
The Acute Crisis

Towards a recovery plan for
acute mental health services
in New Zealand

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Foreword

The Mental Health Commission has known for some time that New Zealand's acute mental health services often fail to respond well to people in acute crises. We believe this is because many of these services are themselves in a state of crisis. This paper looks at what is happening and suggests some ways forward.

All health services have a duty to respond quickly and competently to people in health emergencies. This does not happen reliably in the mental health sector. People in crisis, or their referrers, are frequently turned away by crisis and acute mental health services. People who are admitted to hospital-based acute services often find them frightening, impersonal and untherapeutic. This would be inexcusable in any other area of health and it urgently needs to be addressed.

In order to promote healing, acute mental health services must be accessible, acceptable and effective. This paper examines a range of the alternatives to acute inpatient units for people in crisis that have proved to be more acceptable and at least as effective. It focuses narrowly on acute services, which are high cost, and cover short periods of urgent need – yet they are pivotal to the whole design of mental health services.

Although many people acknowledge the shortcomings of New Zealand's hospital-based acute services, the adoption of other options for acute care has been slow. The Mental Health Commission encourages the development of recovery-focused acute services in people's own homes or in a community setting.

Although the process of deinstitutionalisation began in New Zealand decades ago, the last of this country's psychiatric hospitals closed less than 10 years ago. Community-based non-acute services have grown and developed over the last 10-15 years and the number of acute beds has decreased. But, in our view, the process of deinstitutionalisation is not yet over. Acute services still need to be made less institutional, as do the human interactions that take place inside them.

We assert that most, if not all, people can be better served in home or community-based acute mental health services. However, the vast bulk of acute services still remain in a hospital setting. The wider range of community and home-based recovery-focused acute mental health services needs to be high on everyone's agenda.

Introduction

Acute services exist to respond to the needs of individuals in crisis.

All individual human crises have common elements. They are temporary states that overwhelm the person to the point where they cannot function with their usual personal resources or natural supports, and need external or expert assistance (Hoff, 2001). When the person's state is associated with a suspected or diagnosed mental illness, they are defined as having a mental health crisis or an acute episode. A healthy response to crisis treats it as an opportunity for development, not just as a risk that needs management (Hoff, 2001).

There are some parallels between individual crises and systems' crises. Systems in crisis cannot function adequately within their existing world view, structures and processes; a new paradigm and fresh strategies are the only way to recover from the crisis. The people responsible for these systems have to be realistic about the risks inherent in the crisis, but they also need to use it as an opportunity to develop a more responsive system based on a new, more fitting paradigm (Kuhn, 1962). In some ways the system of acute mental health services in New Zealand mirrors the crises of the individuals the system exists to respond to.

Every year thousands of New Zealanders use acute mental health services. They come from all communities, age groups and ethnic groups. An increasing proportion is less than 20 years old. Māori are over-represented and Asians are under-represented in acute services. A growing minority have drug-related mental illnesses. People who have experienced deprivation, trauma and abuse are more likely to use these services, as are people who have used them in the past and have not recovered the personal, social and economic losses associated with major mental illnesses. There is still no reliable information on how many New Zealanders experience mental health crises and do not get assistance from mental health services.

Acute inpatient units are the backbone of acute services in New Zealand and other western countries. Although a variety of alternatives to acute inpatient units have been tried and tested over the last 30 to 40 years, they have all remained the exception rather than becoming the norm. In many countries, including New Zealand, most people in crisis have only one option – admission to an acute inpatient unit.

In addition to acute inpatient units, many District Health Boards (DHBs) in New Zealand fund or provide some crisis respite services. One DHB provides a home-based acute service. There are one or two day acute services attached to acute inpatient units that provide follow-up services rather than an alternative to acute inpatient admissions (Reet, 2004). Few alternatives to acute inpatient units have been publicly funded in this country.

In its assessment of acute services, this paper takes into account the values inherent in mental health policy and the expectations of those who use the services, as well as evidence from acute service evaluations.

The explicit consideration of values, in addition to evidence, is becoming more widely accepted in the mental health sector – particularly in England where Values Based Practice is promoted by the National Institute for Mental Health in England (NIMHE) (Woodbridge & Fulford, 2004).

Please note that this paper deals only with the 'slice' of services commonly known as adult acute services. It does not deal with crisis assessment services, or with services provided in the aftermath of a crisis. Nor does it focus on acute services for people whose primary problem is alcohol and drug abuse, people using forensic inpatient services or those using child and youth services. However, there may be lessons in this paper for these other types of acute services.

