

OPEN ALL HOURS?

A Review of Crisis Mental Health Services



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Foreword

In an ideal world, people can get help before they are in a crisis situation. However, the next best thing is getting the right kind of help when you need it.

Entering a crisis service, or any mental health service when you are in a crisis should be a turning point in a person's journey towards recovery. We called this review "Open all hours?" because the most obvious criteria for a crisis service is that it is accessible. The other criteria relate to the way the service operates.

This review shows that there are issues that must be addressed at a national level and locally. There is too much variation in the mental health sector's ability to respond to people whose situation is critical.

A handwritten signature in black ink that reads "Barbara Disley". The signature is fluid and cursive, with "Barbara" on top and "Disley" below it, both starting with a capital letter.

Barbara Disley
Chair

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Executive Summary

Crisis mental health services play a critical and valuable role; they are crucial to the delivery of mental health services in New Zealand. Furthermore, they underpin both District Health Board mental health services as well as services provided by non-government organisations (NGOs) and community agencies.

Crisis services are faced with considerable challenges but many still offer good services. Service users identified the main strengths of crisis services as those professional, experienced clinical staff who are working effectively with service users and families in a particularly difficult area of mental health. Several services provide short-term community-based acute treatment and follow-up that goes beyond immediate crisis assessment and referral to a community service. Crisis respite stood out as a very effective way of averting escalation of a crisis and as an alternative to admission. In general, stakeholders strongly supported an increase in crisis respite options.

What is working well

The review shows that some crisis services deliver a good service. Service users identified the main strengths of crisis services as those professional, experienced clinical staff who are working effectively with service users and families. Several services provide short-term community-based assertive acute treatment and follow-up that goes beyond immediate crisis assessment and referral to a community service. Crisis respite stood out as a very effective way of averting escalation of a crisis and as an alternative to admission. In general, stakeholders strongly supported an increase in crisis respite options.

At the service delivery level, certain practices underpin services that appear to be working best. The following practices are essential to develop if all services are to function effectively:

- A comprehensive range of service protocols that cover all critical and essential areas of delivery. Service protocols need to be easy to understand and up to date, and developed with the advice of clinicians and service users. They must have cultural input.
- Clear processes for interaction between the crisis service and other services that set out roles, responsibilities and expectations, and support the development of common understandings and constructive dialogue. Processes may include a formal protocol or memorandum of understanding, regular meetings, joint training, information sharing and other initiatives. Key requirements include regular liaison and clear protocols for practices between crisis services and child and youth services, older peoples services, accident and emergency facilities, alcohol and drug services and police.
- Understanding and responding to the needs of service users and families, including understanding the diversity of needs and cultural factors.
- Use of the recovery approach, including effective intervention practices that foster voluntary engagement with crisis services and reduce the use of compulsory treatment.
- Provision of an appropriately skilled and experienced workforce that includes the right mix of roles and expertise. Safety issues need to be addressed, and provision made for ongoing training, staff support and staff development.

Shortcomings

Despite identifying positive aspects of crisis services, the review also found a number of significant shortcomings that have a negative impact on service users in crisis. All stakeholders agreed on the issues and problems to be addressed.

Issues to address at a national level are:

- A clear overall direction for crisis services is lacking. There is no coherent framework and policies for the provision of crisis services that include a clear definition of crisis, national service specifications and standards.
- A focus on the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) has the potential to drive access to crisis services and restrict voluntary early intervention, service responsiveness and flexibility. There is a need to monitor the level and extent of the use of the MHA, and to foster voluntary engagement with crisis services that reduces the use of compulsory treatment.
- There is limited attention to the professional development of the crisis services workforce, including recruitment and retention issues, lack of crisis training opportunities, lack of widely agreed and implemented competencies for crisis workers, and lack of systems and processes for supervision and external clinical review. There is also a pressing need to improve national-level overview and assessment to ensure that crisis services staff have the requisite skills, knowledge and supervisory support required to undertake their work.
- A coherent, standardised mental health data collection and monitoring framework to assess service activity and quality is required.

Service delivery issues

- Eligibility criteria for using a crisis service are poorly understood, not only by the public, but also by the range of services that interact with crisis services. In general, there is poor provision of information about services (including criteria for entry to services) to service users, families, other agencies and the community.
- After-hours coverage is characterised by slow response times, lack of staff, lack of available medical cover in some areas, and little or no access to Maori and Pacific support services.
- In rural areas there are problems in accessing services, response times and the range of services available. Staff face difficult challenges as referral options are limited.
- In larger Hospital and Health Services (HHSs) a high demand on inpatient units and community mental health services contributes to limited options for referral.
- There is lack of ‘recovery planning’, including service users making advance directives in partnership with service providers.
- Few specific crisis services exist for Maori. Those services available had poor medical coverage and in one place were not part of HHS services.
- There is inadequate provision of services for Pacific people, including access to a Pacific mental health service and very little coverage of crisis responses by Pacific mental health services.
- There are specific gaps in crisis services for children and youth, older people and for those with alcohol and drug problems. There is a lack of suitable providers and a lack of suitably qualified and skilled staff.

- There is inadequate response to people in a state of intoxication. This problem has not been satisfactorily addressed anywhere. In part it is a reflection of poor interface between crisis services and alcohol and drug services. It also reflects the limited recognition by some crisis workers of the potentially serious risks for people in a state of intoxication.
- There is evidence of poor co-ordination and lack of co-operation between crisis services and other mental health services, which impacts on service continuity, responsiveness and recovery.
- Deficiencies in liaison and co-ordination between crisis services and other health and social services are apparent, including poor understanding of the roles and responsibilities of the various services. Crisis and other services often have unrealistic expectations of the varying capability of the range of services to respond to crises.

Section 1: Introduction

The Blueprint for Mental Health Services in New Zealand: How things need to be (Mental Health Commission 1998) identifies four service requirements for people who are acutely unwell or in crisis. They are:

- crisis teams
- crisis respite
- acute inpatient services, and
- intensive inpatient services.

As part of the Mental Health Commission's (MHC) statutory role to report to the Minister of Health on the implementation of the National Mental Health Strategy, the MHC has commissioned this report on the current provision of crisis services.

This review reflects the importance of services that support people whose mental health has deteriorated to such a degree that they need urgent specialist assessment and treatment or that they are at risk of harm to themselves or others. Urgent specialist assessment and treatment are critical components of recovery.

1.1 The review's scope and purpose

The Terms of Reference for the review of crisis services are outlined in Appendix 1. It should be noted that the review has focused on services specified as crisis services. It does not cover services in other parts of mental health services that may be associated with crises. It is acknowledged that, for example, all specialist services such as Child and Youth, Older Peoples, Maori, Pacific Peoples, Early Intervention, Dual Diagnosis, Alcohol and Drug, Forensic Services and community mental health teams, manage crises to some extent. The review does not evaluate risk management assessment policies and procedures. Nor does it consider the interface of crisis services with ambulance services.

The purpose of this review of crisis services is to:

- describe current national policy directions, requirements, and accountability arrangements for the delivery of crisis mental health services
- describe current crisis service provision and identify areas for development (the quantity, quality and models of current service provision)
- obtain mental health services staff views and expectations of crisis service provision (including crisis services staff and other services which interface with crisis services)
- report on service user and family views and expectations of crisis service provision (e.g. accessibility, timeliness and responsiveness)
- obtain stakeholder feedback on service provision, service interfaces and gaps (key stakeholder groups include Maori, Pacific peoples, general practitioners (GPs), police)
- identify and report on any barriers to service development and service improvement
- make recommendations for actions needed to further the development of crisis services.

1.2 Why a review of crisis services is needed

There are several reasons why this review of crisis mental health services has been undertaken. Funding for mental health services is still insufficient to achieve the National Mental Health Strategy goal of provision for the 3 percent of the adult population most severely affected by mental illness. While this situation remains, a priority for services must be the group of people with the most urgent and acute needs.

Key reasons for undertaking this review include:

- ***Crisis services play a key role in the spectrum of mental health care***

Crisis services are frequently the entry point to mental health services and act as gatekeepers to other mental health services. It is here that difficult triaging and rationing decisions must be made. Crisis services have a central role in responding to and managing demand for mental health services.

Effective links between crisis services, other mental health services, and external agencies are critical to the effective working of crisis services. The responsiveness and effectiveness of crisis intervention services are likely to impact on the workloads of all other mental health services and affect the ability of these other services to perform their own roles to maximum effect. For example, non-government organisations (NGOs) depend on crisis services as they are not required to provide crisis care. In addition police and GPs may play a key role in the crisis response. For Maori, access to appropriate cultural input (e.g. cultural assessments, access to kaumatua) are important quality processes. Similarly, Pacific people require appropriate and timely cultural input.

- ***A variety of crisis service models and practices are used***

The most obvious distinction is between a ‘stand-alone’ service and a crisis service that is integrated into community mental health services. But that is not the only distinction. Service activities also vary throughout the country, and from urban to rural areas. In addition, crisis services vary in the way they relate to alcohol and drug services and deal with the particular needs for intoxicated people in crisis. There appears to have been little examination of regional differences in crisis response times. Little is known about how services are offered to Maori and Pacific peoples.

- ***Legislative focus***

Crisis service delivery in New Zealand has been influenced by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). Internationally, crisis services originated from ‘crisis theory’ in which interventions were predicated on the basis that therapeutic options, rather than legislative requirements, took precedence. Crisis and other acute community assessment and treatment services existed in many areas prior to the MHA coming into effect. However, that legislation placed an emphasis on the availability of a particular class of clinician, the Duly Authorised Officer (DAO), which has appeared to determine configuration and more recently responsiveness of crisis services, at least in some areas.

- ***Monitoring the quality of services***

Crisis services are generally purchased as part of community mental health services and are thus difficult to monitor separately. A review of quality specifications and monitoring found that the Health Funding Authority (HFA) has not actively and consistently used reporting or audit mechanisms to monitor the quality of services against standards (Ministry of Health 2000).

1.3 Sources of information

The review was planned and conducted between August and October 2000, with some additional information being obtained early in 2001. At the time of the review HHSs provided most crisis services. When the District Health Board (DHB) structure replacing the funding and planning functions of the HFA came into effect in October 2000, crisis services became part of DHBs. Mental health funding responsibility was subsequently devolved to DHBs in 2001/02 as they developed capability in assessing local population needs, consulting local communities, and planning and contracting services to address regional and local needs. There is little indication of how crisis services should be developed under the new arrangements.

The review collected information from three main sources:

- National policy and direction from the Ministry of Health and Health Funding Authority were examined.
- The provision of crisis mental health was investigated through surveys of each of the 21 former HHS Mental Health Services and site visits to 6 DHBs. Questionnaires for the survey of the HHSs are contained in Appendix 2.
- The views of key stakeholders were sought, including crisis team staff, managers, service users and their families, general practitioners (GPs), police and representatives of NGOs that provide services for people with mental illness.

The Commission convened an advisory group consisting of mental health practitioners and managers, service users, cultural advisers and representatives of the Ministry of Health to oversee the review. The purpose of the group was to advise on the process, methodology and content of the review.

It was important to obtain the views of service users, as they have personal experience of crisis mental health services. In total 55 service users participated in the focus groups. In addition consumer advisers at a National Association of Hospital and Health Services Consumer Advisers (NAHHSCA) meeting provided their perspective informed by contact with local service users. The review team understood that some service users may have declined to participate in the focus groups, as they did not wish to revisit a time in their life remembered as traumatic, or did not want to be critical of a service they might need to use again in the future. The timeframes that the review operated under may have also limited the participation of service users. However, the combination of focus groups and consumer adviser views has provided a breadth of experience to inform this review.

Considerable limitations in the availability and reliability of data have affected the review. The 21 HHSs were surveyed to obtain information on the quantity, nature and extent of crisis services. The HHSs varied greatly in their provision of consistent, detailed and reliable information on their crisis services. This was due to variation in the monitoring and reporting processes established in HHSs. While some areas provided the information required, not all services were able to provide the same set of information about their services. Some areas provided data that was patchy in quality. Consequently, caution has been exercised in presenting information, and any data limitations are identified. The qualitative information obtained from site visits has been essential for gaining a comprehensive picture of crisis services.

In addition, data from the Mental Health Information National Collection (MHINC) was limited. At the time of the review only nine HHSs were able to report their crisis service data separately from community mental health service data. Although data was obtained from MHINC, its usefulness was limited and therefore it has not been included in this report.

Despite the limitations of data, the Commission considers that the review has gathered sufficient information from a range of sources to clearly identify the issues and ways forward for crisis services. One of the significant changes required is improved data collection and reporting processes for crisis services, including a standardised crisis service data set.

1.4 Content of this report

The report starts by setting out the broad framework in which crisis mental health services are provided. The legislative, policy, funding and purchase parameters are outlined (Section 2).

Section 3 describes the delivery of crisis mental health services. The section commences with an overview of the paths a person experiencing a crisis might expect to follow through services. Then this section looks at what happens ‘on the ground’, using information obtained from a survey of the 21 former HHS mental health services and site visits to six DHBs that included interviews with staff, service users and other stakeholders.

Issues relating to the delivery of crisis services are addressed in Sections 4 and 5. Section 4 presents service users’ and family members’ views and experiences. Section 5 summarises the range of issues identified by all stakeholders.

Section 6 provides an overview of key issues that need to be addressed in the future development of crisis services and presents recommendations for actions needed at national and service delivery levels to improve crisis services.

Section 2: Frameworks for the Provision of Crisis Mental Health Services

Crisis services are designed to support people when their mental health has deteriorated to such a degree that they need urgent specialist assessment and treatment, or that they are at risk of harm to themselves or others. The Ministry of Health *Mental Health Common Base Definitions* (1997) states:

"Crisis intervention is short-term, focuses on solving immediate problems, aims to re-establish former coping patterns and problem-solving ability. Understanding what constitutes a crisis and possessing basic knowledge of crisis intervention will influence the quality and course of the individual in crisis"
(Ministry of Health 1997: 2)

Crisis services should address the crisis needs of both those people who have not previously been in contact with mental health services, and also people who have recurring mental health crises.

To assist people to move from crisis to recovery, crisis services need to provide systematic triage, assessment and referral processes to non-crisis mental health services, or to other services they may need, such as housing.

2.1 The Mental Health (Compulsory Assessment and Treatment) Act 1992

The Mental Health (Compulsory Assessment and Treatment) Act 1992, (MHA) while not directly concerned with crisis service delivery, contains a number of provisions relevant to crisis responsiveness.

The MHA sets out a definition of a class of persons who may be subject to compulsory assessment and treatment. This definition establishes a threshold for entry to the provisions of the MHA related to presence of symptoms as well as degree of seriousness of the impact of these symptoms. The MHA does not intend to preclude people who do not reach this threshold from obtaining services, but simply establishes the criteria for application of a compulsory process.

The MHA also establishes roles of identified clinical practitioners, including Duly Authorised Officers (DAOs) and Responsible Clinicians. It sets out a requirement for services to ensure that at all times sufficient health professionals are designated as and available to exercise the functions and powers of DAOs.

In practice, DAOs are often required to be available within crisis services, as this is commonly a point of entry to a process of compulsory assessment and treatment. DAOs must therefore be available after-hours.

The MHA also sets out classes of persons who may not be subject to the provisions of the legislation. The MHA does not intend that these persons are not entitled to assessment by mental health services, where appropriate, but rather it simply limits the application of the compulsory provisions. Indeed assessment will often be a crucial first step in determining whether the person meets criteria for obtaining a service, whether under compulsion or otherwise.

2.2 Funding and accountability arrangements

The provision of integrated and effective services is facilitated by having clear specification of the service funding, resource allocations, access and coverage requirements. In the case of crisis services, there is no one document that sets out components and specifications for a crisis service. The specifications for service are primarily set out in the:

- Funding Agreement.
- HFA Mental Health Purchase Framework and Service Specifications.¹

At the time of the crisis review, the Funding Agreement was between the Minister of Health and the HFA. The Funding Agreement does not specify the quantity or nature of crisis services to be delivered for a particular region. It does, however, set out principles and guidelines upon which crisis service configuration and delivery is built.

The Service Coverage Schedule of the Funding Agreement sets out acute and crisis service requirements in the context of personal mental health services and drug and alcohol services. These are described in Infobox 2.1.

Infobox 2.1: Service Coverage Schedule: Requirements for crisis services

Personal mental health services (pp. 113–117)

Services for people in crisis or having an acute episode (especially when their or someone else's safety is at risk) including:

- acute services provided within an inpatient setting, such as a specialist psychiatric hospital ward or mental health facility
- 24-hour mobile crisis services
- community-based crisis respite, including a treatment component (services which provide people, including caregivers, with a break so crisis can be eased)
- training and monitoring of duly authorised officers under the Mental Health (CAT) Act 1992 and the Mental Health Amendment Act
- consultation/liaison.

Decision-making criteria

- On referral (including self-referral) the criteria for assessment are based on the person having an identifiable or suspected psychiatric disorder.

Time

- When assistance is required under the Mental Health (CAT) Act or the Mental Health Amendment Act, 90 percent of people should be assessed within four hours.
- If a person is assessed as needing hospital care under the Mental Health (CAT) Act or the Mental Health Amendment Act, 90 percent should be admitted to a hospital within six hours of being seen by a doctor or health professional.
- The HFA will ensure that crisis services to deal with a critical or urgent mental health need will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act or the Mental Health Amendment Act) as follows:
 - i) Telephone or other remote assistance will be available at all times with minimal delay.
 - ii) Where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided as soon as possible.
 - iii) Other services will be arranged where required including acute inpatient admission and crisis respite.

¹ When this review was undertaken, the key organisations in the funding and provision of crisis mental health services were the Ministry of Health (MoH), the Health Funding Authority (HFA) and providers, mainly HHSs and a few NGOs. The MoH managed the Funding Agreement between the Minister of Health and the HFA, which set out the services that the HFA would fund and how it would deliver on the Crown's Statements of Objectives for health and disability support services. The HFA contracted for services with providers and monitored performance against those contracts.

