description	Any examples in Aotearoa?	Summary of the international evidence
	people who are in acute mental distress		experience, and clinical and social outcomes (Anderson et al., 2022).
Mental health inpatient units	Inpatient care within a hospital setting for people in the acute stage of mental illness, who need a period of close observation and/or intensive investigation, support, and/or intervention	Yes	Optimal physical environments are associated with better client outcomes. Buildings designed to reduce conflict and the use of restrictive practices are producing some positive outcomes (Finnerty, 2021). Research is needed to assess the clinical effectiveness and cost-effectiveness of aspects of mental health inpatient care in relation to their impact on tāngata whaiora outcomes (Paton et al., 2016).
Intensive psychiatric inpatient units	Smaller, locked wards, with greater security and higher staffing levels compared with mental health inpatient units	Yes	Further research is needed to assess the clinical effectiveness, cost-effectiveness, and experience of aspects of intensive mental health inpatient care in relation to their impact on tāngata whaiora outcomes (Paton et al., 2016).



He whiringa kē mō ngā ratonga tūroro tauroto | *Alternatives to acute inpatient services*

In this section, we spotlight four examples that demonstrate the success and benefits of alternative models to acute inpatient care. We highlight them as viable alternatives to inpatient care that respond to calls from tāngata whaiora and lived experience communities for a wider range of options, while also having the potential to relieve pressure on inpatient care.

We chose these examples to showcase the range of options that are possible as each one illustrates a different design and model of care. Tupu Ake is an example of a peer-led acute care residential service and was the first of its kind in Aotearoa. Te Whare Matatini Hauora is a Kaupapa Māori acute care residential service. Taranaki Retreat is a community-led, residential acute care and wrap-around service. Te Puna Wai is a Kaupapa Māori and peer-led crisis café service.

Examples

Tupu Ake

Tupu Ake is a peer-led mental health service in South Auckland providing an alternative to acute inpatient care. Since 2008, Tupu Ake has offered a home-like environment where up to 10 people can stay for short periods. The purpose of the service is to provide brief support to people (guests) requiring an acute level of care in a community setting. Tupu Ake also provides day support for up to five more people.

Peer support workers engage with residents through their shared experiences, demonstrating recovery and giving hope. In a 2017 evaluation, guests report high levels of engagement and satisfaction with their experience, strongly related to the supportive peer environment and model of care (Butler and Kongs-Taylor, 2017).

The peers would be the number one thing that made a difference. Someone came and said in a peer support way, 'This is my experience'. It just blew me away. ... I thought 'Wow, I can talk, I can share what I'm going through.' ... This is massive, the fact people have had the same experiences. It's because of this I am now able to speak more freely with the support people I work with.

Guest, Tupu Ake

Guests shared that Tupu Ake helped them feel hopeful for recovery from the acute distress they were experiencing (Butler and Kongs-Taylor, 2017).

They gave me hope, that it's not all that bad experiencing this and that I'm not a hopeless basket case. ... When I have bad days and start thinking I can't face things anymore, I think about the hope they gave me.

Guest, Tupu Ake

Coming here felt safe without being locked up while I got my head together, Tupu is a time out healing space. A space it is safe to be depressed without having to put on a happy face.

Guest, Tupu Ake

Tupu Ake is showing highly promising outcomes as an alternative to inpatient care (Butler and Kongs-Taylor, 2017).

I first came to Tupu Ake 3-4 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.

Guest, Tupu Ake

Coming to Tupu Ake has stopped me from going to the inpatient lots of times. I would get worse in an inpatient because of the environment. If you're in hospital and you've gone backwards and think 'Am I that bad?'

Guest, Tupu Ake

Te Whare Matatini Hauora

Te Whare Matatini Hauora is a Kaupapa Māori service in Titahi Bay (Wellington region) providing a range of crisis respite options for adults in crisis who require an alternative to acute inpatient care. This four-bed residential service provides a home-like, informal environment in a suburban setting.