Mental Health Policy

The *Blueprint* (Mental Health Commission, 1998) introduced the recovery approach to mental health services, stating they should be delivered in the least restrictive setting with the least coercion, and with a variety of treatment options. Services needed to minimise disruption to people's lives and enable them to fully participate in the service and in wider society.

The second mental health and addiction plan, *Te Tahuu: Improving Mental Health 2005-15* (Ministry of Health, 2005), both echoes and develops *The Blueprint*. It says there should be a wider range of services and they must be:

- focused on enabling people to lead their own recovery
- high quality and trustworthy
- based on good evidence
- provided in the least restrictive environment
- balanced between biological, psychological and social factors
- responsive to all cultures and age groups
- delivered in recognition of whānau ora.

The overall aim of Māori health policy is whānau ora. *He Korowai Oranga: Māori Health Strategy* (Ministry of Health, 2002) defines whānau ora as 'Māori families supported to achieve their maximum

health and wellbeing', both for individuals and the collective. There are many social, physical, psychological and spiritual contributors to whānau ora. In an interpretation of whānau ora for the mental health setting (Mental Health Commission, 2005) five concepts are highlighted:

- tino rangatiratanga (self-determination)
- tūrangawaewae (home, place of standing, restoration of mana)
- ngakau mahaki (empathy)
- tikanga (right behaviour, safe and ethical practice)
- whānaungatanga (respectful, harmonious relationships).

All these policies suggest we need a broader range of acute services providing a wider range of interventions tailored to different needs. These services should be delivered in the most open environment possible to allow people to stay connected to their day-to-day lives, their whānau and communities. The users of the services, and their whānau need to take a lead in decision-making about their care, treatment and lives; services are there to restore their mana. People need to have confidence in acute services. And acute services need to be based on knowledge of what works.

Expectations

The expectations of people who use mental health services were considered unimportant in the institutional era, but this is no longer acceptable. The social trends of consumerism, anti-discrimination and human rights, combined with the current policy that people must be enabled to lead their own recovery (Ministry of Health, 2005) give a clear indication that these people's views are vital to the development and delivery of services.

Various surveys of people's views about what they need from services when they are in a mental health crisis have shown with overwhelming consistency that they want:

- a safe unthreatening environment
- a small number of other people around them
- accepting people to talk to
- help to solve problems

- a choice of psychotherapy, complementary and medical treatments
- acknowledgment of their strengths
- direct involvement in decision-making about their care
- to learn from the crisis and find personal meaning in it.

(Faulkner & Warner, 2002; Lapsley *et al.*, 2002; Mead, 2002; Mental Health Commission, 2004; Mental Health Foundation, 2001; Mental Health Foundation & Sainsbury Centre for Mental Health, 2002; Rose, 2001; The Sainsbury Centre for Mental Health, 1999a, 1999b)

While these expectations are framed differently from policy, they dovetail well. People using the services place a lot of emphasis on personal experience, whereas policy provides an overview of the whole system.

Acute Service Evaluations

Evaluations of acute services provide direct evidence about what works, usually in terms of outcomes, satisfaction and costs. As we shall see, the results of these evaluations endorse the general policy directions and show that people's expectations can be met.

The major models of acute services are acute inpatient units, day hospitals, partial hospitals, crisis houses, crisis respite, home-based treatment and family crisis homes. Their ad hoc development has created a somewhat confusing picture. Some of the models blur into others, making them difficult to neatly categorise. Also, some of the same models are known by several different names.

Most of the options described are not just alternatives to acute inpatient units – they also may be used to prevent the need for admission or as a 'step down' after admission, particularly the semi-institutional options. This paper focuses on the role of these acute options as alternatives to admission only.

INSTITUTIONAL ACUTE SERVICES

Acute inpatient units

In New Zealand, acute inpatient units are typically 15 to 60-bed wards on general hospital sites with an institutional ambience. The older acute inpatient units are often run down, do not have single rooms and lack private living spaces. Dining is communal and the nurses' office is often placed strategically where they can view different corridors. Most inpatient units in New Zealand have seclusion rooms and secure areas for people in intensive care.

The main interventions in acute units are medication and containment. Many people are there under

the Mental Health Act and the vast majority are on medication. Typically, there are few other treatments or services available to people – such as peer support, advocacy, psychological treatments, or even staff members to talk to. Often there are not enough focused activities to keep people occupied.