Infobox 2.1 (continued)

Additional quality requirements

The HFA will require providers of mental health and substance abuse services, in providing those services, to adhere to the following specific Ministry of Health protocols and guidelines (as they may be altered by the Ministry from time to time):

- National Mental Health Standards (1997)
- Procedural Guidelines for the use of Seclusion (June 1995)
- Procedural Guidelines for Physical Restraint (June 1993)
- Guidelines for Reporting and Reviewing Incidents (June 1993)
- National Protocol for Methadone Treatment in New Zealand (May 1996)
- Guidelines for Clinical Risk Assessment and Management in Mental Health Services (July 1998)
- Guidelines pertaining to the Mental Health (CAT) Act 1992 or the Mental Health Amendment Act.

Compliance with the Mental Health (CAT) Act 1992 and the Mental Health Amendment Act

Mental Health Services shall meet the requirements of the Mental Health (CAT) Act and the Mental Health Amendment Act. Mental Health Services shall, therefore, include:

- a) the employment of, and provision of resources to, appropriate directors of Area Mental Health Services (as designated by the Director-General of Health), responsible clinicians and duly authorised officers under the Mental Health (CAT) Act and the Mental Health Amendment Act
- b) provision for second opinion by psychiatrist under Section 59, Section 60 and Section 69 of the Mental Health (CAT) Act and the Mental Health Amendment Act
- c) the payment of legal and other fees specified by the Mental Health (CAT) Act including the fees of medical practitioners under Section 134 of that Act and the Mental Health Amendment Act
- d) the training and monitoring of duly authorised officers under the Mental Health (CAT) Act and the Mental Health Amendment Act in accordance with the Ministry of Health guidelines issued for that purpose from time to time
- e) administration of the national victim notification register.

Mobile crisis services

Mobile crisis services will be guided by written policies and procedures that:

- a) include a clear statement of conditions when a minimum of two clinicians should attend a call-out; and
- b) ensure that services are deployed and equipped in a manner that enables the staff to carry out the services as required under the Mental Health (CAT) Act and the Mental Health Amendment Act; and
- c) provide for emergency admission to acute Inpatient Services; and
- d) set out arrangements for effectively working with Police.

Further detailing of the nature of crisis services funded by the HFA is set out in the HFA Mental Health Purchase Framework and Service Specifications (Appendix 3). These documents specify both the general requirements for all mental health services, and more closely the function and nature of crisis intervention services. The Mental Health Purchase Framework definitions include crisis teams under Community Mental Health teams as one of a range of services. Crisis teams are not defined as a requirement. The Service Specifications provide a service description for a crisis intervention service. They do not define a particular model of delivery, although they establish expectations that shape the structure and internal processes of services to meet these requirements.

Crisis intervention services²

The function of the crisis intervention service is described in the HFA service specifications as providing “rapid assessment and intervention for eligible persons”. It is expected that intervention will occur “in a highly mobile fashion to be available at the point where the crisis is occurring”.

The specifications describe the nature of the service as including not only any tasks necessary in relation to the MHA, but also assessment, development and implementation of a treatment plan, referral to other services for ongoing treatment and provision of advice, information and support to other caregivers and family as appropriate.

The minimum processes that service users can expect to access are defined as:

- advocacy
- assessment
- case management
- discharge planning
- early identification
- legal compliance
- management of risk
- peer support
- service handover
- support
- therapy
- treatment
- rehabilitation.

The specifications also require that a multi-disciplinary team provide the service. In addition, there should be effective liaison with police, GPs, residential providers and ambulance services, and that there are formal protocols with such services that set out the nature and extent of involvement.

Kaupapa Maori crisis intervention service³

A service description is provided for a Kaupapa Maori crisis service. The specification is the same as for the crisis intervention service, with the addition of kaumatua, cultural advisers and/or cultural workers and any other professional staff in accordance with the needs of the tangata whai ora.

² HFA Service Specifications for Adult Mental Health Services 2000: 27.

³ HFA Service Specifications for Kaupapa Maori Mental Health Services 2000: 22.

Reporting and monitoring

While those service specifications appear comprehensive, it must be recognised that crisis services are purchased as part of adult community mental health services. Consequently, they are not always separately identified within contracts. Instead, for many service providers, the delivery of crisis services is merely noted in the overall coverage statement within their service contracts. There is not the requirement for mental health service providers (previously HHSs and now DHBs) to separate their reporting for community mental health services, either in reporting for MHINC or in reporting to the HFA. This does not allow performance of crisis services to be monitored easily. Some HHSs have, however, chosen to report on their crisis service separately for MHINC purposes.

The HFA formerly, and now the Ministry of Health, is only able to monitor total adult community mental health service provision. Dollars spent on crisis services per se cannot be described. For crisis respite there is a separate purchase line and \$6.26 million is budgeted for this. The only form of monitoring of crisis respite appears to be dollars expended.

Section 3: Delivery of Crisis Mental Health Services

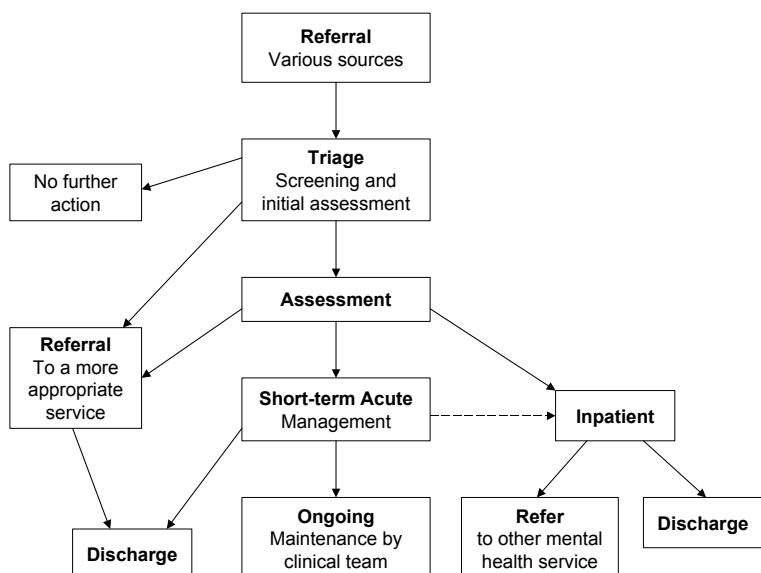
Crisis services around New Zealand have many different names, are configured in various ways and offer different ranges of interventions. Several definitions of crisis are used. In part this diversity is due to a lack of detailed specification of crisis services. It also reflects the way in which services have developed in response to local population needs including cultural requirements, and differences between urban and rural population densities and service capacities.

Despite such variation, crisis services generally have the following common components:

- They carry out triage and assessment of those people in the most acute or serious need. Some crisis services also offer short-term monitoring of medication and supportive treatment.
- They cater primarily for adults, although some services provide crisis services for older people, young people and children, depending on the availability of other mental health services for those groups. After-hours care of all groups is usually undertaken by crisis services.
- Crisis services are also involved in compulsory processes defined under the MHA.

Figure 3.1 sets out the typical paths a person experiencing a crisis may follow through services. The parts of the path that are defined as crisis services differ from area to area. In some areas, the crisis service consists of triage, assessment and short-term acute management. In other areas, the crisis service includes those components with the addition of ongoing maintenance by the clinical team. Inpatient services may also be included as part of the crisis service in some areas. After the crisis has resolved and where ongoing care is required this will usually be provided by a community mental health team. If ongoing care within the mental health service is not needed the person will be discharged altogether from the service, often with referral back to a GP, although this practice varies from area to area.

Figure 3.1: Paths through crisis



3.1 Levels of crisis service delivery

HHSs reported wide variation in the levels of service delivery. The number of people accessing crisis services in a 12-month period⁴ ranged from 129 people per 100,000 population up to 1682 per 100,000 population. The average was 564 per 100,000 population. The three HHSs with a crisis service as part of community mental health teams were among the six services with the lowest numbers of people accessing their services in crisis, with an average of 279 people per 100,000 per annum between them.

For the HHSs with crisis teams separate from their mental health teams, there was a wide range of team sizes. When FTEs per 100,000 population are considered, the range was from 3.9 FTEs to 11.5 FTEs, with a mean of 6.5 FTEs. It is unclear how adequate the FTEs are as the characteristics of the population, such as age and ethnicity profiles, population density and geographical coverage, and the availability of other services are not known. Therefore it is difficult to tell whether the wide variations in population density covered and numbers of people serviced are problematic for accessing the service and service quality.

Age, sex and ethnicity data obtained from the HHSs surveys was poor. Eleven HHSs did not collect ethnicity data for those accessing crisis services and four provided estimates only. Eleven HHSs could not provide age data. Therefore, no age, sex or ethnicity data is reported here.

3.2 Who delivers crisis services

HHSs delivered most crisis services. However, in at least three areas, some aspects of crisis services for a defined geographical area were provided outside of the HHS services, by iwi-based or NGO providers. This was particularly so for remote rural areas. In one remote area the iwi-based service provided crisis services, although with access to a doctor and hospital admission. In another rural area a Maori crisis nurse was employed by an NGO and worked in relative isolation, although on occasion referring to the HHS-based crisis team.

It appears that the majority of staff in crisis services were nurses.⁵ Eight crisis teams included social workers. One HHS reported employing four crisis support workers in addition to their clinical staff. Crisis support workers are not clinically trained, but specialise in supporting the service user through the clinical process during a crisis.

Nine of the HHSs with separate crisis teams indicated that the crisis team had at least one doctor on staff. Two indicated that they had a shared doctor and three that they had access to a doctor on call. Five HHSs indicated no doctor on staff, but did not indicate what arrangements were for cover. In one area crisis work was not routinely carried out in conjunction with or with reference to a doctor. Instead, crisis staff used their discretion to inform or consult with medical staff. There was no system of routine review of crisis work that included a medical staff member.

Fifteen of the HHSs stated that DAOs were available to the crisis team from other parts of mental health services, mainly community mental health centres. Five HHSs noted that DAOs were only in crisis services.

⁴ Data was requested of HHSs for the period September 1999–September 2000, or the last 12 months for which data was available.

⁵ This is based on the responses of 18 HHSs. Three HHSs did not respond to this question.

3.3 Models of crisis service delivery

The review found that crisis services were either integrated into community mental health services, or operated as stand-alone services. However, there were a number of variations within these two broad approaches.

Stand-alone services

Stand-alone services are characterised by a distinct team of crisis staff, generally with some or all of them being Duly Authorised Officers with a focus on urgent assessment and crisis intervention. Most of the 21 services reported having stand-alone crisis services operating 24 hours a day. One HHS indicated that it operated two stand-alone crisis teams. Two HHSs had stand-alone services that covered only a part of their geographical area, with a rural area covered by an integrated service.

Some of the stand-alone services limited their role to crisis intervention. This meant that after a few days, the service user would be referred on to community mental health services. In contrast, other stand-alone teams offered acute community-based treatment, including access to respite care. Some teams reported delays in transferring a person from the crisis team to the community mental health team due to heavy community caseloads. This situation contributed to the considerable variation amongst stand-alone crisis teams in the length of time they were involved with a person.

The stand-alone teams also differed in whether they accepted referrals from individuals already in contact with another mental health service, or only from newly presenting people. Some services limited the crisis team response in normal office hours to newly presenting people and expected current users of community mental health services to have their urgent and crisis needs met by their clinical team. Although those crisis services tended to have a threshold for intervention, this threshold was not always well defined. Case managers in community services reported needing to re-prioritise their work to respond to their service users who needed a crisis response that could not be met by the crisis team.

Stand-alone teams had the capacity to work after-hours, but there was variation in the medical staff support available to the teams, and in the nature of the service provided after-hours.

Integrated services

In the integrated model the team undertakes all aspects of mental health care, including crisis response. There was variation in the configuration of crisis services that were integrated into mental health services. One HHS's crisis service was part of the community mental health team and Maori teams. Another HHS reported that its crisis services were part of community mental health teams.

As with the stand-alone teams, the integrated teams reported various arrangements for response. In some integrated services all staff undertook all aspects of mental health care for all people in their area, including crisis response. In other places there were specialist roles within the team, with dedicated staff providing the crisis response.

The integrated services provided crisis services to newly presenting people and to current service users. The latter service was generally in conjunction with the usual clinical staff involved in the care of that person. After-hours there was usually an arrangement for some staff to be available for crisis work on a rostered basis, with on-call arrangements overnight.

Comparing the two models

The stand-alone model appeared to be better understood by some stakeholders. For example, in one area where the crisis service was in transition from a stand-alone service to an integrated service, service users and families were anxious that a ‘real’ crisis service would be lost. However, staff in integrated services were generally enthusiastic about the continuity of care afforded by an integrated model. While the advantages and disadvantages of the two models have been analysed in England, there has been no comparative evaluation of the two models in New Zealand.⁶

3.4 Accessing crisis services

Initial contact

A person wanting help may enter a crisis service in a number of ways, according to the time of day, whether he or she is already engaged in the mental health service or not, the route of referral and the location of the service. Individuals may refer themselves to the service, or be referred by a family member, a mental health service, a GP, police, NGO or other means. While the most usual way of entry would be by a telephone call to the service, occasionally a person may walk in to the service. Sometimes contact is made by fax, e.g. a referral from a GP.

All HHSs reported that their crisis services were listed in the local phone book. This meant that a person needed to know the name of the HHS in order to access a crisis service.

There is no standard name for a crisis service in New Zealand. Names appear to have been chosen to reflect the local service context and the MHA. CATT was the most common name used. Infobox 3.1 shows the variation in service names and acronyms used around the country.

Most services use the word ‘emergency’ or ‘crisis’ in the service name. One ‘crisis’ service did not wish to be called a crisis service; instead they wished to be known as an ‘intensive team’, despite recognising that the public may not know what this meant. Some teams also used the word ‘emergency’ which suggests a more serious situation than a crisis.

Infobox 3.1: Examples of crisis service names

CAT: Community Assessment Team	CATT: Community Assessment and Treatment Team
MCT: Mobile Community Team	MHEAT: Mental Health Emergency Assessment Team
PEHTT: Psychiatric Emergency and Home Treatment Team	PES: Psychiatric Emergency Service
SMET: Southland Mental Health Emergency Team	TACT: Timaru Assessment Crisis Team

⁶ A study by Minghella et al 1998 in England identified the following advantages of the stand-alone model: staff can develop specialist skills; the team can be flexible and rapid in its response because there is no ongoing case load, and it is geared to providing 24-hour care. Disadvantages are the risk of poor integration with other mental health services. The advantages of the integrated model are identified as continuity of care for the service user. However, there may be difficulties in managing ongoing case loads with crisis response.

Some services published contact details of crisis services alongside accident and emergency services at the front of the telephone directory. One service was identified in the telephone directory by name but without indication of the crisis response nature of the service. One service described itself in the telephone directory as a crisis team, but in the service brochure was called a “Rapid Response Team”.

In addition to telephone directory entries, 10 services had brochures describing the crisis service. Some brochures described mental health services including the crisis service, while others had a brochure for crisis services alone. One crisis service had a 39-page booklet describing all mental health services provided by the area. One service ran a weekly advertisement in the local newspaper in order to inform the public.

In their information provided to the public, most services used clinical and technical terms without clarification. For example, terms such as “DAO” were not explained.

The threshold for intervention

At the initial point of contact, whether by phone or in person, triage will occur. Triage is the process of screening referrals to determine eligibility for the crisis services, priority and the nature of action required. A nurse usually does screening and initial assessment. At this point if it is appropriate, brief counselling may occur to solve the issues over the phone or face-to-face. The person may be referred to another service (not necessarily a mental health service), or no further action may be taken.

Triage may involve a decision to invoke the MHA. In order to invoke the MHA, an initial assessment of the person will be undertaken. If the MHA is not invoked, the person may or may not receive further in-depth assessment or treatment.

Variations in interpretation of crisis have implications for how crisis services define the threshold for intervention. Across the HHSs a variety of definitions of crisis were used. Eight services based their definition around notions of distress, risk and safety and the need to intervene. Four definitions related to services provided. Four services used the HFA service specification definition.⁷

Not all HHSs had a definition of crisis. Three services did not have a definition of crisis and one service indicated that crisis was defined by the service user. One staff member noted: “We (crisis services) just get on with the job rather than thinking about definitions”.

In some areas there was a view that criteria for the compulsory provisions of the MHA or risk of harm needed to be met before a crisis response was appropriate. However, few HHSs were able to provide useful information in regard to the percentage of first contacts that were related to MHA activity. Those services that did provide useable information showed a wide variation in the number of Section 8⁸ assessments reported to be carried out in the previous 12 months. There was a spread from less than 20 per 100,000 population to more than 300 per 100,000 population. The reasons for such wide variation are not known.

⁷ “To provide rapid assessment and intervention for eligible persons in crisis” (HFA Service Type Description for Crisis Intervention Service 2000).

⁸ Section 8 assessment refers to the requirements for entry to the compulsory assessment processes of the MHA. A completed application under Section 8 requires an application for assessment to be accompanied by a medical certificate completed following examination of a proposed patient by a registered medical practitioner.

Face-to-face assessment

If further action is required after triage, a detailed face-to-face assessment then occurs. That assessment may happen at the person's home, a GP's surgery, or the person may be asked to attend a clinical or community team base.

The average time between initial contact and face-to-face assessment was not recorded by five services. For those that provided the information, the time between initial contact and face-to-face assessment ranged from 30 minutes to eight hours, with 11 services reporting a delay of less than four hours. Crisis services differed widely in both the number of people in their areas, and geographical coverage. These factors can affect response times markedly.

Areas with a mainly rural⁹ population reported that their crisis teams covered long distances. The longest reported travel time from the crisis team's base to the furthest point in the area was five hours. Three hours twenty minutes was the average travel time reported by the HHSs serving mainly rural populations. In those HHSs more work was done by telephone and more often police were involved in attending people. The time required to cover long distances in rural areas is likely to result in fewer people served and fewer crisis contacts for each FTE in the team, and will require larger teams to provide the same level of cover per 100,000 people.

