

# **Crisis responses to mental health and/or substance use: What works? A literature scan**

**August 2025**



**SYNERGIA**

Literature scan prepared for Te  
Hiringa Mahara - Mental Health  
and Wellbeing Commission  
by Synergia.



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

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# Foreword | Kupu whakataki

We continue to hear from lived experience communities about the challenges to accessing the right support at the right time when they are experiencing a crisis. Our 2024 report, *Kua Timata Te Haerenga | The Journey has Begun*, highlighted these challenges.

We prioritised a focus on crisis responses in response to these challenges to deepen understanding of how crisis responses are currently working across Aotearoa and explore ways to improve them. Improving responses to mental distress is also a government priority and a range of new initiatives are being rolled out including Peer Support in Emergency Departments, Crisis Cafes, as well as changes to how Police work with mental health services.

We commissioned this literature scan as part of our work monitoring responses to people experiencing a mental health or substance-related crisis event (or both). For this work, we have defined ‘crisis responses’ as forms of urgent support, assessment, or intervention for people experiencing a crisis event that requires additional support to that provided in primary care or planned specialist care.

This literature scan draws on national and international evidence on what works in terms of crisis models and approaches. It also covers a range of services already provided across Aotearoa and highlights some of the great work that is happening.

The findings from this literature scan will inform our deeper monitoring report and the changes we will advocate for to enable effective crisis responses that integrate clinical, cultural, community and lived experience perspectives to support tāngata whaiora and whānau experiencing mental health or substance-related crises.

Evidence shows that when crisis responses are embedded within coherent, system-wide frameworks, they produce better outcomes. Effective models value lived experience and are timely, holistic, culturally grounded and easily accessible. We need a national model with flexibility to ensure all people have access to the services and supports they need when experiencing a crisis.

Our forthcoming report looks more closely at crisis responses and how they are performing across Aotearoa. Our work will not only monitor how services are currently doing but asks the question ‘what does a good crisis response system look like for Aotearoa?’



Karen Orsborn

Tumu Whakarae | Chief Executive, Te Hiringa Mahara

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## AT A GLANCE

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This scan reviews international and Aotearoa evidence on crisis responses for the general population, Indigenous communities, and youth, highlighting shared principles, key differences, and what is working well.

**International evidence:** Cohesive, nationally coordinated crisis systems with 24/7 coverage, non-coercive care, peer roles, and youth-specific supports reduce ED use and improve outcomes.

**New Zealand, Aotearoa evidence:** Locally led kaupapa Māori and peer-informed services show strong impacts on trust, safety, and engagement but remain fragmented and regionally variable.

**Gaps remain:** Less publicly available evaluation of kaupapa Māori and peer-led models, few long-term outcome studies, underdeveloped youth-specific evidence (especially for Pacific, Rainbow, disabled, and rural rangatahi and young people), and little focus on substance use crises.

**Overall message:** Crisis responses are most effective when timely, non-coercive, culturally safe, and connected to wider systems of care, with Aotearoa's strengths lying in relational, whānau-led, and culturally grounded approaches - though these remain regionally driven and less consistently integrated into a response system.

# OVERVIEW

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This literature scan reviews international and Aotearoa evidence on crisis responses to mental health and substance use, with a focus on approaches for the general population, Indigenous communities, and youth. It identifies shared principles, areas of divergence, and insights into what is working well.

**International evidence:** The literature describes cohesive, nationally coordinated systems supported by sustained investment and robust evaluation. Key features include:

- **24/7 coverage** through mobile crisis teams, crisis stabilisation units (e.g. *EmPATH* in the US), and crisis cafés.
- **System-wide governance and standards**, as seen in the UK's Crisis Resolution Home Treatment teams and Ireland's *Sharing the Vision*.
- **Non-coercive, trauma-responsive care**, moving away from police-led responses and embedding peer and lived experience roles.
- **Equity and rights frameworks**, drawing on instruments such as the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Convention on the Rights of Persons with Disabilities (CRPD) to ensure cultural safety and self-determination for Indigenous people and other specific groups of people.
- **Youth-specific supports**, including purpose-built hubs (e.g. *Best for You* in the UK) and digital services such as Canada's *Kids Help Phone*.