Over the last decade, acute inpatient units in New Zealand and some other western countries are reputed to have become increasingly overcrowded and more difficult to work and live in. Some people are discharged too soon in order to free up places; others stay for many months because they have nowhere else to live. The pressure on acute units means that only the most disturbed and distressed people get into them, creating a more chaotic environment in acute settings. Adolescents and young adults can find acute inpatient units particularly traumatising. In recent years, a small but increasing number of people who have become violent as a result of using methamphetamines have been admitted to acute wards. Acute inpatient units are not popular places to work and many have problems finding and keeping skilled staff.

New occupational health and safety regulations may encourage the use of seclusion and restraint. Also, many people believe that a few high profile homicides committed in the last decade have encouraged clinicians to quickly resort to admissions to acute inpatient units and compulsory treatment, to avert any risk of serious incidents, inquiries and media attention.

Acute inpatient units are regarded by many as the neglected arm of the mental health system. Over the last 15 years, most innovation and energy has gone into non-acute community-based services.

Evaluations

Acute inpatient units in New Zealand have never been formally evaluated but evaluations of similar acute services in other countries reinforce what we know anecdotally here – that acute inpatient units are often unpopular with service users and families, as well as staff who tend to find them stressful and unsatisfying to work in.

The Mental Health Commission has sought people's views of New Zealand acute inpatient units through service user forums in all but one of the 21 DHBs and in interviews with 40 young adult service users (for a forthcoming research report). Although there were positive comments from some respondents on the improving attitudes of staff and on new or renovated buildings, most of the comments were negative. It is common for service users in acute inpatient units in New Zealand to experience:

- a restrictive institutional environment
- overcrowding
- physical, verbal or sexual violence, or the fear of it
- traumatic experiences in seclusion
- lack of empathetic attention from staff
- over-reliance on medication and lack of psychological assistance
- boredom.

Internationally, evaluations of acute inpatient units are usually done in comparison to alternative acute services. Some of these evaluations are referred to in the sections below. The evaluations consistently show that acute services do not generate better clinical or psychosocial outcomes than the alternatives, and sometimes the outcomes are worse. People using them also tend to be very unsatisfied with acute inpatient units.

In a British survey of 343 service users (MIND, 2000), 45% responded that staying in an acute inpatient unit had a negative effect on their mental health, and 27% responded that it had a positive effect. Forty-five percent found the ward atmosphere depressing and bleak, and 82% said they talked to staff for 15 minutes or less a day. Sixteen percent experienced sexual harassment on the ward.

In another British survey (Mental Health Foundation, 1997), 401 service users were asked – 'What do

you feel you need when in distress?' The report states that 'responses to this question were strongly dominated by the need for someone to talk to or the need for support from other people'. Only 8% wanted existing services, 6% wanted medication and 2% wanted hospital admission.

An American qualitative study of people's views on what helped and hindered their recovery (Onken *et al.*, 2002) concluded 'Participants reported that [hospital] settings cause them to lose living skills and re-traumatise them. The lack of access to the outside world gives the sense of being locked away... People lose a sense of being a citizen and a community member. Physical and emotional abuse and the abuse of power and authority in hospitals is detrimental... there is a lack of alternatives to hospitalisation.'

SEMI-INSTITUTIONAL ACUTE SERVICES

Day hospitals and partial hospitals can be described as semi-institutional in both their language and features, because they are either located in hospital settings and provide just a day service, or provide what are referred to as 'inpatient' services in a non-hospital setting. Internationally, these options tend to be an adjunct to an acute inpatient unit and are used more often to prevent crises or as a 'step down' from the acute unit, rather than as an alternative.

Day hospitals

Day hospitals, in hospital or community settings, provide a place for people in crisis to stay during the day but return to their homes or a crisis respite service at night. Day hospitals are often run in a similar institutional way to inpatient units, providing medication and a place to be, but are more likely to provide activities, talking therapies and support services.

Evaluations

Day hospitals are cheaper to run, often preferred by service users and their families, and have clinical and psychosocial outcomes similar to or greater than acute inpatient stays. (Harrison *et al.*, 2003; Horvitz-Lennon *et al.*, 2001; Marshall *et al.*, 2001). Other studies have concluded that day hospitals are

a feasible option for a quarter to a third of those who would otherwise be admitted to acute inpatient units (Horvitz-Lennon *et al.*, 2001; Marshall *et al.*, 2001). One study found that a day hospital combined with crisis respite was on average 20% cheaper per person than the inpatient unit. The cost difference was explained by the hospital's higher overheads (Sledge *et al.*, 1996a; Sledge *et al.*, 1996b).