Those HHSs serving mainly urban populations reported an average travel time of 90 minutes, while the average travel time was 136 minutes for HHSs with a mix of urban and rural populations.

After-hours access

All HHSs reported that fewer crisis staff were available after normal working hours, i.e. during evenings (after 10.30 or 11 pm), overnight and on weekends. Only two HHSs reported that staff members were on-site and taking calls overnight. In both cases two staff members were available.

All other HHS reported they used an on-call system and of these all but three had people on "second call" to back up those on "first call". Eleven HHSs reported they had a total of two people available on-call, whether first or second call. Two reported only one person available on-call and four others reported three or four people available on-call.

One HHS reported that the crisis team has no access to a psychiatrist for the full 24 hours a day, and this was a service that had only one person available on call overnight.

In general, crisis services covered crises for other mental health services after hours. These included child and youth mental health services, older people's services, drug and alcohol services, kaupapa Maori services and Pacific people's services.

Accessing crisis services from other mental health services

Some services provide crisis services for children and young people, older people, and those using drug and alcohol services, depending on the availability of other mental health services for those groups.

⁹ HHSs defined whether they served 'mainly urban', 'urban/rural' or 'mainly rural' populations. These categories were not defined in the survey.

Thirteen HHSs stated that young people in crisis between 8.30 am and 5 pm would be seen by child and youth services. Three HHSs said that if the person were known to the service, the child and youth service would see them, but if not, the crisis team would be called. One HHS stated that a joint child and youth/crisis team assessment would be undertaken, and the remaining four HHSs said they would use the crisis service. In some small services child and youth staff were also crisis team members.

For child and youth crises after 10.30 pm and in the weekends, 20 HHSs said that the crisis team would be used. Four noted that the on-call child psychiatrist would be involved. One HHS stated that the child and youth service would deal with the person and would consult the crisis team if needed. One service noted that a child and youth "Rapid Response Team" is planned which will work evenings and weekends.

Most HHSs reported that if an older person has a crisis during the day they would be assisted by the local service for older people. However, five HHSs stated that the crisis team would be used, mainly because in some places the service for older people consisted of only one or two staff. If the person was known to the older person's service, they were more likely to be seen by that service. All HHSs reported that the crisis team provided after-hours care at evenings and weekends.

The majority of HHSs reported that people in crisis using drug and alcohol services would be seen by the drug and alcohol service during the day. The remaining HHSs used crisis services. For evening and weekend crises, all but two HHSs reported using the crisis service. These two services had on-call alcohol and drug workers who would attend first then call the crisis team if needed. In one HHS a person calling after-hours by telephone is told to call their GP or hospital emergency department. Another noted that if the person were intoxicated they would return the next day to assess him/her when sober.

3.5 Interventions and care

After assessment individuals may either:

- be referred on to a more appropriate service or community agency, such as counselling services, GP or community organisation; or
- receive short-term acute management by the crisis team or following immediate referral to another community mental health service. Short-term acute management could involve visits by a member of the crisis or community mental health team or respite care; or
- receive short-term acute treatment as an inpatient. This may involve admission under the MHA.

The interventions that crisis services offer ranged from a limited set of interventions to an extensive menu of interventions. In general, the range of responses offered may be described in three ways:

1 Limited to crisis response. This includes any of the following:

- telephone triage/advice/assessment
- face-to-face assessment (mental status examination)
- suicide/risk assessment, action plan
- medication dispensing
- MHA implementation and advice (DAO function)
- admission to hospital
- crisis respite accommodation and monitoring

- transport (with police)
 - referral to appropriate service.
- 2 Crisis response plus brief interventions. This response includes any of the above responses that are required and in addition one or more of the following:
- counselling or brief supportive therapy
 - urgent family counselling
 - brief assertive follow-up
 - problem-solving
 - cultural assessment and support
 - family and service user education about mental illness and crisis interventions
 - medication reviews
 - brokerage to community services and resources
 - anxiety reduction strategies.
- 3 Crisis response, brief interventions plus medium term interventions. This response includes any of the above responses that are required and in addition one or more of the following:
- relaxation
 - stress management
 - supportive psychotherapy
 - primary health promotion and education
 - short-term therapy
 - risk management and suicide prevention.

Those HHSs offering a crisis response and brief interventions (category 2) were divided into those services where a health worker outside of the crisis team retains primary clinical responsibility and involvement with the person in crisis, and services where the crisis worker assumes primary clinical responsibility.

Only two services indicated that they never assume primary clinical responsibility for brief or ongoing interventions (categories 2 and 3). Ten of the 21 services indicated that they do not undertake ongoing therapy or intervention beyond crisis resolution (category 3).

3.6 Clinical service protocols

The Review Team developed a list of areas of clinical activity or processes and standards relevant to the operation of crisis services that were regarded as sufficiently important that they should be documented in the form of service policies or protocols. No protocols are required in contracts or set out as part of service specifications. The list of areas is set out in Table 3.1. HHSs were asked to forward copies of policies or protocols in regard each of the areas. Percentages of HHSs supplying these are shown.

These percentages are taken as a proxy for the percentage of HHSs that have developed those protocols. This table provides information only on the extent to which protocols may have been developed across crisis services. No assessment of the quality of protocols was made. Nor was information collected on the extent to which protocols are actually followed in practice.

Coverage of service protocols can be divided into three broad groups. The first group consists of protocols that the large majority of HHSs (80–100 percent) have. These are protocols covering assessment, MHA transport, memorandum of understanding with police, inpatient service access, triage and prioritisation, communicating extreme risk, complaints and risk assessment.

The second group of protocols (from 50–79 percent of HHSs) includes some key practice areas such as critical incident debriefing, critical incident review, MHA implementation and cultural assessment for Maori.

The third group of protocols (from 0–49 percent of HHSs) shows that many HHSs appeared to lack protocols in areas of responsiveness including consumer satisfaction, family satisfaction, staff satisfaction, cultural assessment for Pacific service users and protocols for minority groups.

Table 3.1: Crisis service protocols

Service protocol	Percent of HHS with protocol
Assessment	95%
MHA transport	95%
Police memorandum of understanding	95%
Inpatient service access	86%
Triage and prioritisation	86%
Communicating extreme risk	86%
Complaints	86%
Risk assessment	82%
Critical incident de-briefing	77%
Notify crisis staff re concern	77%
Cultural assessment for Maori	73%
Eligibility criteria	73%
Transfer of care	68%
Crisis staff notify re clients seen	68%
Critical incident review	68%
Mental Health Act implementation	59%
Feedback to referrers	59%
Staff counselling	55%
Number staff for callout	55%
Notes access	41%
Consumer satisfaction	36%
Family satisfaction	27%
Staff satisfaction	18%
Cultural assessment – Pacific	18%
Protocols for minority groups	18%
Pre-planning for crisis	5%

3.7 Crisis services for Maori

HHSs reported that Maori are identified at the first point of contact. From that point on all acknowledge that appropriate Maori input for Maori is important. Appropriate Maori input is most likely to occur in the two areas where there are Maori crisis teams. Similarly, those HHSs who have Maori mental health services and/or Maori crisis workers reported that much effort goes into meeting the needs of Maori.

HHSs reported that Maori families and whanau are involved in the process of assessment and treatment. Involvement ranged from active involvement at the point of entry, to the accommodation of whanau preferences where possible. One HHS mentioned the Treaty of Waitangi as a guide in involving families.

Table 3.2 shows the Maori workforce available in HHSs for crisis services. Nine HHSs reported having no Maori staff as part of their crisis team. However, all but two HHSs reported having access to Kaupapa Maori Services, although this term was not defined.

Table 3.2: Maori workforce

Service*	Number of HHSs providing service
Maori crisis team	2
Kaumatua/Kuia	19
Maori mental health worker	20
Traditional Maori healing practices	14
Iwi support worker	11

Source: HHS survey

* Categories may overlap.

Two HHSs had a Maori crisis team in addition to the general crisis team, although one of these teams was defined as 'part-time'. One HHS had a Maori crisis team integrated with Maori community mental health services, and another had a Maori crisis worker attached to a Maori NGO who worked with the HHS crisis team. In a few cases, where Maori staff were scarce and in areas with a large distance to cover, cultural input was ad hoc.

For crises during the day, nine HHSs stated that they would access their Kaupapa Maori Services in the first instance and call on the crisis team if required. Eight reported using the crisis team, or community mental health team where crisis services are integrated, but would also seek advice from Maori workers. Two HHSs had a Maori crisis team.

For evenings and at weekends, nine HHSs noted that the crisis team would deal with a crisis. The two HHSs with a Maori crisis team stated that those teams would respond after-hours. One HHS noted that if a crisis was expected after-hours, the Kaupapa Maori team would give the crisis team a risk management plan.

HHSs described a variety of processes for working with a Maori service user. One HHS stated that cultural assessments are done in all cases of crisis, some joint assessments are done with the crisis team (i.e. clinical and cultural assessments), and cultural protocols are adhered to. Two HHSs had comprehensive policies for access between Kaupapa Maori Services and crisis services.

For services that have access to separate Maori mental health services, Maori staff may provide a cultural assessment. In other services Maori staff working in the crisis team provide expertise. Most services noted that strengthening on-call cultural expertise is necessary in order to ensure cultural needs were better met.

3.8 Crisis services for Pacific people

Fifteen HHSs reported having no Pacific staff in crisis services. Three HHSs had one Pacific staff member and one HHS cited 6.25 FTEs.

Nine HHSs stated that they have access to a Pacific peoples' service. Four of the five HHSs with a Pacific population of greater than 6 percent had access to their own Pacific mental health service, although at the time of the review one HHS had not appointed clinical staff.¹⁰ In two of those HHS areas there are also local Pacific NGOs providing mental health services. The other HHS with a significant Pacific population accessed a local Pacific NGO providing mental health services.

One other HHS accessed a local NGO that serves Pacific people and three reported accessing some other Pacific health service. Two HHSs reported that their only access to Pacific languages interpreters was through the main hospital.

Only one of the four HHSs with a Pacific mental health service catered for people in crisis during the day. The remaining three HHSs with a Pacific service used their crisis service with input from their Pacific service, such as help with cultural assessments, interpreting if needed, and home visits. All four HHSs used crisis teams in the evenings and at the weekends, rather than their Pacific services.

¹⁰ Five HHSs had Pacific populations that are greater than the 6 percent representation of the Pacific population in the general population. Those areas are West Auckland (Waitemata DHB), Central Auckland (Auckland DHB), South Auckland (Counties-Manukau DHB), Hutt Valley (Hutt DHB) and Wellington and Porirua (Capital and Coast DHB). In the remaining HHSs, Pacific people made up less than 2.4 percent of the total HHS population.

Section 4: The Views and Experiences of Service Users/Tangata Whai Ora and Family Members

The views and experiences of service users are critical to this review. They have clearly identified problems and shortcomings in services that struggle to respond and provide them with support. Service users' needs must be fully understood and considered in developing more effective and responsive crisis services. Similarly, it is important to understand the experiences and perspectives of family members as they may play a vital role in the initial identification of a crisis, subsequent assistance with care, and recovery.

It should be recognised that while the views of service users/tangata whai ora and family members are covered together in this section, they do not always have the same views and interests. Service users and family members share some common interests in the responsiveness of services and the recovery of people experiencing a crisis. But there are nevertheless potential tensions between the interests and experiences of service users and their families. One obvious area is around decisions about forced compulsory entry to a service, particularly inpatient services, and another is around the access of family or friends to information about the service user.

4.1 Service users' views and experiences

In all, 55 service users took part in the focus groups conducted for the review. Although some service users declined to participate, a range of views were obtained from service users during the site visits. A consumer adviser perceptive was gained through a meeting with the NAHHSCA in Rotorua in November 2000. Consumer advisers who attended the meeting were involved with a number of hospitals and identified several areas where improvements in service delivery are needed.

Service users outlined various experiences with crisis services, which they said ranged from excellent to inadequate. In general, service users had higher expectations than services delivered, and while strengths of services were identified, at times they felt that delivery fell well short of required standards. When delivery is inadequate, the consequences can be disastrous and traumatic for individuals and their families.

Service users reported both strengths and weaknesses in some particular aspects of crisis services. For example, they commented both positively and negatively about staff skills and attitudes, crisis respite, service responsiveness and the involvement of police. Service users also noted that service quality and consistency was often variable within particular services, as well as across services.

4.2 Family members' views and experiences

Family members were interviewed as part of the site visits. The views of family members ranged from being very satisfied with crisis services through to very critical. Like service users, family members had expectations of what should be available and considered that delivery was not up to standard in some respects. For example, some family members noted that there appeared to be a considerable gap between the respective mission statements of HHSs and mental health services and the reality of what happens 'on the ground'. Family members also reported both strengths and weaknesses in some particular aspects of the service.

4.3 Service user and family satisfaction feedback mechanisms

It should be noted that the majority of services do not appear to have routine or regular ways of gathering information on service user/tangata whai ora and family feedback about services. Just over one quarter of HHSs provided to the review team their protocols for obtaining views about family satisfaction with crisis services, and just over one third provided protocols for obtaining consumer/tangata whai ora views (see Table 3.1 in Section 3).

4.4 Strengths of crisis services

“Very honest ... very genuine ... very helpful. They visited my home; I could build up trust with them. It was great that I could talk confidentially without having to enter the system. I could keep my independence without getting a label.” (Service user)

“Services do need encouragement, we always complain about what they do wrong but we rarely turn around and say what was right!” (Service user)

Service users reported some positive experiences and identified aspects of crisis services that were working well. These were:

- staff expertise and commitment
- police involvement (although this was not a positive experience for all service users)
- crisis respite
- relapse prevention plans and crisis plans (including advanced directives).

Family members also reported positively on some aspects of crisis services, and in particular the inclusion of families by some services.

Staff expertise and commitment

In general, service users considered crisis staff to be dedicated, skilled and hard working. Service users acknowledged that the work can be very stressful for crisis staff and they often do the best they can. They reported that many staff are responsive, supportive, helpful and good at fully informing services users. In one area service users felt that crisis services were trying to take on board what service users say. Designated triage staff were seen as very effective, particularly in areas where crisis services were integrated with other mental health services.

There was also a view that staff were knowledgeable. Service users in some areas considered that the MHA process was properly enacted by staff.

Police involvement

Some service users reported that crisis staff and police worked together well. In one place police, especially community constables, were seen as supportive and helpful. Other service users in one rural area thought that police were the best people to contact first when in crisis, because they knew they would at least get a faster response than that provided by the crisis service. Although those service users noted a good response from police, they did not see police involvement as a desirable substitute for the crisis service.

Crisis respite

Service users saw crisis respite as very effective and welcomed this alternative to going to hospital. Crisis respite was seen as a useful option within the range of acute treatment services.

Crisis respite was considered to be working extremely well in all areas visited, however availability was limited and people commented that more crisis respite options were needed. The NAHHSCA saw the availability of crisis responsiveness as very important.

Crisis/relapse prevention plans

Service users saw relapse prevention plans and crisis management plans as useful, where they are used. They suggested that more use of relapse prevention plans is needed as it is one way in which service users can gain insight into their own crisis. Even better is the concept of a “collaborative crisis plan” between service user and staff.

In mental health care in New Zealand advance directives are currently being discussed and debated in professional and service user forums (Fowler, 2000). Advance directives are an example of partnership between clients, their families and mental health service staff. Advance directives are a written document, detailing an individual’s wishes and preferences in relation to health care and treatment. This document is for use at a time when the individual is unable to clearly articulate his or her wishes. The application of advance directives in mental health care may extend to preferences regarding medication, preferred treatment setting, and who information can be shared with, as well as other aspects of care and treatment.

Currently advance directives are rarely used, although templates are available. They are not written into mental health legislation and have not been tested in the court system. However if a service user with acute mental health needs produced an advance directive, their preferences for care and treatment could aid mental health professionals in the provision of care.

Inclusion of families

“I have nothing but praise for them.” (Parent)

Family members acknowledged that overall services were improving in the way they worked with families. Feedback from family members in two site visits was very positive. Family members appreciated being believed when they approached the crisis service, being included in the process, and being informed about such matters as the nature of the illness, medication, local support groups, and options for available practical help.

Some parents reported receiving excellent service from the crisis team. They appreciated the efforts of staff in a time that was very distressing for all. Some family members reported feeling like they were working in partnership with clinical teams, towards the common goal of recovery for their son or daughter.

Some family members said they had received good written information, practical advice and support. They were linked into the local family support organisation. Appropriate information and support was considered to be very useful in times of crisis when distress and anxiety are high for all involved.

4.5 Areas for improvement

"A person needs to be looked at as if this is a person that needs help but so often resources are used for not doing anything." (Service user)

Despite some positive comments, service users identified a wide range of areas where crisis services could be improved. Service users and the NAHHSCA group considered that, while crisis services are critical to the overall working of the mental health sector, they are the weak link in mental health services. There is a sense that crisis services are under the most pressure, yet they have the least resources, in terms of funding and staff. They cited instances of crisis services under pressure because of difficulties accessing inpatient or respite beds, supported accommodation, emergency accommodation and other community and health services.

Family members also identified areas where services could be improved. They recognised that crisis work is very stressful and believed that crisis staff should be well supported and resourced in order to perform well.

The following issues were highlighted:

- problems in accessing services, including lack of information about crisis services
- inappropriate use of the Mental Health (Compulsory Assessment and Treatment) Act
- inadequate after-hours care
- shortcomings in crisis respite
- problems with interfaces between crisis and other services, such as accident and emergency facilities, police and DWI
- inadequate provision of services in rural areas
- inadequate staff numbers, retention and training
- an overall lack of service responsiveness, particularly for some groups and individuals.

4.6 Access to services

Service users' comments about access to services focused on:

- information about crisis services
 - the threshold for intervention
 - response time
 - use of telephone for entry and assessment
- availability of different service options.

Family members raised issues about lack of information about crisis services and slow response times.