Te Whare Matatini Hauora provides services in a manner that reflects Māori aims and aspirations and Māori models of practice underpin those services. Reconnection to culture is one of the many ways in which Te Whare Matatini Hauora supports its

tāngata motuhake¹¹ through workshops, such as workshops focused on making korowai or tokotoko panels.¹²

I don't think I'd ever truly been respected culturally in my own 'culture' as I have at Te Whare Matatini Hauora. I feel a great spiritual and cultural shift in my wairua and tinana.

Tāngata motuhake, Te Whare Matatini Hauora

I especially enjoy the 'karakia kai' and attitude for gratitude that is linked to each meal.

Tāngata motuhake, Te Whare Matatini Hauora

Te Whare Matatini Hauora also supports its tāngata motuhake to look at their holistic wellbeing. For example, it offers workshops on topics such as rongoā, where tāngata motuhake learn about collecting, using, and making traditional Māori medicine. Staff also have a holistic outlook on healing and link their tāngata motuhake to other supports as needed.

Te Whare Matatini Hauora is available to people of all ethnicities who choose to receive services from a Kaupapa Māori paradigm. Its most recent intake data indicate that approximately 50 per cent of its tāngata motuhake identify as Māori.¹³

They were very loving, plenty of aroha, support, manaakitanga, hospitality, caring, and comfort.

Tāngata motuhake, Te Whare Matatini Hauora

The culture here is very awesome!

Tāngata motuhake, Te Whare Matatini Hauora

Preliminary data show promising outcomes based on the testimonials of tāngata motuhake who have used the service.

Extremely helpful! I honestly felt so fragile after a suicide attempt, I feared I'd lost all hope of recovery. This illustration became clear after 3 days [of staying at Te Whare Matatini Hauora]. Fear was overshadowing reality.

Tāngata motuhake, Te Whare Matatini Hauora

¹¹ Tāngata motuhake is the term Te Whare Matatini Hauora uses for guests to its service.

¹² All quotes from tāngata motuhake in this section are from tāngata whaiora evaluation surveys provided by Te Whare Matatini Hauora.

¹³ Data provided directly by Te Whare Matatini Hauora.

I would scream from the rooftops with the gratitude I have for this service. ... So yes, I am incredibly grateful!

Tangata motuhake, Te Whare Matatini Hauora

I think the Te Whare Matatini Hauora service is outstanding and the simple, supportive approach should be the path to the future of mental health recovery in New Zealand.

Tangata motuhake, Te Whare Matatini Hauora

Taranaki Retreat

The Taranaki Retreat is a community-led initiative in the Taranaki region that provides a comprehensive, holistic range of services, including a four-bed residential service for people experiencing acute distress. Its mission is to deliver community-based wellbeing, addiction recovery, and suicide prevention and post-intervention non-clinical services.

During 5-day or 10-day stays, The Retreat offers a calm, safe, and homely place to ‘re-find yourself’, and have the basics of life covered—giving ‘space to breathe’. The Retreat also offers day-visit facilities and support to individuals and whānau who are feeling unsafe and need to be around people to avoid attempting suicide.

The Retreat offers a comprehensive kete of over 50 elements including support groups, programmes, and outreach support visits. Two evaluations demonstrate that the care was well received and guests described it as personalised and flexible (Magill, 2021b; Young, 2020).¹⁴

I think [the Retreat] was friendlier [than a clinical service]. I think it was calmer. Because you didn't have to do things on time. There was lots of offers of things, but nothing was set in concrete, nothing.

Guest, Taranaki Retreat

They allowed me to breathe, they didn't, you know, you guys didn't force me into anything. You just let me take my own time, when I was ready and if I didn't choose not to then that was okay and I didn't feel any pressure what so ever. So, for me, you guys provided everything I needed.

Guest, Taranaki Retreat

¹⁴ All quotes in this section are from the evaluation by Maree Young (2020) and the summary of a PhD thesis completed by Rowan Magill (2021b). Taranaki Retreat provided both of these sources.

And I just felt I just wanted to cry because I felt safe and I felt cared for, really cared for.

Guest, Taranaki Retreat

Taranaki Retreat incorporates Te Ao Māori ways of working, such as by using Te Whare Tapa Whā.¹⁵ Data show a good reach within the Māori community, with 71 per cent of guests identifying as Māori (Young, 2020).