Partial hospitals

Partial hospitals are sometimes synonymous with day hospitals but some partial hospitals provide additional services, such as 24-hour crisis assessment, a small number of emergency crisis beds and 24-hour crisis support phone services. Other partial hospitals include community inpatient units, half-way hospitals or community treatment units. These are generally small residential services outside hospitals and often attached to community mental health centres. They usually provide for people with less severe problems who need less staff cover (Boardman & Hodgson, 2000).

Evaluations

Evaluation of a partial hospital in Manchester, England, showed that the combination of a day acute service, crisis beds and crisis phone support services under the same roof was a viable alternative to acute inpatient care (Walmsley, 1998).

COMMUNITY-BASED ACUTE SERVICES

Community-based acute services tend to be small and situated in home-like, informal environments in suburban settings. Like the institutional and semi-institutional options, these services can provide for people who have associated substance abuse, are violent, facing criminal charges, suicidal, severely psychotic, physically unwell or under compulsory treatment. However, some community-based acute services take only people in less severe crises.

Crisis houses

Crisis houses are a short-term residential option for people in mental health crises. Some are closely aligned to the local acute inpatient unit. Others are run by community organisations or service users.

The houses are located in ordinary streets and normally provide for fewer than 10 people. People usually stay for under three weeks. Some crisis houses do not accept people under compulsory treatment and they are not always staffed for 24 hours. Some providers of crisis houses run other crisis services such as family crisis homes, home-based treatment, crisis assessment and a day service for people in crisis.

Crisis houses tend to adhere to the view that mental health crises are a turning point and an opportunity for growth rather than just risks that need to be managed. They provide a listening ear, personal support, practical advice and complementary treatments as well as medication. Crisis houses may vary to a degree in their culture and values. Some are very psychosocially-oriented while others use a more equal blend of medical and psychosocial therapies.

Peer-run crisis houses

Some crisis houses are run by service users and have a strong peer support ethos. A peer-run crisis house in the state of New York (NEC, 1999) provides a large range of services – peer counselling, advocacy, access to community resources, crisis intervention, support groups, information, a rage room, massage, meditation, and skills training in preventing crisis. Peer-run crisis houses work to maximise individual power, reinforce responsibility, create a supportive peer environment, and practice reciprocity between help givers and receivers (Mead, 2002).

Soteria House

Soteria House (sometimes referred to as a recovery house) is one of the best known examples of a predominantly psychosocially-oriented crisis house, which operated in California in the 1970s. It has been described as 'small, homelike, quiet, supportive and tolerant' (Mosher, 1999). Soteria had no more than six to eight residents at one time and was staffed by mental health professionals and service users, including ex-residents. Some residents stayed for significantly longer than they might in an acute inpatient unit (Mosher, 1999). Although Soteria, and other recovery houses modelled on it, are cheaper to run on a day-to-day basis, the cost per individual is about the same as acute inpatient units, due to the longer stays in them.

The focus in recovery houses tends to be on interpersonal relationships, strengths and skill development. However, there is no organised therapy – every human encounter for residents and staff is regarded as an opportunity for understanding and growth. Psychiatric drugs are used sparingly, especially in the first two weeks of stay. There is an expectation of recovery (Mosher, 1999; Thomas, 2004).

Cedar House

Cedar House is an interesting example of a more medically-oriented crisis house that provides for people in severe crisis in Boulder, Colorado. It is a large house situated in a semi-commercial middle class neighbourhood, near parks, shops and other facilities. It is home-like, with an open door, an open fire and pets. It provides for up to 15 people for an average of one to two weeks. Many have severe psychosis and are under compulsory treatment. The only people the house does not take are those who are actively violent, extremely disruptive, or suicidal and likely to walk away. It caters for two-thirds of people who would otherwise go to hospital and could cater for more if there were more places.

The Cedar House staff include nurses who provide 24-hour cover, psychiatrists, therapists, social workers and a case management aide. They provide assessment, drug treatment, psychotherapy, family therapy and practical assistance. There is also a part-time cook and cleaner as well as an administrator. The absence of physical coercion and the normalising environment maximises service users' self-esteem, self-control and ability to behave responsibly. People receive smaller doses of anti-psychotics than in local hospital wards. People who are well enough are given chores, encouraged to support each other and mix freely with staff. There have never been any complaints about Cedar House from the neighbours (Warner, 1995).

Evaluations

Generally evaluations of crisis houses compared to acute inpatient units show improvement in people's satisfaction, similar or better outcomes, reduced admissions to the acute inpatient unit and lower costs (Boardman & Hodgson, 2000; Clarke *et al.*, 1997).