Information about crisis services

Service users commented on a lack of information about what crisis services do, and for whom they provide services. They wanted an adequate range of services and clarity about what is provided. Many service users were unsure about what the criteria are for a "crisis" in order to be accepted by the crisis service. Some service users thought that there should be a universally agreed definition of a crisis that is clearly communicated to the public.

Some service users said there were difficulties in identifying who to contact when in crisis. This was especially difficult in some rural areas, as well as being a problem for new service users.

The NAHHSCA pointed out that if crisis staff consider some calls to the crisis service to be “inappropriate”, then sometimes it is because the purpose and activities of the service are not clearly conveyed to the public.

Family members also wanted clarity about the criteria for a “crisis” and entry into the service.

The threshold for intervention

“There are no rights or protection for people who are not under the Act – sometimes you don’t get into hospital, you just end up in respite or you get left at home.” (Service user)

Service users perceived that the threshold for intervention of ‘harm to self or others’ is too high. There was also concern that some crisis services narrowed their focus of intervention to individuals who met the criteria for invoking the MHA (see 4.7 below). It was particularly noted that the threshold was too high for rural areas, where in general there are fewer mental health and accident and emergency services available.

Some service users felt that they were given contradictory messages. On the one hand they were asked to take responsibility identifying their early warning signs, yet when they contacted the crisis team they were often told they fell below the threshold for assistance. This was particularly frustrating for individuals who did not receive help, and who were then later admitted under the MHA.

Some service users who already had contact with a community mental health service, e.g. through a case manager, felt that the crisis service did not see them as a priority and expected them to get help through their existing contact.

Service users considered that there are different types of crisis and would like services to be more flexible in responding to those needs. One service user commented that there are two ‘layers of need’ – one is acute crisis where people need to be seen face-to-face, and the other is a different (but as important) layer where people need someone to talk them through their crisis using telephone counselling skills. Appropriate telephone counselling may prevent an acute crisis.

Response time

“All this delay increases the risk, there is a decline in your sickness and things get worse with your family/whanau or where you are living and there is more risk of harm.” (Service user)

At times contacting a crisis worker is very difficult. Service users viewed the service specification criterion for response time for assistance under the MHA, of 90 percent of people to be assessed within four hours, as too long in a crisis.

Service users generally viewed after-hours response times as too long. Some service users were concerned that only one staff member had visited the person in crisis, when the requirement is for two staff to attend call-outs.

Service users said that at the very least, their telephone call should be acknowledged. In their experience people were often left not knowing how long they would have to wait for assistance, or whether the crisis service would return their telephone call at all.

Family members were also concerned about slow response times that were far longer than specified times, and about only one staff member attending call-outs.

Use of telephone

"It's not written down anywhere but it seems that if you can ring up yourself you can't really be in crisis." (Service user)

Some service users considered that recorded telephone messages were inappropriate for crisis services. An example was given of a person who left three messages on an answer phone over a 15-hour period before being contacted by crisis staff.

Other comments related to the mechanisms for filtering calls after 10.30 pm or 11 pm. In several areas after-hours inpatient unit staff answer calls and undertake triaging when crisis staff are unavailable. Service users commented that some inpatient unit staff appeared to be doing this work half-heartedly. Other staff were considered to ask too many questions before they would act.

There was also a sense among service users that some crisis staff "play down" the seriousness of callers' situations or do not believe them. Service users acknowledged that crisis staff have to prioritise calls but some service users felt that it was not always possible to make an accurate assessment by phone and that more face-to-face assessments are needed. Telephone triage was considered to be over-used. A general view was that there are too few face-to-face assessments done in the person's home.

Lack of availability of service options

Service users gave several examples where no or few service options were available for their particular needs.

Some service users wanted alternatives to admission to hospital. In those instances hospital admission was seen as adding to the trauma of the crisis. This was particularly true for Maori in rural locations where admission meant they would be distant from whanau. Yet for others, admission to an inpatient unit was seen as a positive turning point in a person's life.

The particular needs of sole parents with children were raised. Their family responsibilities are not always considered when crisis services conduct triage and plan admissions.

One service user commented that the importance of maintaining employment and managing contact with the employer while accessing services was often not acknowledged, much less addressed.

4.7 Use of the Mental Health (Compulsory Assessment and Treatment) Act 1992

“Crisis workers seem to ‘section’¹¹ people at the drop of a hat and this has a detrimental effect on the person concerned, it can be a real set back in a person’s recovery. Instead of proper risk assessments they seem to ‘section’ for the safety of the workers.” (Service user)

In their experience, services users found that use of the MHA varied. They considered that in some instances the MHA is invoked too quickly, rather than exploring other options. Examples were given where the MHA had been used as a threat if the individual did not comply with requests to answer questions. Service users in one rural area thought that the MHA was used more for the safety of workers than for service users, as it allowed workers to involve police.

In some sites crisis staff appeared to have few other options for assistance if the MHA is not used. One rural service user considered that the service would only intervene if a person was doing harm to themselves or others, and if that were not the case there was no legal basis for intervention.

In general, service users pointed out that being ‘sectioned’ had an adverse effect on them, and was often regarded as a set back to recovery. They identified a pressing need for people who are treated under the MHA to receive detailed information on the MHA and its implications for them. Service users were also keen for staff to receive more training on the MHA.

4.8 After-hours care

Service users pointed out that people are more likely to become distressed during the night, precisely a times when services appear to be least able to provide prompt and responsive services. Service users emphasised that there is a slow response after-hours, especially on Friday nights and weekends. It was thought that more on-call staff were needed after-hours. Service users also noted that in general, crisis services have to cover for other services (such as child and youth, older people’s and alcohol and drug services) after-hours, which adds to the stress on crisis teams.

Some service users have experienced problems with inpatient staff handling crisis calls overnight, and considered that more inpatient staff expertise in crisis work was required. Service users also identified a lack of cultural support for Maori and little involvement of kuia and kaumatua after-hours.

Family members were also concerned with slow response times after-hours and the lack of staff available after-hours.

¹¹ Being compulsorily assessed and treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

4.9 Crisis respite

"If you are too psychotic or too elevated it is not the place to be – you feel unsafe, particularly with other residents there, you can trigger someone else off and if the staff can't cope with it, then they ring crisis [services] or the police."
(Service user)

While service users were generally positive about crisis respite services, they nevertheless identified some problems with variation in the quality and availability of crisis respite. There was also a concern that crisis respite could be used inappropriately as a substitute for other care.

Service users identified an overall shortage of crisis respite and wanted the length of time for crisis respite extended to more than the usual three-day limit. In particular, there is little or no access to crisis respite in some rural areas. The NAHHSCA group was concerned about lack of funding for crisis respite.

Service users also wanted more options for crisis respite to be available. Questions were raised about the suitability of crisis respite being located within supported accommodation where residents have different needs. The use of retirement homes for young people was also seen as inappropriate. The NAHHSCA group perceived that crisis respite is sometimes used, not for the service user's benefit, but to fill service gaps, when hospital beds are unavailable.

Several service users and the NAHHSCA observed that there is a lack of trained and appropriately qualified caregivers in crisis respite, with a particular need for more Maori caregivers. The NAHHSCA noted a need for clear information on job competencies, skill and qualification requirements. The NAHHSCA also commented on inadequate pay in crisis respite.

4.10 Interface with other services

Service users noted that where regular liaison meetings and/or protocols were in place between services and agencies, the relationships seemed to work reasonably well and to assist expectations of each other, referral processes, and information exchange.

However, service users also identified a range of problems with the interface between crisis services and other services. Sometimes problems were experienced in moving between crisis and other mental health services. Several service users commented that their follow up after the crisis was not well handled. They found that no clear plans were made for interventions. Where relapse plans were in place they were not always followed by crisis services.

Service users have also experienced problems with the interface between crisis services and other health and social services, including accident and emergency services, police, and Department of Work and Income.

Some family members noted that information is not passed on to the clinical team undertaking the continuing care of their son or daughter after a crisis. They also commented critically on the use of accident and emergency facilities for crisis work.

Use of accident and emergency facilities

"It is very disempowering to see them [crisis staff] in the Emergency Department – it is distressing waiting in the open room for a person distressed, suicidal or psychotic – being left there waiting is the equivalent to leaving a person in pain." (Service user)

"There is a lot of discrimination against people presenting with apparent substance induced states, and suicides. Proper triage doesn't happen, just put an automatic lumping of people into the 'mental line'. Staff attitude and understanding is limited, particularly about people who are distressed. There doesn't even seem to be a willingness to change practice. There needs to be proper space and privacy for assessments." (Service user)

Service users criticised the use of accident and emergency facilities for crisis work. It was reported that one area uses accident and emergency facilities for most crisis work after 5 pm. People were expected to go to the emergency department where the crisis worker would meet them. This resulted in transport problems for service users. Although the service would pay for a taxi, service users considered this to be unsatisfactory, as they felt vulnerable being picked up by an unknown taxi driver when they were unwell.

The NAHHSCA pointed out that sometimes accident and emergency staff immediately refer a person with a psychiatric history to mental health services, without addressing their medical needs. This can happen when a person arrives requiring attention to a range of problems and where the physical problem is not clearly evident, or there is accompanying emotional disturbance.

Family members commented that sitting for several hours in an emergency department with a very agitated and unwell person was distressing for all concerned. One family said they were told "if we come to your house we will have to commit him". Consequently, the family felt that was a threat, and that there was no other option but to go to the hospital's accident and emergency department.

Involvement of police

"It is not good to be told 'ring the police' when you need a mental health service." (Service user)

"When police come out they are 'the muscle'. Clinicians need to be able to tell police to calm down. Police need to be more clinically aware of how to deal with people who have a mental illness rather than just upholding the law." (Service user)

Although some service users had positive experiences with police, others queried their involvement, and there was a view that on occasion police are inappropriately used.

Some service users believed that police should have a warrant before they enter a house, although police can enter premises when requested to do so by a Duly Authorised Officer. Clear information to service users and greater awareness by mental health workers and police about the impacts of entering a house on the service user would help in managing situations where police were required to enter homes.

Service users commented that people are not informed about when the use of police might occur. Many people are frightened of police and their presence may escalate the situation. There are also safety concerns. Some women commented that they preferred women police officers, or at least one woman officer, to attend. Service users wanted to see police receive more training on mental health issues. However, it was also acknowledged that some police officers are well informed about mental health issues and relate well to people in distress.

Sometimes police are called out rather than the crisis team if there has been past violence or threat of violence. On other occasions police cells are used for individuals in crisis, particularly those who are intoxicated. Service users considered that police are relied on to provide after-hours services because of a lack of crisis staff. One rural service was reported as only having one person working after-hours who did all assessments at the local police station. This was regarded as an inappropriate venue for conducting mental health assessments. In another location family members reported ringing police first in a crisis, as past experience suggested that they could not rely on the crisis team attending quickly.

Department of Work and Income (DWI)

"A crisis can happen anywhere ... the policies of government agencies don't reflect the people they have to deal with ... in the last year there have been five tangata whai ora who have received trespass orders put on them by WINZ."
(Service user)

Some service users have found that DWI staff lack knowledge and understanding of the needs of people with mental illness, and require training in how to work more effectively with them.

4.11 Rural issues

Service users and family members generally agreed that services in rural areas were inadequate. They raised a wide range of issues including:

- very slow response times
- lack of information about how to contact a crisis service
- a lack of crisis respite and accommodation options in rural communities
- problems of staff capacity
- transport difficulties experienced by both users and services.

Service users considered it was unsafe for female staff to travel alone to people in crisis, as they were doing in some rural areas. Service users also considered that some cars used in rural areas were unsuitable for the conditions, and too small. They thought that larger four-wheel drives were more appropriate.

The NAHHSCA commented that in rural areas there is a heavy reliance on GPs who may have inadequate skills and scant knowledge of mental health issues.

Maori service users raised a number of rural issues. They found it particularly difficult to access services. It is common in rural areas of high Maori population for people not to have telephones or cars. They cannot be easily rung back by the crisis worker; nor can they easily go to the service. Maori service users pointed out that illiteracy hampered some individuals in accessing services. Some had also experienced difficulties in accessing supported accommodation, particularly urgent accommodation. Service users in two rural areas with a high Maori population referred to the use of back-packers accommodation because of a lack of alternatives, such as NGOs providing accommodation in the area.

Maori service users in one rural area noted a high turnover of medical staff, and staff lacking in understanding of cultural issues.

4.12 Workforce issues

In all areas, service users and family members said that more crisis staff were needed, particularly overnight when most crises are likely to occur. Service users and consumer advisers acknowledged the difficulties crisis service staff have covering their areas. They also commented on the high rate of staff burnout and staff turnover.

Service users were concerned that there be an appropriate mix of men and women staff, and adequate representation of Maori and Pacific staff. Some service users observed that some medical staff who have been trained overseas appear not to acknowledge or understand cultural issues, and consequently it was difficult for them to assess people adequately. Training for crisis respite and inpatient staff was also identified as needed.

4.13 Responsiveness

“They come in like a whirlwind, and do more to escalate the situation than calm it down.” (Service user)

“The approach of crisis workers towards tangata whai ora in a crisis situation needs to change. There needs to be more compassion and understanding ... staff may have been in many crisis situations but for the person concerned it is often new and frightening, however crisis workers don’t seem to take this into consideration.” (Service user).

Service users identified a wide range of areas where they felt services did not respond to people’s needs. Some of the issues identified affect all service users, while other issues are particular to certain groups of users.

In general, service users identified the following shortcomings in the responsiveness of crisis staff:

- poor judgement on the part of crisis staff, which resulted in escalating the crisis
- staff not listening to the service user
- staff not believing the service user. This is particularly when a person is defined as not meeting crisis service entry criteria.
- a lack of awareness by staff about how frightening a crisis is for people
- the need for crisis staff to have more understanding and empathy
- staff becoming de-sensitised to crises, so that they “stop listening or begin not to listen” over time.

The NAHHSCA commented that crisis services appear not to be driven by the needs of service users, but rather by the requirements of contracts, service constraints, (such as the availability of beds or respite care) and staff skills, experience and availability.

Service users thought that services would be improved if those with experience of using the crisis service were able to work alongside crisis staff, and if opportunities for staff training were increased.

Responsiveness to Maori

The criticisms that Maori have about crisis services are similar to those of service users in general. However, Maori service users also identified issues particular to their experiences and needs as Maori.

Maori service users and their whanau considered that the crisis team should include Maori workers to ensure culturally safe processes for Maori, especially when MHA processes are used. They supported the involvement of kaumatua and tangata whai ora on visits. It was felt that Maori would wish to deal with a crisis themselves, or with the help of known networks. There was some concern about being taken away from whanau.

However, some Maori whanau reported difficulties with services for Maori. One family stated that the psychotic symptoms of a young Maori woman with schizophrenia were not recognised by the Maori crisis team but rather assessed as “behavioural problems”. Other family members in the same area believed that Maori are less likely to be admitted to hospital via the Maori team, as admission is seen as not “healthy” for Maori service users. The family members also pointed out that no effective alternative treatments appeared to be available.

Responsiveness to Pacific people

Many of the issues for Pacific people are similar to those raised by other service users. However, there were some significant access issues for them. Pacific service users noted that there are very few services available specifically for Pacific people and there are not many Pacific staff working in crisis services.

Pacific service users emphasised the importance of family involvement throughout the process, and wished for greater staff recognition and understanding of Pacific cultures. They also said that there needed to be better access to interpretation services.

Specific needs

Service users identified certain individuals who did not receive good service. There is an impression that crisis staff avoid working with people with borderline personality disorder. Service users further observed that crisis workers “don’t want to know about” individuals who are intoxicated. They said that a process is needed to ensure intoxicated people are safe rather than being left in police cells.

Families gave examples where crisis teams were unresponsive to the needs of children and young people. They suggested that a separate crisis team for children and youth may need to be established in cities that have the population to sustain them.

Responsiveness to families

Family members criticised crisis services for failing to include them, a lack of information about crisis services, and the length of time spent waiting for the crisis staff to attend an often very distressing situation.

Carers and family members observed that they would like to be taken seriously when they call for assistance, and that they are given credence for the changes that they notice in someone who they know well. They talked about the importance of “being believed and respected”. Family members generally know their son or daughter well and thus need to be believed and have their opinions respected when they ring the crisis team.

Some parents thought staff were misusing the Privacy Act because they were unable to get information about their son or daughter, such as a report on their progress. Even if the young person or adult had stated that they did not want their parents to know (e.g. in the case of an overdose), parents believed it was their right to be told at least a summary of the situation.

Section 5: Key Themes and Issues

5.1 What is working well

The main areas that stakeholders identified as working well in some respects are:

- acceptance of the National Mental Health Standards
- the establishment of memoranda of understanding between crisis mental health services and other services
- the establishment of clinical service protocols around certain aspects of delivery
- crisis respite.

It should be noted that stakeholders also commented on the areas listed above in identifying where improvements are needed. There is no one component of crisis services that all stakeholders considered to be successful in all respects. Consequently, those areas that are identified as working well are also discussed in reference to aspects needing improvement.

5.2 Areas for improvement

While all stakeholders considered that crisis services play a crucial and valuable role that underpins mental health services, they nevertheless expressed a wide range of criticisms about the ability of crisis services to be effective.

A variety of concerns were expressed about a lack of clear, comprehensive and consistent policies, service specifications and procedures at national level that could guide service delivery.

Significant problems were also identified around the everyday operation of services. These focused on:

- difficulties in accessing crisis services
- inadequate service coverage
- lack of service responsiveness
- lack of continuity between crisis and other mental health services
- interface problems around co-ordination, co-operation and the respective roles and responsibilities of crisis services and other health and social services
- workforce issues.

5.3 National policies and procedures

Stakeholders wanted a stronger framework of policies and procedures to guide the design, planning and delivery of crisis services. This includes such matters as:

- the need for greater clarity around service specifications, including the need for a statement setting out the core components of crisis services
- variable implementation of the National Mental Health Standards
- uneven development of clinical service protocols
- gaps in information system development, poor quality of data collection and lack of monitoring of crisis services.