The evaluations from both guests and staff offer evidence that Taranaki Retreat is effective in providing acute care (Young 2020; Magill, 2021b).

Before I came to the Retreat, the week before, I tried, I wanted to commit suicide. I had it planned out and I was on my way. Those weeks before coming to the Retreat were getting tougher and tougher. And yeah, there was a lot of me that just wanted to hurry up and die.

Guest, Taranaki Retreat

Then I saw 'Good Sorts' [segment] on TV. And that's where I saw the Retreat. And I said to my wife, 'I've got to go there'. And she said, 'Why?!'. And I said, 'Because I'm blimmin' suicidal.'

Guest, Taranaki Retreat

Mate, [the Retreat] saved my life. Literally saved my life, without a doubt.

Guest, Taranaki Retreat

The feedback I receive from the people I refer to Taranaki Retreat allows me to say with 100% certainty that Taranaki Retreat is a needed and valuable service for the Taranaki Community. I believe they are a strong suicide prevention initiative.

Support worker who refers tāngata whaiora to Taranaki retreat

Te Puna Wai

Te Puna Wai is a peer support service on the outskirts of Palmerston North for people with mental health distress, which is available after hours and on weekends. The international term for this type of service is a crisis café. The purpose of Te Puna Wai is

¹⁵ Te Whare Tapa Whā is a model developed by leading Māori health advocate Sir Mason Durie in 1984. The model describes health and wellbeing as a wharehau (meeting house) with four walls. These walls represent taha wairua (spiritual wellbeing), taha hinengaro (mental and emotional wellbeing), taha tinana (physical wellbeing), and taha whānau (family and social wellbeing). The connection with the whenua (land) forms the foundation. When all these things are in balance, we thrive (Durie, 2004).

to provide a peer-led, culturally safe, and welcoming environment for whānau whaiora¹⁶ experiencing mental health distress.

The crisis café operates on a drop-in basis and acts as both an early intervention service and as a crisis alternative to inpatient care. One of its main objectives has been to reduce unnecessary mental health and addiction presentations to ED. A preliminary evaluation suggests that the café is likely to be reducing the number of total mental health presentations in ED (Tyacke, 2023).

Visitors to Te Puna Wai support this claim (Tyacke, 2023).

Since coming to Te Puna Wai I haven't been back in Ward 21. When I feel depressed and down I can come here and get support. If I go to ED or ring the crisis team, I can end up feeling worse. ED is cold and clinical and with helplines I feel like the response is copy and paste. At Te Puna Wai I feel welcomed, I can feel the love and I get a tailored response just for me.

Whānau whaiora, Te Puna Wai

I started coming along to Te Puna Wai a year ago when I went into crisis and was told about Te Puna Wai instead of having to be in ED waiting. I came in on a Saturday for the first time and had a great chat with one of the staff members who helped de-escalate the situation and made me feel confident to stay safe when I got home.

Whānau whaiora, Te Puna Wai

Te Puna Wai is a Kaupapa Māori service that uses Te Whare Tapa Whā as its model for service delivery. It has peer workers on duty who can 'kōrero' (i.e., speak to visitors who need to or would like to use te Reo Māori). Sharing kai is part of the café experience and facilitates conversation and building of trusting relationships. The evaluation shows that 31 per cent of visits to the café were from whānau whaiora who identify as Māori (Tyacke, 2023).

The evaluation report (still in draft) highlights that the aspect visitors to Te Puna Wai most appreciated was access to 'peer workers with similar experience' (35 per cent). The second-most appreciated aspect was that it provides a 'safe and friendly space' (30 per cent) (Tyacke, 2023).

The evaluation shows that the vast majority of respondents (80 per cent) are 'very satisfied' with the café, while 13.3 per cent are 'satisfied'. No visitors reported any level of dissatisfaction with the café (Tyacke, 2023).

¹⁶ The name that Te Puna Wai uses for tāngata whaiora accessing its service.