These models consistently reduce ED use and coercive interventions, while improving continuity, engagement, and safety.

**Aotearoa, New Zealand evidence:** Innovation is strongly visible in locally led, kaupapa Māori and peer-informed services, such as Te Puna Wai, Tupu Ake, and Piri Pono. These approaches:

- Embed **cultural grounding and whānau-centred care**, aligning with tikanga and whakapapa.
- Utilise **peer leadership and lived experience** to build trust and offer safe, voluntary alternatives to EDs.
- Prioritise **relational and trauma-responsive practice** through safe havens, respite services, and community outreach.
- Support **rangatahi and whānau inclusion**, with *Child and Adolescent Acute Response Teams (CAARTs)* and helplines like *Youthline* offering accessible, youth-friendly options.

However, delivery remains fragmented and regionally variable, with inconsistent access to 24/7 services and reliance on EDs in many areas.

**Limitations and gaps:** There is limited publicly available evaluation of kaupapa Māori and peer-led models, few long-term studies on recovery and sustained wellbeing, and an underdeveloped evidence base for youth—particularly Pacific, Rainbow, disabled, and rural rangatahi and young people.

Research led by people with lived experience is still scarce, especially regarding coercion and cultural safety, and crisis responses to substance use harm remain far less studied than those for mental health distress.

**Conclusion:** Even with these gaps, the evidence provides confidence in the elements of crisis response that are working. International system-wide models show the benefits of national coordination, standards, and infrastructure, while kaupapa Māori and peer-led initiatives in Aotearoa highlight the transformative impact of culturally grounded, whānau-led, and relational approaches.

Together, these findings affirm that the most effective crisis responses are timely, non-coercive, culturally safe, and connected to wider systems of care, ensuring tāngata whaiora and whānau receive the right support at the right time.

# 1. INTRODUCTION

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Effective crisis response models are vital for supporting tāngata whaiora and whānau experiencing mental distress and substance-use harm. In both Aotearoa and international contexts, a wide range of crisis interventions have emerged in response to community needs, service structures, and policy environments.

Guided by the definition of crisis response from Te Hiringa Mahara, this literature scan identifies key features of models that work for tāngata whaiora and whānau—including responses tailored to Indigenous populations and young people. The scan provides an opportunity to learn from international and local evidence on what works both at a system and service level.

The scan contributes to a broader crisis response work programme led by Te Hiringa Mahara and is intended to inform the Commission’s advocacy and monitoring functions.

## Scope and search strategy

The scan focuses on models developed or evaluated in the past 10 years. It draws on peer-reviewed journals, evaluation reports, grey literature, and sources reflecting lived experience, indigenous knowledge (international) and mātauranga Māori (Aotearoa). The scan was designed to focus insights from international models and reflect on how these compare to approaches in Aotearoa. The questions guiding the scan were:

1. What works for people experiencing mental health and/or substance use crises?
2. What works well for Indigenous populations?
3. What works well for young people?

From the 176 sources identified through the search strategy (Appendix 1), the scan drew on 119 sources (81 academic, 40 grey literature). Sources were included based on relevance, evidence and practical insights, and alignment with the scan’s equity and Indigenous focus.

## Document structure

The literature scan begins in Section 1 by setting out its purpose, scope, and context. Sections 2 to 4 examine the evidence in detail, focusing on what works in crisis responses for the general population, for Indigenous communities, and for youth. Section 5 brings together key considerations for strengthening responses in Aotearoa, and Section 6 concludes with the main insights from the scan.

To support these findings, Appendix 1 outlines the search strategy used, while Appendix 2 presents case studies showcasing a range of approaches in both international settings and Aotearoa. A full reference list is provided in Section 8.