Greater clarity around crisis service specifications

There appears to be widespread ambiguity and confusion about where crisis response sits in the range of community mental health services, what needs will be met by crisis services and what needs will be met by other components of the mental health system.

Service users, families, NGOs, GPs and police in general appeared to have a wider understanding and interpretation of what a crisis is than do crisis services, and consequently greater expectations of the scope of services that will be provided. Some clinicians, service users, families and caregivers expressed concerns that there is little understanding of the services provided by crisis teams. Some GPs reported being confused about the criteria for crisis service intervention and some NGOs were also not clear about the criteria for a 'crisis'.

Implementation of the National Mental Health Standards

There was widespread acceptance of the National Mental Health Standards by providers. Just over half the HHSs reported having fully or nearly implemented the National Mental Health Standards. However, they felt that little support or resourcing had been put in place to assist with implementation. There was perceived to be a large gap between national documents and planning for follow-up actions. It was suggested that there needed to be a well-planned and resourced process to ensure the continued implementation of standards.

Some HHSs noted reasons why implementation had been difficult. These included:

- the detailed and demanding work required to set up documentation systems
- lack of suitably qualified staff
- budget constraints
- lack of organisational support
- competing pressures from other requirements.

In 1999 HHSs were required to internally audit their services against the National Mental Health Standards and report this to the HFA. Only three HHSs sent this information to the review team as requested. One HHS noted that the audit was currently being done. Two noted that the crisis team was not audited separately.

Four HHSs reported other types of self-review. One HHS stated that it undertook a monthly internal audit of clinical files. One stated that it had undertaken an internal review of its crisis service in October 2000. Another HHS had done a document review using SGS Healthmark¹² against standards. One HHS had undertaken an audit of National Mental

¹² A third party accrediting organisation.

Health Standard 15 (Consumer Assessment) in October 2000. However, overall it appears that self-auditing is not widespread, as was intended by the HFA.

Furthermore, it was not apparent that external auditing of crisis services is widespread. Most HHSs had not been reviewed or monitored by the HFA. Only four reported having been reviewed and one reported that one of its two teams had been reviewed. Four HHSs stated that they had been accredited (e.g. by Standards New Zealand or Quality Health New Zealand). One HHS indicated that it had conducted a cultural audit trial in 2000.

Clinical service protocols

The review team compiled a list of areas and standards relevant to the operation of crisis services that were regarded as needing to be documented in the form of service policies or protocols. Clinical service protocols establish policies and procedures to guide clinical practice. Some HHSs had a useful framework for all policies. Their service protocols were developed with the advice of clinicians, service users and cultural input. They used a standardised (sometimes computerised) format and ensured the protocols were easy to understand by the use of flowcharts and simple language. Effective protocols were also up to date.

The large majority of HHSs provided to the review team their service protocols for “Triage and Prioritisation”, “Assessment”, “Risk Assessment”, “Communicating Extreme Risk”, “Inpatient Service Access” and “Complaints”. In addition all but one HHS provided their MoUs with police. All those MoUs included protocols around police transportation of service users. Some of the police MoUs were very detailed in terms of roles and responsibilities at the local level whereas others were modelled on the national level MoU between the Ministry of Health and the New Zealand Police.

The review team recognises that the range of policies and protocols that HHSs were asked to provide are not necessarily required of crisis services. There are some for which compliance is expected, such as the Ministry of Health guidelines for review and reporting of incidents, and the national MoU with the New Zealand Police. Somewhat surprisingly however, some key safety matters of relevance to crisis services, such as number of staff for a call-out, critical incident debriefing, critical incident review, MHA implementation and access to clinical notes, appear not to be supported by documented standards in many services. Nearly 20 percent of services do not appear to have protocols or policies in regard risk assessment, another key area of attention for crisis staff.

Almost all HHSs did not appear to have protocols around areas of responsiveness. In particular, very few HHSs provided to the review team their service protocols for “Cultural assessment – Pacific” and “Protocols for Minority Groups”. Similarly few HHSs appeared to have service protocols for seeking service user, family and staff feedback. Only one HHS provided a “Pre-Planning for Crisis” protocol that outlines a system for ensuring the service user had the opportunity for stating what actions or treatment were wanted if he/she became unwell.

It is difficult to be clear of the significance of these findings. Although a systematic assessment of the quality of the protocols was not undertaken, some general observations can be made:

- there was little shared information about service protocols within or across HHSs.
- in HHSs with more than one crisis team each team had different protocols reflecting different practices (e.g. different criteria for entry).
- within some HHSs there was no consistency in the way their protocols were written

- some protocols were confusing and often out-of-date
- some protocols appeared to have little clinical, cultural or service user input into their development.

Given the apparent importance of consistency of responses of staff involved in crisis work, both within services and across the country, there may be opportunities for co-operation between services in developing uniform policies and protocols. Sharing examples of good protocols among DHBs may advance the development of service protocols. In addition the input of consumer advisers and cultural advisers should be encouraged.

Information system development and data collection

This review sought a range of data from HHSs. It is clear from the variation in their responses and inability to respond to several questions that most mental health services' information systems, whether computerised or manual, do not allow for complex data requests. A wide range of basic information was not collected in some HHSs, and over all there were significant gaps in information collection. Data also tended to be patchy in quality.

The review found the following significant information gaps:

- 11 HHSs did not collect ethnicity data and four could provide estimates only.
- 11 HHSs did not provide age data and two could only provide percentages in each age group.
- 17 HHSs did not collect any information on diagnosis or could provide estimates only. Only one HHS was able to provide detailed information on diagnosis and three others gave some data. A national picture of diagnosis could not be gained.
- Most HHSs were not able to provide information on how many first contacts were MHA related.
- The accuracy of data obtained on the number of Section 8s is unclear.
- Only one service was able to provide information on whether the crisis was a new presentation, or acute exacerbation of serious mental illness.
- 11 HHSs did not give data on the average number of contacts per clients. Data on first and follow up contacts with clients was not collected by 13 HHSs.

A number of staff identified specific deficiencies in HHS operational systems for data collection and recording. These included:

- collection of clinical data being added on to systems developed for other purposes
- use of both paper-based and computerised systems for data recording
- problems in the way information is entered
- use of clinical staff to enter information
- lack of efficient ways of recording text information
- considerable variation in the capability of HHSs to computerise medical records.

Difficulties in gathering data for this review illustrate general problems in monitoring crisis services. Currently it is difficult to monitor either the quality or quantity of crisis services delivered. Monitoring of crisis services is hampered because of the way that those services are purchased, as part of adult community mental health services. Monitoring consists of regular reporting by HHSs of total community FTEs against the contracted amount. There is little ability to identify crisis service activity within the context of community mental health services as a whole. Only the total dollars spent on community mental health services and total crisis respite dollars can be described. Furthermore, even those few reporting

requirements that are relevant to crisis service activity are inconsistently achieved because of the poor state of reporting nationally.

5.4 Difficulties in accessing crisis services

Difficulties in accessing crisis services stood out as the key concern of many stakeholders. Poor access was not only a significant barrier identified by service users and their families, but also mentioned by NGOs, police, and GPs. Frustration about access to services after-hours was particularly high, and is dealt with as part of deficiency in service coverage in 5.5 below. The main problems of access revolved around:

- use of the MHA to determine entry to the crisis service
- lack of information about how to access the crisis service
- poor response times
- over-reliance on telephones for assessment
- inappropriate use of accident and emergency facilities.

Use of the MHA to determine entry

In some areas there was a view that criteria for the compulsory provisions of the MHA needed to be realised before crisis response was appropriate. Over time day-to-day activities in some services have narrowed to focus on the MHA, with a tendency to set a response threshold that is determined by criteria for entry to the compulsory provisions of the MHA. In those circumstances, legislative requirements rather than clinical need may drive responses and actions of crisis services.

It should be acknowledged that some services did not focus solely on the MHA, and employed ongoing therapy or interventions beyond the crisis resolution. A few services described a wide range of interventions and therapies, including relaxation, stress management and supportive psychotherapy.

Lack of information

Access problems start at the fundamental level of not knowing how to access a crisis service. It is not always easy for the public to find out about crisis services and how and where to access them. For example, the way in which services are listed in the telephone directory varied considerably from region to region. Many people do not know the name of their HHS, yet most crisis services were listed under the HHS. There was also variation in HHS use of brochures, newspapers and other media to advertise services.

Staff held diverse attitudes towards the provision of information about crisis services, ranging from support for public dissemination of information, to concern about possible inappropriate use of the service if it is too widely known. One area reported that the access to the crisis service through an 0800 number resulted in them being “too available”, with non-crisis calls “clogging up” their system. Some crisis service staff referred to “lightweight” calls for assistance, which they thought fell short of the threshold for crisis response, but which they acknowledged were directed to them in the absence of other services, especially after-hours.

Response times

The expectations that service users, families and other agencies had of appropriate timeframes for response tended to be shorter than crisis service staff felt they were able to meet. There was a huge variation among HHSs in the average time length between initial contact and first face-to-face assessments. Variation was related to the FTEs per 100,000 population served and dispersal of population. Response times were longest in rural areas. Stakeholders considered that response times after-hours were the most inadequate.

Use of telephones

The most common way of entering a crisis service is by phone. However, service users and families in particular identified a range of problems with the use of phones. Sometimes, particularly after-hours, the first point of contact is an answer-phone. Service users viewed the use of answer-phones and voice message systems for crisis services as inappropriate.

Once a person has entered the crisis service by phone, a triage process is undertaken. Service users felt that telephone triage was over-used, although it was recognised that calls need to be prioritised. In general, service users wanted more face-to-face assessment. There were wide variations among HHSs in estimations of percentages of face-to-face versus telephone interventions. One HHS estimated that only 13 percent of people are seen face to face.

Telephone triage appeared to work best when designated triage staff (clinicians who screen and assess all calls) are used. They are able to provide continuity of service, know service users and referrers, such as GPs, and become familiar with the range of available resources in the community.

Use of accident and emergency facilities

All services were able to offer direct assessment, at the person's home or at other community locations. However, this does not always happen. In a few cases, an accident and emergency department has been the point of access for the service user.

Accident and emergency services were not a specific focus of the review but several comments were made about the interface between crisis services and accident and emergency facilities. One area used accident and emergency facilities for after-hours crisis mental health activities. Although staff in that area regarded this as a good solution, service users, families and police commented negatively on the use of accident and emergency facilities for crisis work.

Crisis service staff reported that some accident and emergency staff were reluctant to deal with service users. Some clearly lacked knowledge about mental health issues, and stigma surrounding mental illness was also an issue. Furthermore, the accident and emergency department does not provide a calm and private environment for service users to feel safe when unwell. Some crisis staff, particularly in large cities, did not favour the use of accident and emergency facilities, as they considered people who present with mental health problems would be seen as low priority.

5.5 Inadequate service coverage

Stakeholders identified inadequate service coverage as a key issue. They emphasised the following shortcomings in services:

- patchy after-hours coverage
- inadequate coverage of rural areas
- lack of processes to deal with non-urgent calls.

After hours coverage

All stakeholders were concerned with deficiencies in after-hours coverage, from 10.30 pm onwards and at weekends. Stakeholders thought that in general, after-hours service was inadequate, that response times were too slow and that more on call staff were needed. Police in particular considered that more crisis staff on-call overnight were needed. Some staff reported that higher levels of burnout occurred for staff who provided after-hours crisis cover.

There was little or no access to Maori or Pacific support services after-hours. Staff from services providing Maori or Pacific services agreed that an increase in cultural input was needed after-hours, as well as during the working day.

Rural areas

Almost all stakeholders – HFA, police, service users, families, GPs, crisis service staff, NGOs – identified a clear lack of service provision in rural areas. Crisis service staff reported the demands of covering large areas as a considerable source of stress for them.

The key issue was the distance needing to be covered by a crisis team, with the average of over three hours travelling time to respond to a service user. NGOs in particular noted that access after-hours appeared to be very slow in rural areas.

In rural areas more work was done by telephone and more often police were involved. Police noted that if some HHSs had cars that were larger, and/or four wheel drives, then less police time might be used in transporting people. Police reported that, sometimes, crisis staff in one area had suggested to distressed families that ringing police would guarantee speedier action.

Non-urgent calls

In general, service user views of appropriate threshold and response differed from the views of service providers. In particular, service users identified a need for a level of response short of a crisis service, but more immediate than waiting for ‘routine’ assistance from a community mental health service.

Some staff of crisis services were aware of those needs, but referred to them as “lightweight” calls for assistance, which they felt fell short of the threshold for crisis response. Often such needs were directed to them in the absence of other services, especially after-hours.

If crisis services focus solely on crisis assessment, referral and acute community treatment, then a process for undertaking less urgent work is needed. This process would cater for those not needing MHA intervention, but needing a higher level of input than that provided by the community mental health service. There may not be the capacity within the range of community mental health services to respond to varying types and intensities of crisis. It

appears from the review that there is variation across the country in the ability to respond to all types of service user needs.

Suggestions for addressing a level of non-urgent need included:

- establishing a “warm-line” alternative to crisis services. Such a service could include peer support and counselling and involve service users. It could also provide non-urgent clinical advice, for instance about medication.
- providing training for crisis staff in communicating with people who do not meet their entry criteria
- providing good information to stakeholders about crisis service entry criteria
- ensuring good co-ordination between crisis services and other community mental health services
- extending the hours of non-crisis community mental health services beyond 5 pm.

5.6 Responsiveness to service users and families

Services are increasingly aware of the need to be responsive to service users, and their families. All HHSs reported that families are involved at the first point of contact and many commented that more efforts are being made to involve families in the management of a crisis, including Maori and Pacific families.

Responsiveness to Maori

Although almost all crisis services have access to Kaupapa Maori services, several have few Maori staff. In rural areas where there are large distances to cover, Maori cultural input may be ad hoc. However, most crisis services noted that strengthening Maori input was needed, preferably by having separate Maori crisis services in areas that could sustain these, or by increasing the availability of on-call cultural expertise.

Maori staff emphasised the need for crisis staff to understand that for Maori the experience of a crisis and the service process is very distressing. Maori are often fearful of being admitted to inpatient units as they do not understand what happens during assessment and treatment. Culturally appropriate information and support for tangata whai ora and whanau during all crisis processes are needed. Sometimes simple information on what is happening, what the MHA process entails, and what will be the outcome is not provided.

Responsiveness to Pacific peoples

Fewer services are available specifically for Pacific people and there are also few Pacific staff working in crisis services. Four HHSs have specialist services for Pacific people, although at the time of the review one of these had not appointed clinical staff.

Pacific staff said that ideally there should be a separate Pacific crisis team in areas that could sustain one. Where that was not possible, increased access to on-call Pacific staff was seen as important to ensure people’s needs are met. They also suggested that Pacific staff dedicated to working with Pacific people be attached to crisis teams. Both Pacific staff and crisis staff commented that sometimes it was difficult to ensure that Pacific input was available at the beginning of an assessment.

Pacific staff emphasised the importance of family involvement from the first point of contact with the service user. In addition, training of crisis staff in the basic customs and protocols applicable to each Pacific group was seen to be needed as some staff fail to recognise that different Pacific groups have different cultural processes.

Pacific staff said that there needed to be better access to interpretation services. Obtaining ad hoc interpreting services from any available HHS Pacific staff member was seen as inappropriate as most did not have mental health training. There were also instances of using Pacific NGOs for interpretation services, without paying them.

5.7 Workforce issues

Stakeholders highlighted problems with:

- staff recruitment and retention
- skill mix and team composition
- qualifications and training
- clinical review and supervision processes.

Staff recruitment and retention

Problems in recruitment and retention of skilled staff occur across the whole of mental health services and crisis services are no exception. The HFA noted that demand for crisis service staff outstrips the supply. All but one HHS stated that ideally they needed more staff and some HHSs noted a particular lack of Maori and Pacific staff. Managers and DAMHSs reported difficulties in recruiting and retaining skilled staff. GPs also considered that the numbers of crisis staff should be increased.

Service users and consumer advisers also considered there should be more crisis staff. At the NAHHSCA meeting it was noted that in some areas with very small teams it was difficult to ensure that there were two staff to attend calls. In other areas where the minimum standard of two to attend calls could be achieved there were few guidelines to assist with determining an adequate number of staff to meet demands on the service. Monitoring of staff safety needs to be improved.

The most common reasons given for needing to recruit staff were:

- to achieve adequate and safe nursing cover
- to improve skills in crisis work, including recruiting more medical staff
- to meet cover for sick, study and annual leave
- to prevent burnout of existing staff
- to meet *Blueprint* recommendations.

Skill mix and team composition

The HFA commented that difficulties in obtaining skilled workers was a problem for many regions. From the site visits it appeared that many staff in the larger cities had generally been working in crisis services for some time and were very experienced. However, staff in rural areas were less likely to be experienced.

The HFA service specifications state that crisis teams should be multidisciplinary. The majority of staff in services were nurses. However, there was some diversity. Two HHSs had used psychologists in the past for supervision of crisis staff and one HHS employed four crisis support workers who worked alongside clinicians. In an environment of staff scarcity

this is an option that might be explored by other areas, although clear roles and responsibilities would need to be delineated.

Mental health service managers and DAMHs in particular noted a lack of medical input into some crisis teams. One area had no psychiatrists and relied on Medical Officers of Special Scale¹³ and visiting locum psychiatrists. One HHS reported no medical cover after-hours except telephone consultation.

Qualifications and training

Training of crisis staff requires urgent development. It appears to have low priority and a low profile. Only two HHSs noted that some of their staff had undertaken crisis intervention training. In one HHS, four staff had undertaken a distance learning training programme from Australia. The other HHS reported that 80 percent of its crisis staff had undergone training. It is likely that this was internal training sessions as there is no training specific to crisis intervention available in New Zealand.

Fifteen HHSs reported that they had no separate budget for training of crisis staff but did have a budget for staff training in general. Two estimated a budget each of \$10,000, three quoted around \$4000 and one quoted \$40,000 which included training for medical staff.