I've been here in crisis before. I left with a plan and felt much lighter, I could also come back during the weekend for support. I always feel listened to and sometimes that's all I need, is to be listened to and know I matter and that I have support.

Whānau whaiora, Te Puna Wai

Common factors that contributed to the success of the alternative options

Across all four service examples, common themes emerged.¹⁷ We highlight these themes in this section as they may be contributing to the success of these services as effective alternatives to acute inpatient services.

Tāngata whaiora felt supported and accepted

Each service emphasised its intent to offer support and acceptance or non-judgement as fundamental to its model of care.

A supportive environment where we [people experiencing mental distress] can be ourselves, in an atmosphere of peace and tranquillity. With understanding and love we will inspire others to grow and renew with encouragement and hope

Plaque in entranceway to Tupu Ake

[We emphasise] encouragement rather than requirement or expectation.

Leadership, Te Whare Matatini Hauora

This sense of being supported and accepted was an important part of what tāngata whaiora considered to be helpful when they used the service.

It was ok to be just the way I was and no one tried to change or influence my feelings. They understood and weren't trying to justify why it wasn't normal to feel like that because factors (e.g., education, family) in my life.

Guest, Tupu Ake

I have rang the Crisis Line and been in ED many times and I always feel like a burden, rushed and embarrassed. They have conversations

¹⁷ This analysis is based on the data from the examples above.

in the waiting room. Here [at Te Puna Wai] I feel like they really care, and they never judge. The staff are amazing.

Whānau whaiora, Te Puna Wai

Just her, she just sat there and listened, and you know there's no judgement in what she said, she just made time.

Guest, Taranaki Retreat

Lived experience was valued and used effectively

The four services often saw peers with lived experience as having had their own mental health and/or addiction challenges, while also demonstrating that they have integrated the experience into their lives in a way that has enhanced their journey. All four greatly valued these skills and acknowledged that peers could be taught other skills as needed.

Peers are invested in their roles, because they have been there. You can't learn that in a book.

Pathways leadership team, Tupu Ake

The learning we get from someone who has been there is the most valuable.

Leadership, Te Whare Matatini Hauora

Each of the services used lived experience purposefully and meaningfully. Purposeful disclosure helped to foster environments and interactions of acceptance and non-judgement, trust, and mutual understanding.

I find it easy to talk to the peers, and find they understand, if not your situation, what it is like ... part of what works is they meet you where you are at. ... The peers make you feel valued ...

Guest, Tupu Ake

[My support worker] was telling me a few stories about what he was like. And he was seven years drug-free and sober and all the rest ... I can't agree with psychiatrists ... they haven't gone through it. Whereas [the support worker] had.

Guest, Taranaki Retreat

I felt no judgement and that I could be myself.

Whānau whaiora, Te Puna Wai

Staff (including volunteers) with lived experience inspire hope for tāngata whaiora by breaking down the stigma and discrimination that still occurs when experiencing distress. Seeing and hearing examples from people who have also been through struggles of their own, and whose aspirations are no longer limited by those struggles, normalises the experiences of tāngata whaiora. It helps them to see beyond their current experiences into a future that contains hope and possibilities.

What matters is just how real [the support workers] are. You know, some of these people [at the Retreat] have been through strife in their life.

Guest, Taranaki Retreat

It was meaningful [to the staff] having their journey [of distress], knowing how they became unwell, what had an impact on them so they can work in the space they now do. They let me know it's not over yet and that recovery is a constant journey.

Guest, Tupu Ake (speaking about their peer supporter)

Having peers in the same position helps. It gave me hope and made me realise there is always tomorrow.

Guest, Tupu Ake

Risk and safety were redefined

An important factor contributing to success was the way that these services managed risk and safety. They made decisions about risk and safety in collaboration with tāngata whaiora, really listening to their experience and needs in a given situation.

A supportive relationship is formed, in which the safety valve of a listener, to both reflect and turn to, is available to them to make positive steps for change.

Leadership, Taranaki Retreat

I've been in crisis before. I left with a plan and felt much lighter, I could also come back during the weekend for support. I always feel listened to and sometimes that's all I need, is to be listened to and know I matter and that I have support.