## 2. SYSTEM-WIDE CRISIS RESPONSES

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The literature scan highlighted the value of system-wide crisis response models. International exemplars such as the *Trieste Model in Italy* (1), the *Gold Coast Crisis Stabilisation Unit* in Australia (2), and Ireland's community-based mental health infrastructure (3) illustrate the value of system-wide crisis response models that are integrated, equity-driven, and community-anchored. These systems share several defining features:

- 24/7 mobile crisis teams that provide responses where people are (4,5,6).
- Peer-led crisis houses and cafés offering low-barrier, relational care (7,8).
- Purpose-built therapeutic environments, distinct from emergency departments (EDs), that reduce trauma and support voluntary engagement (9).
- Digital helplines and telepsychiatry, integrated with coordinated follow-up care (1,2).
- Shared governance and national strategy that align services across primary, secondary, and community care (1,2,4).

The literature indicates that these models offer continuity from crisis through to recovery, reduce coercion, improve outcomes, and deliver culturally safe, localised support (1,2,5). Critically, these are not standalone initiatives; they operate within whole-of-system mental health strategies that include national standards, evaluation frameworks, workforce development, and strong interagency collaboration (1,2).

In Aotearoa, many of these elements are present. Services such as *Tupu Ake* (10), *Te Puna Wai* (Appendix 2; 11), *Child and Adolescent Acute Response Teams (CAARTs)* (11), and digital supports like *1737* (13) reflect deep strengths in peer leadership, relational care, and cultural grounding. However, these services often function as regionally led or time-limited initiatives, which may limit their reach and consistency across Aotearoa—particularly for Māori, Pacific peoples, and rural communities (14, 15).

The literature also highlights the importance of embedding crisis response within a broader, coordinated mental health and addiction system, one that supports long-term recovery, community reconnection, and alternatives to emergency or justice-based interventions. Indigenous leadership and co-design are identified internationally as essential for improving equity and are similarly relevant to Te Tiriti o Waitangi obligations and aspirations for mana Motuhake in Aotearoa (16, 17).

Evidence from global and local sources underscores that when crisis response is intentionally structured within an integrated system, services are more likely to be compassionate, culturally safe, effective, and sustainable (1,16, 17). Some international examples of this are shared here:

### Trieste Model (Italy)

**About the service:** The Trieste model was developed in the city of Trieste, Italy, between the 1970s and 1990s. It is based on the principles of deinstitutionalisation,

human rights, and social inclusion. The model radically transformed traditional mental health and addiction services by closing psychiatric hospitals and replacing them with a comprehensive network of community-based services. This transformation was underpinned by Law 180 (1978) known as the “Basaglia Law”, which mandated the closure of psychiatric hospitals and legally formalised the shift to community-based support (1).

At its core, the Trieste Model promotes an ‘open door – no restraint’ initiative which aims to support people experiencing mental distress and substance use crisis to live within their communities rather than in institutional settings. The service includes 24/7 community mental health centres that act as the main entry point into the system. The model provides walk in support, mobile crisis teams, home-based interventions, supported housing, social cooperatives, and employment programmes. There is close collaboration with social services, families, and the broader community (1).

**Referral criteria:** The service is open access, meaning that people can self-refer or walk into a community mental health centre without an appointment. Referrals can also come from primary care, EDs, or social services. There are no exclusion criteria, and the services offered cater to people across the entire spectrum of mental health and substance use challenges (1).

**Workforce involved:** The Trieste model encompasses a multi-disciplinary, collaborative and relationship-oriented approach (1). Each community mental health centre typically includes psychiatrists, psychologists, nurses, social workers, peer workers, and rehabilitation specialists.

**Evaluation status:** The Trieste model has been widely studied and internationally validated as a model of best practice in mental health and substance use support.

Trieste has one of the lowest rates of involuntary hospitalisation for mental health and substance use crisis at 8.1 people per 100,000 population, compared with the national average of 14.5 per 100,000. The number of people subjected to involuntary treatment in Trieste fell dramatically from 150 in 1971 to just 18 in 2019. Several studies have confirmed that the transformation of mental health services since the 1970s has led to significantly improved outcomes for people experiencing mental health and substance use crisis and a reduction in overall service costs (19).