An American evaluation of crisis houses versus acute inpatient units (Goodwin & Lyons, 2001) showed that residents in crisis houses who used it as an alternative to hospitalisation had similar clinical outcomes on discharge, to people who had been admitted to hospital.

Soteria House underwent a rigorous comparative evaluation (Bola & Mosher, 2003). One hundred and seventy-nine people newly diagnosed with schizophrenia were randomly assigned to Soteria or a conventional inpatient ward. After two years follow-up, service users who went to Soteria had better outcomes in terms of their work, social functioning, symptom reduction and they used less medication. Another study of a Swedish recovery house yielded similar results (Cullberg *et al.*, 2002).

The authors of the Soteria study gave several explanations for its better outcomes. The milieu allowed for involvement, support and spontaneity. Staff members were flexible and tolerant. Soteria's therapeutic relationships were enhanced by more staff time, and their promotion of the subjective meaning of psychosis and its place in people's overall lives. Soteria also provided a surrogate 'family' and peers continued to support each other after their stays there. Its philosophy and social processes were egalitarian, with respect for autonomy and the differences between people (Bola & Mosher, 2003).

In a discussion of several American crisis houses, service users maintained more social skills and felt less stigmatised in a crisis house than in an acute inpatient ward. Most of the crisis houses were run for half the cost of the local state psychiatric hospitals, because of lower overheads and the greater ability for psychiatrists, in particular, to delegate responsibility to lower paid staff. Despite their open door policies and the absence of physical coercion, the crisis houses, including Cedar House, generally managed risk well through a high level of staff skill and attention, and the encouragement of people to take responsibility for their behaviour. The crisis houses reported very few incidents of harm to self or others in their services, over many years (Warner, 1995).

In a small British evaluation of three crisis houses (Faulkner & Warner, 2002), 93% of residents felt the service had met their needs and 100% said that

an inpatient unit could not have helped them in similar ways. Most of the residents also said that the physical and emotional environment was pleasant and that staff members were accepting, supportive and available. An American evaluation of a crisis house had similar responses (Warner, 1995).

Crisis respite

Crisis respite is a community-based short term alternative to hospital, usually in a non-acute service setting. In New Zealand, crisis respite beds are often located in motels, rest homes or supported accommodation. The maximum stay is usually four to five days. Clinical staff either visit the person in respite every day or stay with them around the clock.

Evaluations

In an evaluation of a planned and crisis respite service in Christchurch (Gawith *et al.*, 2002), 137 of 321 service users responded. They stated that the staff were caring, supportive and approachable and had time to listen. They also found the environment peaceful, quiet and unstressful. Seventy-nine percent of respondents reported no problems at all. Most problems, such as noise and other disruption, related to the other clients. Staff enjoyed working in partnership with the clients and believed it was important that their physical, emotional, social and spiritual needs were met.

A New Zealand survey returned by 56 of 231 people who used two crisis respite services in the Wellington region, showed that 88% to 100% felt the care they had received and the time spent with staff was very appropriate or moderately appropriate to their needs (Kites, 2003).

However, anecdotal evidence from other parts of the country gives a more mixed picture of crisis respite services. Sometimes people are placed in inappropriate environments. One example of this is an adult being admitted to a rest home where the staff didn't understand mental health issues.

HOME-BASED ACUTE SERVICES

These acute services are delivered in people's homes – either the service user's home or someone else's home.

Home-based treatment

Home-based treatment is a rapid-response acute service provided to people in their own home at any time of day or night. Members of a multi-disciplinary team make up to several visits a day and provide medication, brief counselling, practical assistance, information and support to service users and families. They can provide a service to people who are at significant risk of harm to self or others, as well as those under compulsory treatment. The team remains available until the crisis is fully resolved. Home-based treatment is increasing rapidly in the UK but is provided by only one DHB in New Zealand.

Evaluations

To date, evaluation findings have shown that home-based treatment reduces the number of hospital admissions and generates comparable clinical outcomes. Home-based treatment gives much greater service user and family satisfaction than hospitals (Bracken & Cohen, 1999; Burns *et al.*, 2002; Dean *et al.*, 1993; Houlton, 1986; Howey, 2000; Smyth & Houlton, 2000; The Sainsbury Centre for Mental Health, 2001). In a Bradford home-based treatment evaluation (Relton & Thomas, 2002), 81% of people who had used home-based treatment preferred it to hospitalisation.