Whānau whaiora, Te Puna Wai

Services defined risk and safety from the perspective of the tāngata whaiora, rather than using a clinical definition. The strong emphasis on safety from the perspective of the tāngata whaiora focused on comfort and choice.

It is a place we are not stuck in, but a place we can rest our minds.

Guest, Tupu Ake

When people walk in, they can feel the love and support. They don't feel anxious anymore, and I notice that. Once they walk in, and they settle in, they become/feel safer. People seem more settled so [their] recovery begins quicker.

Registered health professional, Pathways, Tupu Ake

I said to [support worker] about two days before leaving that I didn't feel like I was ready to go. And we had a big talk about that and then ... she came back to me the next morning and said there [were] the options of going to stay on the other side of New Plymouth on a farm with [a trustee] and her husband. And so, I actually did that which was incredibly helpful.

Guest, Taranaki Retreat

A gateway to recovery and accessing other services

These alternative services recognise that acute distress is a snapshot in time that often speaks to aggravating factors in a person's life. The services are designed not only to attend to the immediate needs of de-escalating the current acute distress, but also to support the tāngata whaiora to start addressing the factors that are contributing to the distress.

The services used a holistic outlook to understand what is causing the distress and what supports tāngata whaiora might need to address that distress. One service described itself as 'a gateway service', using the moment of crisis as an opportunity to offer a bridge to other supports.

Seven days is not long, the biggest goal is preparing people for when they go back home, e.g., support, linking back to the community, taking shared responsibility. The wellness plan is a component of this—the back-bone of our work.

Peer support specialist, Tupu Ake

We're not looking to fix all of these areas while people are here. It is just that chance to open doors. I feel as though ten days wouldn't be long enough for anyone—because it's a lifetime thing, isn't it? It's more of a lifestyle thing. [Staying at the Retreat] is a shift in getting a start and getting some grounding with things that they come to realise, [things that] are allowed to come into their mind. And the thoughts and the changes through that time, to take with them.

Staff member, Taranaki Retreat

Many of the services provided day programmes either within their acute care service, or as a branch within one of their other services. These options provided opportunities for continuity of care and were well received by tāngata whaiora.

I have attended day stays for about the last year and a half and am able to attend when I need it. ... This place is my sanctuary. I think what they do here is they help you a lot, then they wean you off ... Being connected and knowing I have a backstop keeps me safe.

Guest, Tupu Ake

Yeah, the support I think is always there. ... I know that I can always go back ... it is just a text or a phone call away, whereas counselling is very like appointments orientated.

Guest, Taranaki Retreat

Many visitors of the café are using the venue as a way to remain stable and socially connected. This means they are less likely to go into crisis in the first place.

Leadership team, Te Puna Wai

Many of the services also talked about their role as being an expert in their communities, with knowledge of which services in the area were best suited to the needs of the individual.

I know the places that I would recommend and the ones that I wouldn't send anyone to.

Leadership team, Te Whare Matatini Hauora

Relationships with local clinical services and crisis teams

Each of the services emphasised its role within the wider community and how working together with other services in the community, including crisis and clinical teams, was more effective than staying siloed.

Clinicians are there to do the clinical and they involve the person and peer support in the process. So, they [peer support workers] can be good advocates. The relationship is different. In respite [services], staff go and drop someone off and leave. In Tupu Ake, clinicians work together with peers and guests to come up with a plan.

Registered health professional, Tupu Ake

We had to make a stand with some practices, e.g., [not] serving section 9s¹⁸ onsite, but we also realised we needed to get the clinical team onsite and how can we work to find the balance.

Team coach, Tupu Ake

When the services were able to work together and respect each other, big shifts in understanding and destigmatisation were evident.

Tupu Ake and the peer movement in Counties Manukau Health is the biggest destigmatising thing I've seen. ... The peer support impact told the sector people aren't hopeless and that they are capable.

Pathways leadership, Tupu Ake

... we had some reservations at first. They quickly disappeared once we realised how valuable it was. It's a valuable part of our acute service.