## Crisis Resolution Service (Ireland)

**About the Service:** Ireland's Crisis Resolution Services (CRS) were introduced as part of the Health Service Executive mental health reform, guided by the national policy *Sharing the Vision – A Mental Health Policy for Everyone*. The CRS model aims to provide person-centred, community-based alternatives to hospital admission for individuals experiencing acute mental health (3, 19). The service focuses on early intervention, aiming to address crises promptly within the community.

The service has two key components:

1. Crisis Resolution Teams (CRTs): Multidisciplinary teams offering intensive, short-term interventions in individuals' homes or community settings, thereby reducing the need for inpatient care.
2. Crisis Cafés (Solace Cafés): Non-clinical, welcoming spaces operating during evenings and weekends, providing immediate support and de-escalation for those in distress.

**Referral criteria:** CRS is accessible to adults aged 18 and over experiencing a mental health crisis that does not necessitate ED admission. Referrals can be made through:

- General Practitioners (GPs)
- Community Mental Health Teams
- EDs
- Self-referral (for Crisis Cafés) (3, 19).

**Workforce involved:** CRTs consist of multidisciplinary professionals, including psychiatrists, psychologists, Mental Health Nurses, Social Workers, and Occupational Therapists (19).

Crisis Cafés are staffed by trained mental health professionals and peer support workers with lived experience, fostering a supportive and empathetic environment.

**Evaluation status:** The service has not yet been formally evaluated. However, its design is consistent with international evidence showing that home-based crisis resolution teams and community crisis cafés can reduce ED presentations, support voluntary engagement, and improve service user experiences.

### 3. WHAT WORKS WELL IN MENTAL HEALTH AND/OR SUBSTANCE USE CRISIS RESPONSES?

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This section draws on international evidence to identify the specific aspects of crisis mental health and addictions models that support recovery. Overall, the insights from the literature related to three key themes:

- Foundational principles
- Nature of support
- Delivery and access.

#### 3.1. Foundational principles

Effective crisis responses are grounded in principles that uphold human rights, equity, and cultural and relational safety. These foundations shape how services are designed and delivered, ensuring support protects the dignity, autonomy, and mana of tāngata whaiora and whānau.

##### **Rights-based and equity-led**

Strong crisis systems are built on rights-based frameworks that prioritise autonomy, reduce coercion, and promote voluntary, least-restrictive support. Internationally, the UN Convention on the Rights of Persons with Disabilities (CRPD) and the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) provide the basis for equity-driven care (22). In Aotearoa, Te Tiriti o Waitangi underpins obligations to uphold mana motuhake, enable Māori leadership, and ensure culturally safe responses (23, 24).

##### **Culturally grounded and relational**

Crisis care is more effective when it reflects the values and lived realities of the communities it serves. For indigenous communities internationally and locally, this means centring care in collective and relational values, such as whakapapa, whanaungatanga, and wairuatanga (in Aotearoa). Models like the First Nations Health Authority in Canada and Aotearoa-based kaupapa Māori services show that culturally grounded care builds trust, improves access, and reduces harm (25, 26).

#### 3.2. Nature of support and responses

Evidence on the nature of support identified the value of:

- Embedding peer support and lived experience to enhance empathy, trust, and cultural safety.
- Applying trauma-responsive approaches to create emotionally and culturally safe environments.

- Non-coercive, person-centred responses to support autonomy and dignity, and reduce harm associated with some traditional police or clinical-led approaches.
- Co-response and collaborative models that provide multidisciplinary responses that reduce coercion.

Peer roles operate in very different contexts. Services like *Tupu Ake*, *Piri Pono*, and *Te Puna Wai* offer voluntary, relational support in home-like settings, while the Peer Support Service/ED pilot places peers in EDs to provide trauma-informed care in high-pressure environments. Both draw on lived experience but serve distinct functions within the crisis system.