No New Zealand tertiary institution offers training in crisis work. The only nationally consistent training for crisis staff has been in relation to the roles and responsibilities of DAOs. Nineteen HHSs described regular training sessions for DAOs. Most reported a bimonthly session with intensive training for new DAOs. Five HHSs reported using DAMHS to conduct training. This training was developed after the passage of the MHA. The DAO is only one (albeit important) component of crisis service delivery, and the extent of this training varies from area to area. Many other roles and functions within crisis services do not have access to formal training.

Neither *Tuutahitia te Wero Meeting the challenges* (Health Funding Authority 2000) nor *He Nuka mo nga Taitamariki: A national workplan for child and youth mental health services* (Health Funding Authority 2000) mention the training needs of crisis mental health services.

There was strong staff support for the development of standards in regard to the training and practice of crisis staff. Several mental health services called for the establishment of crisis competencies. There was also support for crisis staff receiving training on alcohol and drug issues, and child and youth issues. Training for crisis staff on issues specific to older people was seen as important as older people often have physical illnesses and complex medication regimes.

Training for Maori and Pacific mental health services staff in crisis intervention was supported. In addition the importance of cultural supervision for Maori staff was noted in both the survey and by staff in sites visits.

Managers' training was also seen as an area requiring attention. This would involve developing management ability to put in place appropriate systems and processes for supervision, staff support and management of interfaces with other groups. Some considered that managers need to improve their understanding of mental health issues.

¹³ A doctor usually experienced in psychiatry but without a psychiatric qualification acting in a senior medical capacity.

A range of stakeholders also raised the need for training of others involved in working with crisis services, including alcohol and drug workers and child and youth services staff. This could include training of staff in crisis intervention. Some police said that they would like more training in basic mental illness and related issues.

It is understood that nurse training for crisis work is starting in some DHBs in 2001. It is important that such training is consistent and co-ordinated across DHBs. In addition, the first national conference on crisis mental health work was held in May 2001. This provided a good foundation upon which other learning activities might be built.

Clinical review and supervision

The review found that there was little consistency among HHSs in the practice of staff supervision and clinical review. HHSs outlined a range of 12.5 percent through to 100 percent of team members in regular clinical supervision, with the average being 85 percent. All stakeholders saw clinical review and supervision as important, particularly as staff in crisis teams are viewed as working in an isolated way relative to other parts of mental health.

Clinical review is the process whereby there is a structured systematic consideration of assessment and treatment plans for each client, often as a joint process with a number of members of a multi-disciplinary team. This process is critical for the individual's treatment and recovery. In addition it is a fundamental part of 'on the job' learning that assists in the skilling and development of staff.

Staff emphasised that daily clinical reviews which involved discussion of the situations of current service users were important in ensuring the best possible care was offered and informing staff of all issues. While many HHSs noted that regular clinical reviews took place, as well as daily handovers and reviews of progress, other HHSs noted that a lack of available doctors meant that medical input into clinical reviews was compromised.

The review team noted that there was some confusion around what is meant by the terms 'supervision' and 'clinical supervision', and where these fit within a clinical accountability structure. For some, supervision was simply oversight and regular review of practice within the crisis activities. For others it was regular individual time with a supervisor separate from the crisis service for addressing professional or other matters that related to or impacted upon their crisis role. It could involve discussion around specific clinical situations with a senior colleague, or be undertaken in a group.

While some HHSs reported regular supervision of most or all staff, a few reported only a small proportion receiving regular supervision. Staff said that inadequate support was given for staff training, supervision and counselling. They also commented that staff supervision is easy to document as a policy, but more difficult to put systematically into practice. Sometimes supervision meetings are set up but often some other event takes precedence. Often debriefing does not occur. Site visits revealed a marked difference between policy and practice in some areas, with far fewer staff receiving supervision than policies outlined.

Clinical risk assessment and management

Clinical risk assessment and management are important parts of services for people with mental illness. Nearly all HHSs had protocols for risk assessment, some form of alert system, and management of risk. Some HHSs had very comprehensive processes and systems of documentation that could be shared with other HHSs with less experience. Most HHSs also have systems for the review of critical incidents, with some HHSs processes and documentation being very comprehensive.

Staff identified the need for robust processes of external reviews of practices through clinician involvement in supervision, clinical reviews, training, critical incident reviews and debriefing, and service user input. However, it appears that external review is not common in most areas and would be a good way of ensuring best practice.

5.8 Synergies between crisis teams and other mental health services

There was evidence of frustration, unrealistic expectations, misunderstanding of roles and unhelpful attitudes between teams within a single mental health service. Examples included crisis staff believing other services should provide more crisis response themselves; specialist teams being critical of how crisis services dealt with their clients; and inpatient service staff seeing crisis staff as too readily admitting people.

These problems appeared to be more pronounced in areas with little sharing of work, where relative roles and responsibilities were not clearly identified, where there was little appreciation or understanding of areas of expertise and where willingness to share this expertise had not been actioned appropriately.

The need for liaison and co-ordination between crisis teams and other mental health services, such as community mental health teams and inpatient services was apparent. Staff commented that protocols were useful to ensure that staff in crisis teams and community mental health teams were clear about processes for referral and clinical information exchange. Similarly, inpatient staff identified a need for protocols between inpatient units and crisis teams as a way of dealing with problems of unclear admission criteria and inconsistent responses.

Kaupapa Maori service workers commented that further development of protocols between Maori services and crisis services on such matters as cultural assessment and cultural safety would improve service provision for tangata whai ora.

Inpatient services

In most HHSs, crisis service staff decided whether people would be admitted to the inpatient unit. However, eight HHSs indicated that the decision would be made by a combination of people including the crisis team, a psychiatrist, the community mental health service inpatient co-ordinator or other community team member.

Despite service agreements, a number of crisis staff reported that they had difficulties in accessing inpatient beds, including 'regional' beds. In some areas respite was used as a less than satisfactory alternative to inpatient admission. In other cases, people already in hospital were discharged to make room for the new admission.

HHS survey data indicated that 8 of the 21 HHSs had less than the recommended 15 acute inpatient beds per 100,000 adult population. It is not known how many medium term and extended inpatient beds were available. The availability of acute inpatient beds ranged widely from 8.9 beds to 30.8 beds per 100,000 population, with a mean of 16.4 beds per 100,000 population. As a comparison, the *Blueprint* recommends the following resource guidelines for adults per 100,000 population (Mental Health Commission 1998: 99):

- 15 acute inpatient beds or 'care packages', and
- 12 medium term and extended inpatient beds or 'care packages'.

Inpatient staff expressed some frustration with crisis services that was generally related to admission criteria. They recognised that crisis staff are under pressure to find beds in urgent situations. To overcome some of the difficulties in managing demand, one area has developed a 'bed manager' role to prioritise referrals and co-ordinate discharge processes.

Child and youth mental health services¹⁴

Several services reported an "excellent" relationship between the crisis service and child and youth mental health services. Some child and youth services conducted training sessions with the crisis team. Others had developed agreed protocols for access between the services, and liaised regularly. One child and youth service provided a copy of a very comprehensive policy for accessing the crisis service after hours. It appeared that much work had been put into ensuring a smooth interface between the two services.

Areas with large populations highlighted a need for crisis services for children and youth, including a need for secure care, for which there is little provision. While a small number of beds were available, mainly in Starship Hospital in Auckland and the Child and Youth Unit in Christchurch, access in a crisis is nevertheless very limited in most areas. Crisis staff, service users and family members criticised the inadequate number of beds for children and young people. In particular, there was a high level of frustration with HHSs having to provide beds for young people in an adult inpatient unit. Other options used were paediatric units and medical wards with additional specialist nursing provided. However, all saw these options as inappropriate too.

A few HHSs had good respite options for young people. They had a budget, access to age-appropriate respite accommodation and nursing staff. But other HHSs had to place children and young people in adult respite. Three HHSs reported having no access to respite for young people. Some HHS had a budget and accommodation for young people's respite, but there were no suitable providers, trained nursing staff or support staff. They reported having to use unqualified staff. Four HHSs reported that new respite options were currently being worked on with the MOH.

Little provision for secure care was reported. One room in Starship Hospital may be used for secure care. Most HHSs reported having to access beds in adult inpatient units. In March 2001 an eight-bed unit opened at Canterbury Health District Health Board available South Island wide for young people up to eighteen years and older if still at school. However, whilst there are no designated secure care beds, it does include an intensive care locked area.

The need for suitably trained and qualified staff in child and young people's mental health was clearly an issue in some areas. Some child and youth staff noted that staff in crisis teams were not confident or trained in dealing with young people, and others observed that crisis teams in their areas appeared over-stretched. Child and youth staff also reported difficulties in having to liaise with more than one crisis team, each with its own constraints and abilities. Three HHSs reported not having a child psychiatrist, and three others wanted more psychiatrists to be trained in child and young people's mental health.

¹⁴ In 2000 the HFA changed the age range for child and youth services from 0–18 years to 0–20 years. This created an overlap with adult services for 18- and 19-year-olds. Consequently HHS services for child and youth cater for either those 18 years and younger or 20 years and younger.

Older people's services¹⁵

Overall, staff noted positive relationships between services for older people and crisis services.

One HHS identified a need for crisis services for older people. In that area there was no contract for older people's services, and no obvious expertise available for working with that age group, either in crisis services or in community-based organisations.

Most HHSs reported that they had access to inpatient beds for older people. Those that did not, accessed the general adult inpatient unit or occasionally medical wards.

In the South Island respite care for older people was usually provided in a rest home, but it was not necessarily the most appropriate option. Some HHSs reported that no respite care was available for older people.

HHSs identified secure care for older people as an area requiring further development. Only four HHSs reported that they were able to provide secure care for older people.

Some HHSs identified a need for specialised training for nursing staff and for respite staff in older people's issues. One HHS identified the need for a psychogeriatrician. Two HHSs suggested that there needed to be more information provided to rest home staff on preventing crises.

Drug and alcohol services¹⁶

Alcohol and drug workers, police, service users and family members emphasised that assessment of people when intoxicated needs to be improved. People need to be kept safe while intoxicated but it appears that there is currently little provision for this in services. The review found that most crisis workers felt that they do not have a role in intervention until the person is no longer intoxicated. Yet an intoxicated person may be at considerable risk. This results in police or emergency department staff often carrying the responsibility for someone whose risk has been incompletely assessed.

Some intoxicated service users are held in cells, often with no charges having been laid. Police and service users believed that this is inappropriate for people who are unwell or intoxicated. Police in all areas visited wanted a place of safety for people other than police cells. They suggested the establishment of assessment rooms located at mental health services. Alcohol and drug workers also suggested that a facility was needed for people in acute stages of detoxification prior to mental health assessment, so that police cells or family accommodation would not need to be used.

¹⁵ All HHSs in the North Island provided mental health services for people aged 65 and over. Disability support services funded mental health services for people in the South Island.

¹⁶ In general, the HHSs provided drug and alcohol services. Some services were managed as part of mental health services, while others were managed separately. In one HHS an NGO provided the addiction services for the area and the HHS provided dual diagnosis services. In Auckland one HHS provided a regional drug and alcohol service for three HHSs. Some drug and alcohol services reported catering for a very wide age range, including children, young people and those over 65 years. However services mostly catered for those 18 years and older.

Crisis respite

Crisis respite is defined in the *Blueprint* as “home based or other community based service options for people in crisis as an alternative to admission to an acute inpatient service” (Mental Health Commission 1998: 32). All stakeholders saw crisis respite as a valuable innovation and supported the use of such services. Crisis respite was viewed as a very effective way of averting escalation of a crisis and as an alternative to inpatient admission. In general, stakeholders strongly supported an increase in crisis respite options. Nevertheless, there were reservations about how crisis respite is being used in some areas, and the quality and suitability of some facilities.

It was mostly crisis service staff who decided whether people would be admitted to crisis respite. However, in four areas the crisis team and a combination of clinical co-ordinator, manager, or other community service made the decision. In three areas the decision was not made by the crisis team, but by a co-ordinator, an acute team leader, a nurse or DAO.

Eighteen HHSs reported that they had a budget for crisis respite, however there was wide variation in the budgets reported. There was also wide variation in the range of crisis respite options that HHSs had available. Some HHSs used NGOs, rest homes, private hospitals, motels and private homes, with care provided by nursing staff or caregivers. But a few HHSs had no, or limited options for crisis respite.

There needs to be consistent access to an appropriate range of respite services. Key issues are:

- service users want the length of time for crisis respite extended (i.e. more than three days)
- dedicated beds for younger and older people are needed. Rest homes were identified as inappropriate for younger people or acutely ill individuals.
- sometimes respite care is combined with supported accommodation and this is not seen as workable
- there is inappropriate use of respite options when in-patient beds are not available
- there is a lack of respite options for Maori and Pacific people
- there is variation in spending on crisis respite services. Considerable money is spent in this activity in some areas, but there are no useful indicators to judge the merits of this intervention.

5.9 Interface issues with external agencies

Those agencies that have a memorandum of understanding (MoU) or formal protocol with another agency considered this to be an effective device for establishing clear roles and responsibilities and procedures for working together. MoU are often combined with regular meetings. Examples of MoU that stakeholders considered to be working well are:

- the national MOU between New Zealand Police and the Ministry of Health. This was seen to be most useful when implemented at a district level, with agreed roles and responsibilities identified and regular liaison between agencies.
- MoU between crisis services and NGOs.

While some crisis services have developed protocols with agencies that appear to be working well, nevertheless specific gaps were identified in co-ordination and liaison with external agencies. In some areas crisis staff reported that there were no formal processes in place between crisis teams and external agencies. In other areas there was little joint work in regard to common clients. Some HHS staff raised concerns about differing perceptions of the crisis team and external agencies about levels of response.

Crisis staff said that external agencies lacked understanding of the role and functions of crisis services. They perceived that agencies expected crisis services to meet all demands on them. On the other hand, staff in some external services commented that crisis service staff needed to understand more about their services.

Role of the police

Both police and crisis workers appeared to support each other's role. Some crisis services were working hard on their relationship with the police, noting "we need them more than they need us". Police viewed crisis services as essential in the overall umbrella of social services.

However, police and crisis services often differed in their perceptions of their relationship. In some areas, crisis services reported their relationship with police to be good, while the police reported their relationship with the service to be poor. In areas where protocols were established and there were regular meetings between police and front-line crisis service staff, the relationships seemed to work well.

Police consistently reported concerns about their role with people who they recognise as mentally disordered. In some areas, particularly in provincial towns and rural areas, police believed they were acting as 'quasi mental health services' as the public would ring them first if in doubt that mental health services would respond quickly.

Police also pointed out that in large urban areas they were often dealing with several crisis teams, each with differing thresholds for intervention, methods of operating and geographical boundaries. This made decisions about how to respond to people in crisis difficult.

Suggestions for improving liaison and co-ordination between crisis services and police included:

- regular meetings between police and front-line service staff, in addition to district level management meetings
- more discussion of respective roles and challenges
- police wanted clarity around criteria for entry into the crisis service.

General practitioners

Involvement of crisis services with GPs covered a wide range of areas. The most common interaction was over referrals of people to and from GPs. In general GPs found crisis staff to be very experienced, professional and helpful and acknowledged the stressful nature of the work. However, GPs reported a variety of positive and negative experiences with crisis services.

Some GPs reported being confused about the criteria for crisis service intervention and experienced long delays when waiting for crisis staff to arrive. GPs noted problems when a person did not fit the crisis team criteria, for example if he/she were suffering from depression or debilitating anxiety. While the crisis team was not able to respond, there was also often a waiting list of several weeks to get an appointment with the community mental health service.

Crisis staff were also concerned about inappropriate referrals from GPs, such as referrals for work that the crisis team did not regard as meeting a threshold of seriousness or urgency for crisis service response. However, staff of some crisis services also reported that the service was involved in training of GPs, and that GPs were involved in service planning. One service reported a close relationship with GPs as it had no medical cover after-hours, except for telephone consultation.

Several GPs and crisis staff expressed concern that the physical needs of service users were not being adequately addressed, particularly in areas where there were few GPs and in low income areas. Some IPAs working with local HHSs were taking steps to address this issue. However in general it appears that the cost of a visit to the GP often means that service users do not access GPs so that their physical health suffers. Crisis staff also noted that affordability of GP fees sometimes compromised mental health, as some people who were discharged to GP care ceased going because they could not pay, and then became unwell.

NGOs

NGO staff acknowledged the importance and value of crisis teams and overall found crisis staff to be skilled and responsive, given staffing levels and distances to be covered in some areas.

For NGOs, the main issue was one of liaison and co-ordination with crisis services. They suggested several ways of improving liaison and co-ordination:

- a memorandum of understanding and regular meetings to establish a shared understanding of roles and responsibilities
- greater clarity about the criteria for a crisis
- crisis services to understand that when an NGO called for assistance from the crisis service that all possible avenues had been exhausted within the NGO
- regular contact and exchange of information between the crisis service and the NGO so that the NGO is kept informed of the crisis team's contact with NGO clients or residents.

While few NGOs and other non-HHS services are expected to provide crisis services, there was a view that some community-based organisations lack the infrastructure, staff skills and capacity to provide needed services.

Mental health service managers and DAMHs in particular commented that crisis services often have to assist NGOs when a crisis occurs. There was a concern that NGO staff could be better equipped to prevent, or intervene in a crisis situation. They supported more training for NGO staff. Several NGO staff also commented that they wanted basic training in crisis assessment and intervention. Managers and DAMHs were also concerned at what they perceived as alcohol and drug services' lack of knowledge of mental health issues. Crisis staff in particular identified capacity issues with iwi providers who sometimes needed to improve their skill base.

It was apparent that there is a lack of clarity around the role of NGOs, and their interface with crisis services. It is a poorly specified area that is subject to dispute between services. There seems to be little appreciation between sectors and services of the range of services delivered by each organisation, and the linkages required if a person is to receive the appropriate help in a co-ordinated way. Greater clarity through national direction would help.