Registered health professional, Tupu Ake

¹⁸ Section 9 refers to the legal obligations on mental health services for arranging and conducting the time and place for compulsory assessment examinations under the [Mental Health \(Compulsory Assessment and Treatment\) Act 1992](#), including an available psychiatrist to carry out the assessment, giving or 'serving' the person with written notice of the assessment, and transporting the person to the place for the assessment examination.



Whakatepenga | *Conclusion*

This insights paper has explored possibilities and opportunities to grow and develop community-based acute care options, increasing the choices available to tāngata whaiora who need them. The system is under pressure and new ways of working are needed to re-imagine how to respond to people in crisis.

The acute continuum of care is only one part of the wider mental health and addiction ecosystem, and the range of non-acute services available has a large impact on acute services. We need to strengthen services across the ecosystem to establish clear pathways for people to not only access acute services when they need to, but also get the care and support they need to continue their recovery once the acute phase has passed.

This report has been informed by people telling us what they want and the types of services that work for them. Peer-led, community-based, and Kaupapa Māori services are working well and the experiences of those using these services have been positive. In some cases, it is too early to measure improvement in outcomes, but early indications are promising.

We have heard from lived experience communities that they want a greater range of acute options and more choice. We have reflected these voices in this paper. This paper also highlights the potential and value of growing and developing the peer support and Māori lived experience workforces to support a wider range of acute options.

The alternative options we have highlighted share some key features that resonate with those with lived experience. Notably, tāngata whaiora felt supported and accepted by peer-led services and these services managed decisions about risk and safety in collaboration with them. Services also provided a gateway to other services when required and had strong relationships with local clinical services and crisis teams.

These features ensured the success of these alternatives to acute inpatient services and cemented their place as an important and valuable part of the acute continuum of care.

Ngā tohutoro | *References*

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Ki hea rapu āwhina ai | *Where to get support*

Tough times affect each of us differently. It's okay to reach out if you need to or, if you're worried about someone else, encourage them to reach out. We all need a bit of support from time to time. If you or someone you know is struggling, we want you to know that however you, or they, are feeling, there is someone to talk to and free help is available.

People are here for you if you just want to seek advice around how to support people that you're worried about. Whatever support you're looking for, you can choose from a variety of online tools and helplines.

If it is an emergency situation and anyone is in immediate physical danger, phone 111.

Alternatively, you can go to your nearest hospital emergency department.

For urgent help, mental health crisis services, or medical advice

Phone your local [Mental Health Crisis Assessment Team](#) if you are concerned about a person's immediate safety. Stay with the person and help them to keep safe until support arrives.

To get help from a registered nurse, call Healthline: **0800 611 116**.

If you need to talk to someone

Free call or text **1737** any time, 24 hours a day, for support from a trained counsellor, or between 2pm and 10pm for a peer support worker.

Some other great places to get support 24 hours a day, 7 days a week include:

- [Depression Helpline](#): free phone **0800 111 757** or free text **4202**
- [Suicide Crisis Helpline](#): free phone **0508 828 865** (0508 TAUTOKO)
- [Anxiety NZ](#): free phone **0800 269 4389** (0800 ANXIETY)
- [Lifeline Helpline](#): free phone **0800 543 354** or free text **4357** (HELP)
- [Alcohol Drug Helpline](#): free phone **0800 787 797** or free text **8681**
- [The Lowdown](#): for young people, free phone **0800 111 757** or free text **5626**
- [Youthline](#): for young people, free phone **0800 376 633** or free text **234**
- [Are you OK](#): free phone 0800 456 450 (family violence help)
- [Samaritans crisis helpline](#): free phone **0800 726 666** if you are experiencing loneliness, depression, despair, distress, or suicidal feelings
- [OUTline NZ](#): free phone **0800 688 5463** for confidential telephone support for sexuality or gender identity issues
- [Ola Lelei](#): free phone **0800 652 535**, a free national Pacific helpline with Samoan, Tongan, Cook Islands Māori, and English languages available.

For more information about where to get support, visit the [Ministry of Health](#) website.



**Te Hīringa
Mahara**

Mental Health and
Wellbeing Commission