### 3.2.1. Embedding peer support and lived experience

Peer support is increasingly recognised as a core component of effective crisis response. It provides relational, empathetic care grounded in lived experience, which helps build trust and safety especially during acute distress. Peer involvement supports de-escalation, reduces stigma and fear of coercion, and makes services feel more approachable and humane (18, 21, 23, 24). Peer support is valuable not only when tāngata whaiora actively seek help, but also in involuntary or high stress settings (e.g. ED, police response and inpatient settings), where peer support can reduce trauma, rebuild trust, and help avoid clinical or coercive responses (9, 27, 12). Incorporating lived experience into service delivery and design ensures crisis care is not just clinically responsive, but relational and human centred (10, 16, 28, 29).

**International practice:** In the United Kingdom and Australia, peer led and peer integrated models are an established part of the crisis response landscape. In the UK, *Together for Mental Wellbeing* has embedded peer support roles across community and crisis services since 2012 (30). In Australia, the *Urgent Mental Health Care Centre* in Adelaide blends peer and clinical roles to create a safe, welcoming alternative to EDs (31). These models illustrate how peer led approaches can enhance access, reduce harm, and promote recovery.

**New Zealand practice:** Aotearoa has several peer-led and peer-integrated crisis response models that reflect values of manaakitanga, whanaungatanga, and cultural safety. Services such as *Te Puna Wai – Safe Haven Café* (Palmerston North), *Haven* (Auckland), and *Whakamaru* (Wellington) offer non-clinical, walk-in spaces where peer workers support tāngata whaiora to de-escalate distress and connect with community supports (11, 32). These services are low barrier, trauma responsive, and offer alternatives to ED.

*Tupu Ake*, an acute alternative to inpatient care in South Auckland, is co-designed and operates with lived experience leadership. It combines peer support and on-site clinical input in a voluntary, home-like setting that supports emotional and cultural safety (10). Similarly, *Puna Whakataa* offers short-term, peer-informed respite for people in substance use distress, providing a supportive, non-clinical environment (20). These models prioritise trust, cultural identity, and restoration of agency, and are especially valued by tāngata whaiora with past harm in clinical settings.

Aotearoa New Zealand has expanded the peer support workforce into hospital Emergency Departments (EDs) through the PSS/ED pilot. As of mid-2025, trained Peer Support Specialists are embedded at Middlemore, Auckland City, Waikato, Wellington Regional, and Christchurch Hospitals, with further sites (North Shore, Tauranga, and Dunedin) scheduled to join by late 2025.

Peer Support Specialists are a skilled workforce who bring their lived experience alongside formal training in trauma-informed practice, cultural safety, and consumer, peer support and lived experience values. They provide empathetic, non-clinical support, help de-escalate distress, and connect tāngata whaiora and whānau with community-based resources. Their training ensures they can draw on lived experience safely and effectively, protecting both tāngata whaiora and themselves in high-pressure ED environments. Early feedback indicates that their presence enhances service user experience, supports recovery-oriented practice, and contributes to more compassionate crisis responses (33).

**Comparisons:** There is strong evidence that peer-led and lived experience-informed approaches are essential for effective, trauma-informed crisis care. UK and Australian models such as *Together for Mental Wellbeing* and the *Urgent Mental Health Care Centre* highlight the benefits of formally embedding peer roles within mental health and addiction systems, supported by clear frameworks and growing evaluation evidence (30, 34).

In Aotearoa, peer-led responses are less systematised at a national level. While not all peer support approaches are explicitly kaupapa Māori, many draw on culturally grounded practices and locally responsive ways of working. Taken together, both international literature and Aotearoa-based practice demonstrate the value of centring lived experience in crisis response, with Aotearoa offering compelling examples of context-responsive, equity-focused models.

### 3.2.2. Applying trauma responsive approaches

Trauma-responsive approaches acknowledge that many tāngata whaiora and whānau experience distress shaped by past trauma, including systemic harm, discrimination, and coercive care. Trauma-responsive care fosters cultural and emotional safety, empowerment, and trust by prioritising de-escalation, emotional regulation, and collaboration. This helps people feel respected and in control, supporting dignity, mana, and openness to receiving help (35, 23, 26, 36).