In a qualitative evaluation of a home-based treatment service in Wellington, New Zealand, (Reet, Goldsack, Lapsley, & Gingell, 2005) people and their families reported they were treated as individuals, included in decision-making and given hope and encouragement. Nearly all the service users and their families preferred home-based treatment to the acute inpatient unit.

Family crisis homes

Family crisis homes or crisis foster homes describe a service where families or households take people in a mental health crisis into their homes, usually for up to two weeks. The families are rigorously

selected, trained and given intensive clinical back-up. They provide a homely environment, a bedroom, meals and a listening ear. If necessary they also provide assistance with medication, transport and accessing other services. The families are paid for all expenses.

Evaluations

The Dane County, Wisconsin crisis foster homes report very high user and family satisfaction. They are considered to work well because the person becomes a guest in a private home, where they have an incentive to function well and where they receive individual attention. The guests view their hosts as 'nice people' and allies with whom there can be some reciprocity, unlike their relationships with professionals. Family crisis homes are also considered a very cost effective option (Bennett, 1995; Boardman & Hodgson, 2000).

A SUMMARY OF THE EVALUATIONS

These studies show with reasonable consistency that community and home based acute services prevent admissions to acute units, and that in contrast to institutional acute services, they also provide:

- similar or better clinical and psychosocial outcomes
- far greater satisfaction for service users, families and staff
- some cost savings.

(Boardman & Hodgson, 2000; Clarke *et al.*, 1997; The Sainsbury Centre for Mental Health, 2001)

LIMITATIONS OF THE EVIDENCE

Although the evidence in favour of community and home-based acute services is reasonably compelling, all evidence is limited.

There are very few New Zealand-based evaluations of acute services, largely because we have not set up many alternatives to acute inpatient units. Most of the research on the effectiveness of acute services comes out of Britain and North America. However, the findings between these two parts of the world are similar, suggesting that this evidence is likely to be applicable to New Zealand too. But the monocultural nature of the evidence may make it less helpful to Māori, Pacific and Asian services than to main-stream services.

Innovative services tend to do better than the status quo services in evaluations because they often have very committed, forward-thinking staff and tend to be evaluated at an enthusiastic phase of the life of the service.

Many of the evaluations of the alternatives are for services that don't admit the small minority of people with the most severe crises, who are normally placed in intensive care units. Although some of the alternatives do provide for people in this group, and do so successfully, evidence is still lacking about whether every person in a mental health crisis could respond well in a community or home-based service.

Although community and home-based services tend to cost a lot less in the evaluated services, these findings should be regarded with some caution in New Zealand's health funding and regulatory environment, which could limit some of the cost savings possible in other countries.

The Elements of Good Acute Services

In order to achieve a more refined understanding of good acute mental health services, it is helpful to isolate the major elements common to all acute services. These elements include the environment, values, culture, people, competencies and interventions. The ways these elements come together in acute services needs to reflect policy, people's expectations and the evidence.

A SAFE NORMALISING ENVIRONMENT

Policy, expectations and the evidence strongly suggest that acute mental health services should be in a 'normalising', open door, home-like environment that provides for less than 15 people. Acute services should keep people as close to their everyday lives, whānau and communities as possible, where it is easier to facilitate and gauge people's progress. They are better located in the person's own home or local community and not in large institutions – while general hospitals may be well located in the community, they still represent a symbolic exit from community life.

RECOVERY VALUES

Good acute services are underpinned by post-institutional era values. Maintenance has shifted to recovery and segregation to social inclusion. Paternalism is shifting toward self-determination, and the dominance of medical approaches is shifting to more holistic approaches. According to this values base, crisis does not just involve risk to self or others but also an intense subjective challenge and an opportunity for personal development. The service therefore needs to respond to all the facets of crisis.

EGALITARIAN CULTURE

Acute services that align with policy, expectations and the evidence, are characterised by a power structure where staff mingle much more with those using the service than they do in institutional hierarchies. Emphasis is placed on talking, negotiation, self-responsibility and flexible solutions for both staff and service users. Staff attempt to create harmony through the participation of both staff and service users in decision-making rather than using authority to control people.

A WELL MATCHED MIX OF PEOPLE

Good acute services are willing and able to respond well to people whose profiles differ in terms of demographics, the nature of their problems and the severity of them. A wider range of staff give tailored holistic responses to people. These include psychologists, psychotherapists, chaplains, kaumatua, peer support workers, support workers, social workers, occupational therapists, advocates, as well as psychiatrists, nurses and nurse aids.