Section 6: Conclusions and Recommendations

This review of crisis mental health services in New Zealand has found that all stakeholders believed that crisis services play a critical and valuable role. However, the review has found a number of significant shortcomings in crisis services.

It is expected that effective and responsive crisis services would meet the following requirements:

- services would be based on clear and comprehensive service specifications
- people would know how to access services and eligibility would be clearly defined
- services would meet the level of demand
- services would meet quality standards and responsiveness requirements.

Furthermore, the recovery approach should underpin all stages of crisis services. The recovery approach empowers service users, assures their rights, and gets the best mental health outcomes for them. Recovery has been defined in *The Blueprint* as living well in the presence or absence of mental illness. It involves an expectation that service users and their families are treated with high levels of dignity and respect, and that wherever possible their wishes are acknowledged. Although the focus of crisis services is on acute problems and short-term interventions, and may include compulsory treatment, care must be taken not to jeopardise the service user's future contact with the service, or their path to recovery. It is essential that the crisis service fosters relationships and links with other services to ensure service continuity for recovery.

Just as an effective crisis service needs to empower service users, it also needs to ensure that crisis staff are empowered to provide the care and resources needed as indicated in a risk assessment. The configuration of the crisis service must enable staff to act.

The review has found that these requirements are not well covered. There is a high degree of variation in the availability and quality of crisis services. Issues to address at a national level are:

- *The lack of clear overall direction for crisis services.* There is no coherent framework and policies for the provision of crisis services that include a clear definition of crisis, national service specifications and standards. Current specifications do not give sufficient emphasis and priority to crisis services. Nor do they provide sufficient detail on the requirements for and scope of crisis services. A set of core components of community mental health service to meet requirements for satisfactory crisis responsiveness is needed.
- *The potential for the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) to drive access to crisis services and restrict voluntary early intervention, service responsiveness and flexibility.* Service users and their families are concerned that those in crisis who do not meet the requirements of the MHA may not receive assessment and treatment. There is also a need to monitor the level and extent of the use of the MHA. It should be noted that the Commission has clearly stated that "Not meeting the [Mental Health Act 1992] criteria for 'mental disorder', does not imply that mental health service staff who are DAOs can then abdicate responsibility for undertaking any further assessment or action that is clinically indicated" (*Clinical Accountability within the Mental Health Sector 1998*, p. 37).
- *The need for a stronger emphasis on professional development of the crisis services workforce.* This includes improving recruitment and retention, crisis training opportunities, development of widely agreed and implemented competencies for crisis workers, and systems and processes for supervision and external clinical review. There is also a pressing need to improve national-level overview and assessment to

ensure that crisis services staff have the requisite skills, knowledge and supervisory support required to undertake their work.

- *The need for a coherent, standardised mental health data collection, monitoring and reporting framework* in order to assess crisis service activity and quality. This framework should include a standardised crisis service data set.

In addition, the review has identified particular problems around delivery:

- Eligibility criteria for crisis services are poorly understood, not only by the public, but also by the range of services that interact with crisis services. In general, there is poor provision of information about services (including criteria for entry to services) to service users, families, other agencies and the community.
- After-hours coverage is characterised by slow response times, lack of staff, lack of available medical cover in some areas, and little or no access to Maori and Pacific support services.
- In rural areas there are problems in accessing services, response times and the range of services available. Staff face difficult challenges as referral options are limited.
- In larger HHSs a high demand on inpatient units and community mental health services contributes to limited options for referral.
- There is lack of ‘recovery planning’, including service users making advance directives in partnership with service providers.
- Few specific crisis services exist for Maori. Those available had poor medical coverage and in one place were not part of HHS services.
- There is inadequate provision of services for Pacific people, including access to a Pacific mental health service and very little coverage of crisis responses by Pacific mental health services.
- There are specific gaps in crisis services for children and youth, older people and for those with alcohol and drug problems. The main issues associated with these gaps in provision were around a lack of suitable providers and a lack of suitably qualified and skilled staff.
- There is inadequate response to people in a state of intoxication. This problem has not been satisfactorily addressed anywhere. In part it is a reflection of poor interface between crisis and alcohol and drug services. It also reflects the limited recognition by some crisis workers of the potentially serious risks for people in a state of intoxication.
- There is evidence of poor co-ordination and lack of co-operation between crisis services and other mental health services, which impacts on service continuity, responsiveness and recovery.
- Deficiencies in liaison and co-ordination between crisis services and other health and social services are apparent, including poor understanding of the roles and responsibilities of the various services, with services often having unrealistic expectations of response.

Recommendations

The following recommendations focus on what is required to develop high quality crisis services. Agencies responsible for acting on the recommendations should seek and incorporate input from service users.

National level recommendations

It is recommended that the following actions be taken:

National Policy Framework

- 1 The Ministry of Health with service user and other stakeholder participants develop a coherent national policy for the provision of crisis services that includes:
 - national service specifications that ensure agreement, clarity and consistency on the mix and range of services, while allowing variations in models of delivery to take account of local circumstances
 - a clear definition of crisis (including fostering voluntary engagement with services)
 - minimum staffing standards
 - appropriate staff mix in services
 - adequate and appropriate provisions for crisis respite services
 - clear standards for oversight of the assessment and intervention planning and implementation activities of crisis staff
 - clear standards for oversight of the supervision processes within crisis services, including involvement of medical staff in supervision
 - processes for the implementation of reporting and monitoring systems
 - processes for auditing service performance.

A national framework should not restrict services' ability to develop models of delivery that respond to the needs and situations of their local communities.

Core components of crisis services

- 2 The Ministry of Health and District Health Board NZ with service user and other stakeholder participants develop nationally consistent documentation on core components of crisis services that includes:
 - eligibility criteria for service entry, including clear provision for individuals in crisis who do not fall under the MHA to be treated voluntarily, with the expectation that the service is to respond within established timeframes (four hours), or less if the situation demands it
 - common ways to access crisis services across and within DHBs. For example, similar emergency telephone book listings nationally, and similar titles for crisis services
 - capacity for minimum safe number of staff (2) to attend crisis calls at all times
 - capacity for service to respond within established timeframes (four hours), or less if the situation demands it

- clear links between the crisis activities and the remainder of the community mental health service functions, to ensure co-ordinated responses to the range of urgent and non-urgent calls for assistance
- systems to ensure priority is given to acute and crisis demands within the community mental health service, and for redistribution of resources to meet the most critical demands upon the service as a whole
- established agreements between individual components of the community mental health service (including specialist teams) to ensure understanding of and agreement of each other's roles in respect to people in crisis
- clear processes for the transition of individuals through the range of services (when required), including agreements on thresholds for transfer and on transfer of information
- established agreements between community mental health service (including crisis components) and other agencies (e.g. police, NGOs, emergency departments) to ensure understanding of and agreement of each other's roles in respect to people in crisis
- systems to ensure supervision of clinical activity of crisis staff, ongoing professional development of crisis staff and attention to cultural needs of people accessing crisis services
- attention to ensuring that service users and their caregivers/family/whanau are treated with respect and dignity, and that their wishes are acknowledged and taken into account.

Information on the documentation should be communicated to service users and all other key stakeholders, including GPs, NGOs, police and social service agencies.

Workforce development

- 3 The Ministry of Health fund the development of a brief for crisis service training requirements, including an agreed set of standards and competencies and content of training, and investigate appropriate training providers and report to the Minister on appropriate delivery.

Caring for those who are intoxicated

- 4 Establish agreements between individual components of the community mental health service (including specialist teams) to ensure delivery of service and care, and understanding and agreement of each other's roles, in respect to people in crisis and intoxicated.
- 5 The Memorandum of Understanding between the New Zealand Police and the Ministry of Health be expanded to include explicit guidance on managing intoxicated people in crisis, and that those guidelines be incorporated into local agreements between police regions and districts and mental health services.

Information collection and monitoring

- 6 The Ministry of Health continues to improve the quality of Mental Health Information National Collection data through existing data monitoring and quality auditing processes.
DHB providers (using MHINC provider reports) give feedback to crisis services about the quality and completeness of their data and encourage improvement in data collection processes.
DHB use MHINC and internal information to inform their service planning and development specifically with respect to the provision of crisis services.

Research

- 7 The Ministry of Health and the Health Research Council support the funding of research into effective models and configurations of crisis services delivery that enhance service responsiveness and development.

Service delivery recommendations

It is recommended that the following actions be taken:

Responsiveness to service users and families

- 8 The Minister of Health invite the National Health Committee to produce best practice guidelines for working in crisis mental health services that include:
 - best practice in crisis, using a recovery approach, work with specific groups (e.g. Maori, Pacific peoples, children and youth, people with drug and/or alcohol problems, older people, rural populations)
 - working with intoxicated persons and identification of appropriate facilities for safely monitoring people before assessment can be completed and recommendations for definitive treatment finalised
 - quality in the provision of crisis respite options
 - effective crisis service approaches that lead to a reduction in compulsory treatment.
- 9 District Health Boards develop processes to ensure service user and family feedback on crisis services is regularly obtained and acted upon.

Service development

- 10 District Health Boards conduct a review, as a required part of their district and regional planning processes for 2002/03, on crisis respite care to improve access to and quality of respite care, with particular attention to:
 - demand for respite care across all groups, with particular consideration of demand by young people, older people, Maori, Pacific people, and people in rural areas
 - staff numbers and skills required for respite care

- ways of addressing the inappropriate use of respite care when inpatient beds are not available
 - increasing options for respite care, in particular for young people, older people, Maori, Pacific people, and in rural areas.
- 11 District Health Boards develop a quality improvement strategy which includes the following:
- Crisis services review the comprehensiveness and adequacy of their service protocols and ensure that they cover all compliance requirements and key safety matters.
 - Establish mechanisms to ensure that less urgent crisis calls are addressed within the range of services. One option is a 'warm line' service to provide peer support, counselling and advice on non-urgent clinical matters.
 - Implement ways of providing more comprehensive and effective crisis service coverage after-hours in evenings and weekends.
 - Investigate the feasibility and merits of improving access in rural areas for crisis service users through such means as:
 - i use of video-conferencing to access psychiatrists
 - ii provision of appropriate vehicles
 - iii use of helicopters
 - ensure that they have sufficient minimum staffing levels for effective service delivery and methods of dealing with staff stress and burnout
 - develop procedures with other agencies as required to clarify roles and responsibilities, promote liaison, co-operation, co-ordination and best practice in the provision of crisis services
 - District Health Boards work together to promote ongoing innovation, service development and best practice for staff, for example, the training forum/conference initiated by Hutt Valley Health DHB Mental Health Services in 2001.

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Appendix 1: Terms of Reference for the Review of Crisis Services

Introduction

Mental Health Commission role and responsibilities

The Commission's purpose is to ensure the implementation of the national mental health strategy, and to facilitate and report on progress. One of the ways in which the Commission carries out its reporting responsibilities is by examining and reporting on the extent to which the policy direction, funding, specification, and monitoring of delivery of specific services are meeting strategy expectations and objectives.

A previous review of this kind, completed in 1999, reported on mental health services for children and youth. This year the Commission has decided to focus its review on crisis services.

Purpose of the review

- a) To describe current policy directions, requirements, and arrangements for delivery of crisis mental health services.
- b) To identify and report on consumer and family views of crisis service provision.
- c) To obtain stakeholder feedback on service provision and gaps (key stakeholder groups also include Maori, Pacific Peoples, General Practitioners, Police).
- d) To gain an understanding of what key stakeholder groups expect of crisis mental health services.
- e) To identify and report on any barriers to service development and service improvement.
- f) To make recommendations for actions needed to further development.

Scope

This review focuses solely on specially constituted adult crisis mental health services. It does not cover all crisis activity/response that may occur in other parts of mental health services.

Why review crisis services?

Crisis services have a key role in the spectrum of mental health care

Crisis services are frequently the entry point to mental health services and act as gatekeepers to other mental health services. It is here that difficult triaging and rationing decisions must be made. Crisis services have a central role in responding to, and managing demand for mental health services. The responsiveness and effectiveness of crisis intervention services are likely to impact on the workloads of all other mental health services and affect the ability of these other services to perform their own roles to maximum effect. For Maori, access to appropriate cultural input (e.g. cultural assessments, access to kaumatua) are important quality processes. Also, the degree of integration, co-operation

and timely referral between all services in an area is likely to impact on the functioning of the crisis service.

A variety of crisis service models and practices are used

There appears to be a lack of national consistency in this area. The review gives an opportunity to provide a stocktake and description of how each service is operating. This will shed light on access and approaches used and the degree of variation around the country including how services are offered to Maori.

Builds on other work

A review of crisis services will link closely with recent previous work (Acuity Review, MoH, 1997; Risk Assessment and Management Guidelines, MoH 1998; Critical Service Improvement Reports, Mental Health Commission, 1998; Auckland Acute Services Review, HFA, 1998; Review of HFA Quality Specification and Monitoring of Selected Services, MoH, 1999); and with work currently in progress (MoH review of forensic services) and the review of the mental health services interface with courts (Department for Courts 2000).

Responsibilities for the review

The review will be completed by a project team under contract to the Mental Health Commission. The project team will report to and be guided by a project advisory group, to be established by the Mental Health Commission.

Issues to be addressed

The review will gather and analyse information, consult with consumers, families and other key stakeholders, and make recommendations on the following issues:

- a) National policy directions, requirements, and accountability arrangements for crisis mental health services.
- b) The quality, quantity, and models of current provision of crisis services throughout New Zealand.
- c) Interface arrangements and collaboration and co-ordination between crisis services, other mental health services, Police and primary care services.
- d) Service development issues, service gaps and barriers to service development and improvement.

Appendix 2: Questionnaires for the Survey of HHSs

Review of Adult Crisis Mental Health Services (1)

Mental Health Services of Health & Hospital Services

Please return by 20/11/00

Name of HHS Name of Crisis Service

Name and phone number of person completing questionnaire:

Name Phone

Instructions

- “The last 12 months” means September 1999 to September 2000 (or last 12-month period for which data is available).
- The information requested will provide a snapshot of services overall rather than an audit. Comments will not be made on the quality of individual services.
- Please fill numbers in where possible.
- If information is not available please write “Not collected”. Where data is not available (e.g. contacts by type) then please give an estimate. Write this as “Data not collected. Estimated figure is ...”.
- **Please send all completed questionnaires together for each HHS (i.e. 3 x crisis questionnaires per crisis team; and 1 x each Child and Youth, A&D, Older Persons, Maori & PI questionnaires). Please post to Janet Peters, 4/24 Savannah Street, Epsom, Auckland.**
- If you have any queries about the information requested, please ring Janet Peters (09 630 5045 or 025 722 212).
- Thank you for your assistance in this review.

Questions

1 People and area served

Total population served by this service?

(a) Describe geographical boundaries of area served:.....
.....

(b) Mainly urban Mainly rural

(c) Time to travel from crisis team base to furthest point of catchment area?

2 Who actually uses the service, and for what kinds of crises and diagnoses?

(a) Number of people accessing services in last 12 months?

(b) Breakdown of above by:

(i) Age: 0–19 20–65 65+

(ii) Ethnicity: Maori Pacific
European Other

(iii) Diagnosis: Schizophrenia Bipolar disorder
Anxiety Depression
Dementia Other

(iv) Type of crisis:

1 = new crisis: involving people not previously in contact with services,
e.g. suicide

2 = recurring crises: mild-moderate mental health problems

3 = crises for people with serious mental illness, i.e. schizophrenia or
bipolar disorder

1 2 3

(c) Total contacts – with first assessments and follow ups separately identified – in
last 12 months

(i) First assessments

(ii) Follow-ups

(d) Average number of contacts per client.....

(e) Average duration of service in days (i.e. length of time between entry and exit)
.....days (best estimates if data not available)

3 How much of the work is MHA related?

(a) Of first contacts, how many were MHA related?

(b) Number of Section 8s in last 12 months?

4 Timeliness of initial response and first assessment

- (a) What is average time length between initial contact and first face-to-face assessment?.....
- (b) Estimate % face-to-face interventions (versus telephone intervention)?.....

5 Staffing

- (a) Number of clinical FTEs in crisis team.....
- (b) Number of FTEs by profession
Doctor..... Nurse SW OT Psychologist
- (c) Number of DAOs in team.....
- (d) Perceived ideal number of FTEs for crisis team and reason for perceived ideal
 - (i) Ideal number:.....
.....
.....
.....
 - (ii) Reason for ideal:
.....
.....
.....
.....
- (e) Total clinical FTEs in adult community mental health services in HHS
- (f) What roster system is used (e.g. 5s and 2s)?.....
- (g) Why this system?
- (h) For each shift, what number of staff are available on site and in back-up?
 - (i) Morning
 -
 - (ii) Afternoon
 -
 - (iii) Night.....
.....
- (i) % staff with bleepers?.....
- (j) % staff with cellphones?.....
- (k) % staff with laptops
- (l) Number of Maori staff and ideal number
 - (i) Actual
 - (ii) Ideal

- (m) Number of Pacific peoples staff and ideal number
- (i) Actual
- (ii) Ideal

6 Staff training and safety

- (a) % staff trained specifically in crisis intervention in last three years?.....
- (b) Name/location of crisis intervention training programme used in above?
.....
- (c) % staff in regular supervision?
- (d) Annual training budget for the crisis team? \$

Request for Clinical/Service Protocols (2)

Mental Health Services of Health & Hospital Services

Please return by 20/11/00

Name of HHS Name of Crisis Service

Name and phone number of person completing questionnaire:

Name Phone

Instructions

Please note:

- The information requested will provide a snapshot of services overall rather than an audit. Comments will not be made on the quality of individual services.
- **Please forward copies of the following locally developed protocols.**
- **Please do not send national MoH protocols.**
- **If your service does not have a locally developed protocol covering one of the requested service processes, please indicate this in your response and provide a brief description of the processes your service uses.**
- Individual services will not be audited on the existence or quality of these items.
- Please send all completed questionnaires together for each HHS (i.e. 3 x crisis questionnaires for each crisis team; and 1 x each Child and Youth, A&D, Older Persons, Maori & PI questionnaires). Please post all to Janet Peters, 4/24 Savannah Street, Epsom, Auckland.
- If you have any queries about the information requested, please ring Janet Peters (09 630 5045 or 025 722 212).
- Thank you for your assistance in this review.