**International practice:** Trauma informed principles are increasingly embedded in community-based crisis responses. For example, the *Toronto Community Crisis Service* offers non police, community led responses to mental health crises, with trained teams that use trauma informed de-escalation, cultural safety, and peer involvement to reduce harm (24). In the United States, *Street Crisis Response Teams* in San Francisco respond to 911 calls involving mental health and addictions related behavioural health issues without police involvement. They use trauma-informed engagement strategies to defuse situations, avoiding escalation and ED use (37).

When trauma informed care is central to service design, it reduces restrictive practices, improves staff confidence, and enhances the experience of tāngata whaiora (38).

**New Zealand practice:** Trauma informed principles are visible in several crisis responses that prioritise emotional safety and relational connection. Peer led services such as *Tupu Ake* and safe havens like *Te Puna Wai* incorporate trauma informed principles through voluntary, nonjudgmental engagement, fostering safety and trust (21).

**Comparisons:** Both international and Aotearoa-based crisis responses increasingly recognise the importance of trauma-responsive care in fostering safer, more relational and culturally safe experiences for tāngata whaiora and whānau. Internationally, these approaches are supported by system-wide infrastructure, including formal training requirements, integrated service pathways, and consistent evaluation frameworks that enable scale and sustainability. In contrast, responses in Aotearoa are more locally driven, with strengths in cultural grounding, peer leadership, and relational practice, but limited national coordination or consistent implementation across the system.

### 3.2.3. Non-coercive, person-centered responses

The literature consistently highlights the importance of non-coercive, person-centred approaches in mental health and substance use crisis response. These approaches prioritise empathy, de-escalation, dignity, and connection, rather than coercion or control. They empower tāngata whaiora and whānau to shape their care—identifying triggers, choosing preferred interventions, and developing safety or wellness plans. This is particularly important for people who have experienced previous trauma or negative interactions with police or emergency services, as non-coercive responses reduce fear and stigma and encourage help-seeking (14, 40-45). Framing mental distress and substance use crises as health issues, not legal issues, is central to enabling safe and effective responses (46).

**International practice:** Many countries are shifting away from coercive, police-led responses toward therapeutic, community-based alternatives. Models such as the *Toronto Community Crisis Service* and *Queensland's Mental Health Co-Responder Programme* deploy trained community responders and integrated police-clinician teams, resolving most incidents without hospitalisation or coercive interventions (47-49). Peer-run crisis respites in the US and Canada offer voluntary, homelike alternatives to inpatient care, with evaluations showing reduced emergency service use and high satisfaction among those wary of clinical services (28, 50). The *Open Dialogue* approach, developed in Finland, provides immediate network-based support involving the individual, family, and social networks. The approach has been linked to reduced hospitalisation, lower medication use, and better functional outcomes (51, 52).

Ireland's *Crisis Resolution Services* pilot integrates Crisis Resolution Teams (CRTs)—multidisciplinary, community-based professionals—and 'Solace Cafés', which function as crisis cafés offering same-day, walk-in support in non-clinical settings. These

services are designed to provide rapid assessment and therapeutic care without defaulting to emergency services (53, 54). Initial implementation across several pilot sites has shown promise in delivering person-centred, community-based crisis responses with minimal police involvement and positive client engagement outcomes. The model is structured to reduce reliance on coercive systems while prioritising safety, relational support, and recovery pathways

**New Zealand practice:** There are emerging efforts to reduce reliance on police led crisis responses. The *Wellington Mental Health Co Response Team* (Appendix 2; 6, 7) integrates police officers and mental health clinicians, enabling a more coordinated and therapeutic approach to crisis call outs. Peer led models such as *Tupu Ake* (10) offer alternatives to acute inpatient care, prioritising voluntary engagement, emotional safety, and cultural responsiveness.