A BROAD RANGE OF COMPETENCIES

Policy, expectations and the evidence show that teams working in good acute services have many competencies between them. These include people with medical competencies, such as assessment, diagnosis and treatment, as well as psychosocial competencies, such as psychotherapy, practical assistance, problem-solving, advocacy, liaison and recovery. Although service users' competencies can be compromised during a crisis, they are encouraged to use and develop their self-directedness and self-

advocacy in a good acute service, rather than being compelled into dependency and compliance or resorting to rebellion.

A BROAD RANGE OF INTERVENTIONS

Good acute services provide a wide range of therapies, interventions or activities. They include conventional biological treatments such as medication or complementary treatments such as homeopathy. They may also use physical interventions such as massage; however they use

skills and support of staff rather than seclusion or locks and keys to keep people safe. Good acute services also use psychosocial approaches, such as counselling, practical assistance, peer support or therapeutic communities. Finally, people are encouraged to use self-help approaches such as relaxation, finding creative outlets or minimising the distress of hearing voices.

Sadly, none of these elements feature strongly in contemporary acute mental health services in New Zealand.

The Need for Reform

It's clear that the majority of people using mental health services in New Zealand are receiving acute services that lag behind policy, don't meet their expectations and are not based on the best evidence of what works.

Acute services need urgent reform. DHBs that are planning to build new acute units or do major renovations on existing ones need to consider the other options. Mental health funders, managers and other leaders need to initiate the redesign of acute services in New Zealand, in line with the elements described in this paper.

The most observable change suggested by these elements would be the downsizing or even closing of acute inpatient units, and the emergence of smaller community or home-based acute services as the backbone of acute mental health services. But unless other changes are put into place, community-based acute services will run the risk of becoming little institutions. The redesigned acute services must be underpinned by recovery values and more egalitarian cultures. Staff must have a wide range of psychosocial, peer support, spiritual and medical skills and service users must be encouraged to use their resourcefulness and autonomy.

COMMUNITY AND HOME-BASED ACUTE SERVICES

Each DHB needs to provide a combination of community and home-based acute services. The following options described in this paper are consistent with policy, expectations and the evidence:

- home-based treatment
- family crisis houses

- crisis respite
- crisis houses.

Some of the semi-institutional options may also have features that are worth emulating, particularly if they are small, community-based and don't use the language of institutions. Some of these options that house multiple acute services under one roof, such as crisis assessment, crisis beds, telephone support and day respite, could have potential in New Zealand.

The international literature does not focus on acute services for indigenous people and ethnic minorities. Māori need the opportunity to develop acute alternatives for their own people. The preference of Māori service users in a recent consultation undertaken by the Mental Health Commission was for those services to be provided on a marae setting.

A FUTURE FOR HOSPITAL-BASED SERVICES?

The mental health sector needs to research and debate to what extent acute inpatient units can integrate all the elements of good acute services. The answer to this will determine whether or not they should be merely downsized or phased out altogether.

Current knowledge suggests that acute inpatient units can minimise the use of physical force and provide more psychosocial therapies for people, using a wider range of staff with diverse competencies. The environments of acute inpatient units can also be made comfortable and attractive. The location of acute units in general hospitals, with proximity to the emergency department and medical services, may

also be an advantage for a minority of people who need these other services.

However, there are many features of acute inpatient units that may be difficult if not impossible to alter. They tend to be larger than community-based acute services, creating a more institutional ambience, alienation, and less flexibility in meeting the needs of different demographic groups and types of crises. Their location in general hospitals makes them more likely to be exposed to an institutional culture and bureaucratic restrictions. As the evaluations tell us, people in acute inpatient units experience more internalised stigma, disconnection from their communities and loss of living skills than those who use community and home-based services. Institutional services 'contaminate' a person's status and identity through the transition from citizen to patient (Goffman, 1961).

INTENSIVE CARE IN THE COMMUNITY?

Closely associated with the question of the future of acute inpatient services is the need for further research on the best responses for people in the most severe crises, that is, people who currently receive intensive care in acute units.

There is a consensus in the literature that acute inpatient units are still necessary for people in the most

severe crises, despite the wide acknowledgement that acute inpatient units are sub-optimal. This consensus lacks robust evidence, because as yet no mental health system in the world has completely done away with acute inpatient services. It may emerge that this consensus also lacks equity, if it creates the risk that people needing intensive care will be left in sub-optimal acute units while those in less severe crises get all the benefits of innovation.

New Zealand could lead the world if one of our DHBs piloted and evaluated a completely community and home-based range of acute services, including intensive care services.