Clinical Services/Protocols Requested

1 Entry/response

Eligibility criteria for access to crisis service (including entry and exit criteria)

Triage and prioritisation

Number of staff responding to crisis callout

Protocols attached: Y N

2 Assessment

Assessment

Risk Assessment

Cultural Assessment for Maori

Cultural Assessment for Pacific Peoples

Protocols relating to minority groups/refugees

Protocols attached: Y N

3 Mental Health Act

Implementing the Mental Health Act

Transport of clients *being assessed under the MHA*

Protocols attached: Y N

4 Memoranda of Understanding

Local Memoranda of Understanding (e.g. with Police)

Protocols attached: Y N

5 Information exchange

Protocols relating to information exchange between community mental health and crisis services, including:

- Is there a system for MHS staff to notify crisis staff about people of concern?
- Does this information ever contain “pre-planning” information by clients (i.e. where they have agreed a crisis intervention process in advance with their case managing team)?
- How do crisis staff access MHS case notes?
- Is there a process for crisis staff to notify MHS staff about existing clients seen?
- Method of communicating that person is in extreme risk?
- Feedback to referrers

Protocols attached: Y N

6 Inpatient service access

Admission to inpatient services via crisis service

Protocols attached: Y N

7 Transfer of care

Transfer of care

Protocols attached: Y N

8 Complaints and incidents

Complaints
Critical Incident review
Debriefing for critical incidents
Access to staff counselling after critical incidents

Protocols attached: Y N

9 Other quality improvement activities

Obtaining and acting on consumer satisfaction feedback
Obtaining and acting on family satisfaction feedback
Obtaining and acting on staff satisfaction feedback

Protocols attached: Y N

Practice (3)

Mental Health Services of Health & Hospital Services

Please return by 20/11/00

Name of HHS **Name of Crisis Service.....**

Name and phone number of person completing questionnaire:

Name..... Phone

Instructions

- Please complete the following questionnaire. Except where space is provided for your answer, please complete answers on a separate sheet of paper with the name of your HHS and crisis service at the top, using the numbering below. Please staple all material to this page before sending.
- **Please send all completed questionnaires together for each HHS (i.e. 3 x crisis questionnaires per crisis team; and 1 x each Child and Youth, A&D, Older Persons, Maori & PI questionnaires). Please post to Janet Peters, 4/24 Savannah Street, Epsom, Auckland by 20/11/00.**
- The information requested will provide a snapshot of services overall rather than an audit. Comments will not be made on the quality of individual services.
- If you have any queries about the information requested, please ring Janet Peters (09 630 5045 or 025 722 212).
- Thank you for your assistance in this review.

1 Definition of “crisis”

What is the definition of “crisis” used by your service?

.....
.....
.....

2 DAO availability

Is DAO function available through other mental health services (e.g. Community Mental Health Centres)?

Yes No

If Yes, please list other services providing DAO function:

.....
.....
.....

3 How are the following groups served by the adult crisis team?

Please describe the processes followed (or send copies of relevant protocols).

- (a) Children and young people
- (b) Older people
- (c) People with A&D problems
- (d) Maori
- (e) Pacific/minority/refugee peoples (e.g. access to interpreters – including sign language)
- (f) People with a mental health crisis presenting at a hospital emergency department

4 How is the service organised/what model?

- (a) Overall service model and principles used – e.g. stand-alone/integrated/other? Include a copy of the service description where one exists.
- (b) Models for crisis intervention used within service – e.g. case support/case management/other? Include copies of protocols/descriptions of models where they exist.

5 What interventions and therapies does this service provide?

List all types of interventions available directly from crisis staff.

.....
.....
.....
.....
.....

6 Ease of access – how do people find and contact the service?

(a) Is the service 24-hour 7-days? Yes No

If no, what days and hours is the service available?.....
.....

(b) How do people access the service?

(i) One phone number (0800)?.....

(ii) One door?

(iii) Other?

(c) How is service and access communicated to the public? (Send copies of phone book listing and other public information.).....
.....

(d) Does the level of service vary depending on time of day/shift?

Yes No

If yes, how?

(e) Who can refer to the service? Can people self-refer?.....
.....

7 Access to support services

(a) Who 'gatekeeps' for inpatient services?.....

(b) Respite services

(i) Access to HFA funded beds? Yes No

(ii) Access to flexifund? Yes No

(iii) Annual flexifund budget? Yes No

If yes, how much? \$

(iv) % used in last 12 months (to September 2000).....

(v) Who gatekeeps for respite care?

(c) Other services:

(i) Briefly list other MHS services able to be accessed for crisis clients.

.....
.....
.....

(ii) Briefly list NGOs used.

.....
.....
.....

- (iii) What other services would be useful?

.....
.....
.....

8 Maori

- (a) How are Maori identified at the first point of entry to the crisis service?

.....
.....
.....

- (b) How and when is cultural assessment provided for Maori clients? Please describe the process used and how initiated?

.....
.....
.....
.....
.....
.....

- (c) Are Kaupapa Maori services able to be accessed for cultural advice?

Yes No

- (d) What options from the following are available to Maori accessing the crisis service?

	Yes	No
(i) Kaumatua/Kuia?	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Maori mental health worker?	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Traditional Maori healing practices?	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Iwi support worker?	<input type="checkbox"/>	<input type="checkbox"/>
(v) Other, please specify		
	
(vi) How does the service involve whanau?		
	

9 Pacific peoples and minority groups/refugees

- (a) How are Pacific people identified at first point of entry to the crisis service?

.....
.....

- (b) Are Pacific people's services able to be accessed for cultural advice?

.....
.....

- (c) How does the service involve family?

.....
.....

10 Relationships

Internal

- (a) List key MHS that the crisis team relates to.

.....

.....

- (b) List issues with these services – what works/what doesn't?

.....

.....

.....

External

- (c) List key external relationships.

.....

.....

- (d) How does the service interact with GPs?

.....

.....

- (e) List issues with any external agency – what works/what doesn't?

.....

.....

11 Staff training and safety

Describe regular training fora for DAOs

.....

.....

.....

.....

12 Quality improvement activities

National Mental Health Standards

- (a) Do you believe that you have fully implemented the NMHS (and if not, what has limited your ability to do so?)

.....

.....

.....

.....

- (b) In 1999 HSSs were required to internally audit their services against the NMHS and report this to the HFA. Please send a copy of your internal audit of the crisis service.

External HFA monitoring

- (c) Has your service ever been reviewed or monitored by the HFA? (Forward document/results.)

Yes

No

OPEN ALL HOURS?
A REVIEW OF CRISIS MENTAL HEALTH SERVICES

(d) Any other review/audit? (Forward documents/results.)

Yes No

HHS Questionnaires

HHS questionnaires for:

- | | |
|---|----------------------------------|
| 1 | Child & Youth Service |
| 2 | Older People |
| 3 | A&D Services |
| 4 | Maori Services |
| 5 | Pacific Peoples Services |

NB: These five questionnaires (when completed) are to be added to the crisis teams' questionnaires and posted to Janet Peters.

Due date 20/11/00

1 Child & Youth Services

The Mental Health Commission is undertaking a review of adult crisis mental health services in New Zealand. It is important that the needs of young people in crisis are also met.

Please provide copies of existing protocols/guidelines/forms that cover the following issues. If a protocol is not available, please provide a brief description of the process used.

Thank you for your assistance in this review.

- 1 What age group does your service cover?
- 2 If a young person was in crisis during the working day (e.g. 8.30 am – 5 pm) what assistance would they receive?
- 3 If the same situation occurred after hours or in the weekend, what would the process be? Is the local crisis service involved?
- 4 Estimate how many times in the last year the above situation has occurred (i.e. after hours crisis contact)?
- 5 What access to inpatient beds for young people in crisis do you have?
- 6 What access for respite for young people in crisis do you have?
- 7 If extreme violence or self-harm is an issue for a young person with mental illness in crisis, what secure inpatient care is available and how is this accessed?
- 8 Describe the interface between crisis services and your Child & Family Service
- 9 What improvements could be made to ensure the needs of young people in crisis after hours are better met?

OPEN ALL HOURS?
A REVIEW OF CRISIS MENTAL HEALTH SERVICES

- HHS questionnaires for:
- 1 Child & Youth Service
 - 2 Older People**
 - 3 A&D Services
 - 4 Maori Services
 - 5 Pacific Peoples Services

NB: These five questionnaires (when completed) are to be added to the crisis teams' questionnaires and posted to Janet Peters.

Due date 20/11/00

2 *Older People's Services*

The Mental Health Commission is undertaking a review of adult crisis mental health services in New Zealand. It is important that the needs of older people in crisis are also met. **Please provide copies of existing protocols/guidelines/forms that cover the following issues.** If a protocol is not available, please provide a brief description of the process used.

Thank you for your assistance in this review.

- 1 What age group does your service cover?
- 2 If an older person has a mental health crisis during the day (e.g. 8.30 am – 5 pm) what assistance would they receive?
- 3 If the same situation occurred after hours or in the weekend, what would the process be for assisting the person? Would the crisis service be involved?
- 4 Estimate how many times in the last 12 months the crisis service has been involved with a client in an after hours crisis situation?
- 5 What access to inpatient beds for older people in crisis do you have?
- 6 What access for respite for older people in crisis do you have?
- 7 If extreme violence or self-harm is an issue for an older person with mental illness in crisis, what secure inpatient care is available and how is this accessed?
- 8 Describe the interface between crisis services and your Service for Older People
- 9 What improvements could be made to ensure the needs of older people with mental illness in crisis after hours are better met?

- HHS questionnaires for:
- | | |
|----------|--------------------------|
| 1 | Child & Youth Service |
| 2 | Older People |
| 3 | A&D Services |
| 4 | Maori Services |
| 5 | Pacific Peoples Services |

NB: These five questionnaires (when completed) are to be added to the crisis teams' questionnaires and posted to Janet Peters.

Due date 20/11/00

3 Alcohol & Drug Services

The Mental Health Commission is undertaking a review of adult crisis mental health services in New Zealand. It is important that the needs of people with drug and alcohol problems who are in crisis are also met. **Please provide copies of existing protocols/guidelines/forms that cover the following issues.** If a protocol is not available, please provide a brief description of the process used.

Thank you for your assistance in this review.

- 1 What age group does your service cover?
- 2 If a client of your service has a mental health crisis during the day (e.g. 8.30 am – 5 pm) what assistance would they receive? From whom?
- 3 If the same situation occurred after hours or in the weekend, what would the process be for assisting the person? Is the local crisis service involved?
- 4 Estimate how often this happened after hours in the last 12 months?
- 5 Describe the interface between your local crisis mental health services and your Alcohol & Drug Service.
- 6 What improvements could be made to ensure the needs of people with mental illness and alcohol & drug problems in crisis after hours are better met?

**OPEN ALL HOURS?
A REVIEW OF CRISIS MENTAL HEALTH SERVICES**

- HHS questionnaires for:
- 1 Child & Youth Service
 - 2 Older People
 - 3 A&D Services
 - 4 Maori Services**
 - 5 Pacific Peoples Services

NB: These five questionnaires (when completed) are to be added to the crisis teams' questionnaires and posted to Janet Peters.

Due date 20/11/00

4 *Kaupapa Maori Services*

The Mental Health Commission is undertaking a review of adult crisis mental health services in New Zealand. It is important that the needs of Maori who are in crisis are also met.

Please provide copies of existing protocols/guidelines/forms that cover the following issues. If a protocol is not available, please provide a brief description of the process used.

Thank you for your assistance in this review.

- 1 If tangata whaiora in your service experiences a mental heath crisis during the day (e.g. 8.30 am – 5 pm) what assistance is given and by whom?
- 2 If a crisis situation occurs after hours or in the weekend, how is the crisis team involved?
- 3 When the crisis mental health service is working with a consumer who is Maori, are members of your team called in to assist with cultural matters (e.g. cultural assessments)? If yes, how does this happen?
- 4 What works well in the above processes?
- 5 What improvements would you like to see in the future for crisis service provision for tangata whaiora?

- HHS questionnaires for:
- | | |
|---|---------------------------------|
| 1 | Child & Youth Service |
| 2 | Older People |
| 3 | A&D Services |
| 4 | Maori Services |
| 5 | Pacific Peoples Services |

NB: These five questionnaires (when completed) are to be added to the crisis teams' questionnaires and posted to Janet Peters.

Due date 20/11/00

5 *Pacific People's Services*

The Mental Health Commission is undertaking a review of adult crisis mental health services in New Zealand. It is important that the needs of Pacific Peoples who are in crisis are also met. **Please provide copies of existing protocols/guidelines/forms that cover the following issues.** If a protocol is not available, please provide a brief description of the process used.

Thank you for your assistance in this review.

- 1 If a person in your service is in a crisis situation during the day (e.g. 8.30 am – 5 pm) what assistance is given and by whom?
- 2 If this occurs after hours or in the weekend, what would the process be for assisting the person? Is the local crisis service involved?
- 3 When the crisis team is working with a Pacific person, are members of your team called in to assist with cultural matters (e.g. cultural assessments)? If yes, how does this happen?
- 4 What works well in the above processes?
- 5 What improvements would you like to see made in the future in terms of crisis service provision for Pacific peoples?

Appendix 3: HFA Mental Health Purchase Framework and Service Specifications

The Funding Agreement between the Minister of Health and the Health Funding Authority

The purpose of the Funding Agreement is to set out:

- the services the HFA will fund for the people
- how the HFA will deliver on the Crown's Statement of Objectives for health and disability support services.

The funding agreement does not specify the quantity of crisis services to be delivered for a particular region. However, there are several parts of the Funding Agreement that are particularly relevant to crisis services.

The Service Coverage Schedule (Appendix A of the Funding Agreement) documents the range of services funded by the HFA. Key principles underlying the purchase of services include:

- eligibility
- availability (e.g. fair and reasonable and subject to generally accepted clinical protocols)
- quality and standards
- prioritising the purchase of services and managing service risk
- obligations to Maori (under the Treaty of Waitangi)
- government priorities for Maori
- obligations to Pacific people.

In this Schedule, services relevant to the provision of crisis mental health services are described in the following excerpt.

Mental Health and Drug and Alcohol Services

The following Mental Health Services are purchased by the HFA:

Range

Services for people in crisis or having an acute episode (especially when their or someone else's safety is at risk) including:

- acute services provided within an inpatient setting, such as a specialist psychiatric hospital ward or mental health facility
- 24-hour mobile crisis services
- community-based crisis respite, including a treatment component (services which provide people, including caregivers, with a break so crisis can be eased)
- training and monitoring of duly authorised officers under the Mental Health (CAT) Act 1992
- consultation/liaison.

In addition to range, other headings under which services are described specifically relevant to adult crisis mental health services include:

Decision-making criteria

On referral (including self-referral) the criteria for assessment are based on the person having an identifiable or suspected psychiatric disorder.

Time

- When assistance is required under the Mental Health (CAT) Act, 90% of people should be assessed within four hours
- If a person is assessed as needing hospital care under the Mental Health (CAT) Act, 90% should be admitted to a hospital within six hours of being seen by a doctor or health professional
- The HFA will ensure that crisis services to deal with a critical or urgent mental health need will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act) as follows:
 - i. Telephone or other remote assistance will be available at all times with minimal delay.
 - ii. Where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided as soon as possible.
 - iii. Other services will be arranged where required including acute inpatient admission and crisis respite.

The Funding Agreement also outlines (in Appendix C) the information to be supplied to the Ministry of Health by the mental health sector. This information is:

- basic sector information
- information required for policy development
- information required for advice on funding decisions.

For Mental Health information requested three-monthly is under the headings of:

- actual expenditure
- number of people receiving the services
- service capacity
- workforce development.

Additional quality requirements

The HFA will require providers of mental health and substance abuse services, in providing those services, to adhere to the following specific Ministry of Health protocols and guidelines (as they may be altered by the Ministry from time to time):

- a) National Mental Health Standards (1997); and
- b) Procedural Guidelines for the use of Seclusion (June 1995); and
- c) Procedural Guidelines for Physical Restraint (June 1993); and
- d) Guidelines for Reporting and Reviewing Incidents (June 1993); and
- e) National Protocol for Methadone Treatment in New Zealand (May 1996); and
- f) Guidelines for Clinical Risk Assessment and Management in Mental Health Services (July 1998).

Compliance with Mental Health (CAT) Act 1992:

Mental Health Services shall meet the requirements of the Mental Health (CAT) Act. Mental Health Services shall, therefore, include:

- a) the employment of, and provision of resources to, appropriate directors of Area Mental Health Services (as designated by the Director-General of Health), responsible clinicians and duly authorised officers under the Mental Health (CAT) Act
- b) the provision for second opinion by psychiatrist under Section 59, Section 60 and Section 69 of the Mental Health (CAT) Act
- c) the payment of legal and other fees specified by the Mental Health (CAT) Act including the fees of medical practitioners under Section 134 of that Act
- d) the training and monitoring of duly authorised officers under the Mental Health (CAT) Act in accordance with the Ministry of Health guidelines issued for that purpose from time to time.

Mobile crisis services

Mobile crisis services will be guided by written policies and procedures that:

- a) include a clear statement of conditions when a minimum of two clinicians should attend a call-out; and
- b) ensure that services are deployed and equipped in a manner that enables the staff to carry out the services as required under the Mental Health (CAT) Act; and
- c) provide for emergency admission to acute inpatient services; and
- d) set out arrangements for effectively working with the police.

The final section of the Funding Agreement of relevance to the provision of adult crisis mental health services is the Crown's Statement of Objectives which sets out the Government's priorities. It notes:

Mental Health

The implementation of the Mental Health Commission's Blueprint for Mental Health Services is a high priority for the Government. In the immediate future, the HFA should work with the Ministry of Health and the Mental Health Commission to prepare an action plan for implementing the Blueprint.