Peer-led services such as *Tupu Ake* and *Te Puna Wai – Safe Haven Café* provide voluntary, culturally anchored environments that prioritise safety, choice, and relational care, particularly for Māori, Pacific, Rainbow, and disabled youth. Peer-led warm lines – telephone based support services staffed by trained individuals with lived experience – also offer accessible, non-clinical support, empowering tāngata whaiora to guide their own recovery journeys (55, 28, 10).

**Comparisons:** Both internationally and in Aotearoa, the shift toward non-coercive, person-centred crisis care is well established in principle, though implementation varies. Internationally, there has been significant system-level investment in specialist crisis teams, peer respites, and training initiatives. In Aotearoa, while access remains localised and patchy, community-based and culturally grounded services provide strong foundations. The evidence suggests that the most effective responses combine autonomy, relational safety, and cultural responsiveness with system-level investment and consistency.

### 3.2.4. Co-response and collaborative models

Internationally, co-response and collaborative crisis models are increasingly recognised as among the most effective ways to support people and whānau in mental distress or substance use crises. These models typically combine mental health professionals, paramedics, and trained community responders working alongside or instead of police to provide coordinated, therapeutic care (56, 57).

**International practice:** Co response models have evolved to incorporate strong partnerships across health, community, and emergency services. In Australia, the *PACER (Police, Ambulance, Clinician Early Response)* model and the *Safeguards initiative* pair mental health clinicians with police and paramedics to deliver immediate support during crisis callouts. Evaluations show these reduce involuntary detentions and increase satisfaction with services (5).



The *Toronto Community Crisis Service (Canada)* deploys community-based mental health responders to 911 calls, resolving most incidents without police involvement and reducing reliance on EDs (56). Similarly, the long-running *CAHOOTS programme (Eugene, Oregon, U.S.)* dispatches unarmed crisis workers and medics instead of police for most non-violent calls. Evaluations show *CAHOOTS* diverts thousands of calls annually from police and EDs, reduces unnecessary hospitalisations, and saves significant system costs (57).

In remote areas, co response teams use clinician expertise via phone or virtual consultation. This enables real time advice and support when clinicians cannot be present (7).

**New Zealand practice:** Co-response models remain more localised but show similarly promising results. Co-response approaches have been described as “far less frightening” than police-only responses, reducing stigma and fear, and fostering trust among *tāngata whaiora* and *whānau* (6). They also improve coordination among police, paramedics, and clinicians, addressing concerns that traditional crisis responses relied too heavily on coercion and produced poor outcomes (5, 7).

The *Wellington Co Response Team*, for example, integrates police, ambulance staff, and mental health clinicians to respond to emergency mental health and substance use incidents. Evaluation data shows this team reduced ED presentations (from 51% to 29%) and lowered the use of Mental Health Act Section 109 detentions from 21% to 13% when deployed. These outcomes reflect increased cultural safety, earlier engagement, and improved experiences of *tāngata whaiora* (4, 6)

Te Ara Oranga, focused on methamphetamine harm reduction, is a strong example of a co response initiative that includes police, health professionals, and community workers working together to support *tāngata whaiora* and *whānau*. Evidence has demonstrated improved outcomes, community engagement, and reductions in harm (58).

Co-response models that include lived experience and cultural capability provide safer environments for responders and enable more person- and *whānau*-centred support during crises (7, 8).

**Comparisons:** While both international and New Zealand based co response models share common goals, international systems tend to embed these models more comprehensively within a national or regional framework. For instance, models in Australia, Canada, and the UK are increasingly integrated into broader crisis response systems, with clear mandates, consistent workforce training, data collection, and policy direction. In contrast, Aotearoa’s co response initiatives have largely emerged as regional or pilot efforts, resulting in variability in design, availability, and cultural integration. This presents a key opportunity for New Zealand to shift from isolated implementations to a nationally coordinated and equity led crisis response model that builds on both local strengths and international learning.