Intensive care acute services could be set up in the community – in much smaller, more home-like places in quiet settings, outside hospitals and busy suburban streets. Safety could be provided by adequate staff cover rather than locks and keys. Space would need to be generous and flexible enough to meet rapidly changing needs. Rooms could be soundproofed to minimise disturbance and there would need to be spaces where people could express intense feelings without harming themselves, others or the environment. People in community-based intensive care would need to have access to a listening ear, acceptance, peer support workers, focused activities, medication and complementary therapies such as massage and meditation.

Some Ways Forward

RESPONDING TO DIVERSITY

Freeing up resources locked into large acute units will enable better-tailored responses to a wider range of people. Separate provision of acute services needs to be continued for children and young people, adults and old people. In some large districts, separate acute services could be provided for Māori, Pacific people, women, young adults, those affected by trauma and people in severe crises. People living in rural areas need more local and flexible responses. Different groups need to be better provided for, whether or not separate acute services are developed for them.

REFRAMING RISK

Current discussions on risk are centred on clinical risk to people if they are not treated and contained, and the risk to the clinicians or service organisations if a serious incident comes to the attention of the public. They are legitimate concerns but the current preoccupation with them at the expense of other kinds of risks reflects outdated values and culture. More attention needs to be given to the risks to people associated with alienating environments, violence and coercion or the fear of it, the damaging effects of some treatments, the lack of treatment options, and subsequent readmission rates. There are also risks to staff in these situations. More attention to these risks would generate a greater sense of urgency to reform acute services.

PREPARING THE WORKFORCE

The development of a broader workforce more grounded in recovery values and crisis skills is needed alongside the development of new acute services. Those using the services should have access to recovery education where they learn skills to manage

their own problems during a crisis. Employers need to ensure staff are not disadvantaged by the work conditions, pay rates and career opportunities in community and home-based acute services. Mental health professionals, who resist the move away from hospitals, preferring to manage people deemed to be at risk in a familiar environment, need to be given robust arguments and evidence for change.

REMOVING COMMUNITY BARRIERS

The mental health and anti-discrimination sectors need to increase their public relations skills, challenge local body planning processes and advocate for law changes to dismantle community barriers. The 'not in my back yard' lobby in New Zealand, reinforced by unanticipated use of the Resource Management Act, as well as by local body planning processes, can make it extremely difficult for some community services to get established. Community acute services could be even more vulnerable to these barriers.

SORTING OUT FUNDING ISSUES

Funders need to cost new acute services and adequately fund them. The commonly held view in this country that community and home-based acute services are more expensive, despite the international evidence, needs to be tested with cost analyses tailored to the New Zealand environment. Taking a lesson from the earlier phases of deinstitutionalisation, funders need to ensure that additional transitional funding is available if needed, as acute units downsize and community and home-based acute services get established. Otherwise there is a risk that the new services will not get fully established or will be too poorly resourced to reach their potential.

RESEARCH AND EVALUATION

The new acute services need to be evaluated and this should be built into their budgets. A small country like New Zealand has to rely to a degree on international research and evaluation, but we need more rigorous inquiry into what works in mental health services in this country. In a few years New Zealand will be better equipped to routinely evaluate outcomes and satisfaction than it is now, due to Ministry of Health initiatives such as MH-Smart and the consumer satisfaction survey.

UNLOCKING THE SYSTEM

Acute services should not become overloaded with the casualties of failures in other parts of the system; they need to operate in a well-balanced system that is geared to preventing crises and intervening early. Crisis prevention and early intervention often need the involvement of many services, such as treatment, support, housing and employment services.

Working across service boundaries is just as important as the development of discrete models of service delivery; even the best models of service delivery will not work well unless all the other arms of the service interlink smoothly with each other. Permeable boundaries need to exist with families, other acute services, primary and specialist treatment services, and social services. Information, communication and referrals need to flow smoothly and incentives should be built in to the system to create benefits for those using the services.

Conclusion

This paper has confirmed that New Zealand's acute services don't measure up well to current policy, people's expectations, or the evidence derived from evaluations. We have asserted that the deinstitutionalisation of the environments, cultures and practices of acute services lags behind other mental health services. Therefore, community and home-based alternatives need urgent development.

Despite attempts to improve responses, many of our acute units continue to fail people, and some are in a state of crisis. This paper has established a framework for understanding this crisis. But more importantly, this framework has established some compass settings for the mental health sector to develop a recovery plan – so that we can embark on a well-charted journey towards acute mental health services we can all be proud of.

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