## 3.3 Delivery and access

The following elements were identified as aspects of delivery and access that influence the structure and reach of crisis responses:

- Timeliness and accessibility, including mobile teams, 24/7 response, digital tools, rapid intervention models.
- Equitable geographic reach, ensuring access for rural, remote, and underserved populations.
- Integrating services into community to provide ongoing support.
- Workforce wellbeing that supports resilience and safety for people delivering crisis care.

### 3.2.5. Timeliness and accessibility

This section covers crisis supports in both ED-adjacent settings (e.g. *EmPATH* units, *Psychiatric Decision Units*) and community or home settings (e.g. *Crisis Resolution Teams*, *ACITs* in Aotearoa). While different in context, both aim to reduce harm, provide timely, non-coercive support, and connect people to ongoing care.

**International practice:** Countries are developing system wide solutions to provide fast, effective responses that divert people from hospitals or police involvement. In the United States, the *EmPATH* model (Emergency Psychiatric Assessment, Treatment and Healing) introduces specialised, purpose-built spaces within or adjacent to EDs. These calming environments are staffed by mental health professionals and designed to stabilise and support individuals without the chaos and pressure of general EDs. *EmPATH* units have demonstrated significant reductions in inpatient admissions (from 57.1% to 27.3%) and ED wait times (from 16 to 5 hours), while increasing timely follow up care by 60% (14).

The *CALM model* (Crisis Assessment Linkage and Management), used in the US and UK, embeds behavioural health assessment teams within emergency settings to offer on the spot care planning. This approach has shown reductions in ED length of stay (from 9.5 to 7.3 hours) and inpatient admissions (from 46.2 to 31.4 hours), supporting smoother care transitions and better outcomes (61).

In Australia, the *Gold Coast Crisis Stabilisation Unit* (CSU) (3) exemplifies a purpose built, non-inpatient alternative for individuals experiencing acute mental health or substance use distress. The CSU is a 24/7 facility co located with the Gold Coast University Hospital but operates independently of the ED. Staffed by a multidisciplinary team, the unit offers short term, recovery focused support in a calm, therapeutic environment. Its design incorporates soft furnishings, sensory modulation spaces, and access to peer and cultural workers. Early progress findings show the CSU reduces ED presentations, enhances consumer satisfaction, and supports safe, voluntary engagement during acute episodes (2). The Gold Coast Crisis Stabilisation Unit reflects key principles outlined in SAMHSA's *National Guidelines for a Behavioral Health Coordinated System of Crisis Care* (2025), particularly by offering "a safe place

for help” through its purpose-built, peer-integrated environment that diverts individuals from emergency departments and provides immediate, recovery-oriented support (2).

Comparable international examples have also emphasised the importance of cultural and age-responsive crisis care approaches. For instance, the *Manitoba Keewatinowi Okimakanak (MKO) Mobile Crisis Response Team* in Canada is staffed by Indigenous responders who provide trauma-informed mental health support—including sharing circles, debriefing, and safety planning—within First Nations communities on a flexible and culturally safe basis (62). In Australia, Aboriginal services such as *I3YARN*, a 24/7 crisis helpline staffed by Aboriginal & Torres Strait Islander Crisis Supporters, underscore the role of culturally-grounded linguistic and relational safety in crisis interventions (63). Youth-specific models, including mobile and community-led crisis support initiatives in Canada and Australia, reassure the value of deliberately embedding age-appropriate responses into broader crisis systems (youth-specific team references as per earlier practice). These models collectively demonstrate the impact of pairing clinical and peer expertise with culturally respectful, developmentally tailored strategies (62, 63).

**New Zealand practice:** Rapid crisis responses have developed through regionally led innovations within and alongside EDs. Several districts operate *Crisis Resolution Services* or *Acute Community Intervention Teams* that provide urgent, short term mental health assessments to tāngata whaiora presenting in crisis. These services are often embedded within EDs or function as mobile outreach teams. For example:

- Health NZ Waitematā Assessment, treatment and rehabilitation service offers intensive short-term support in the community to reduce hospital admissions (64)
- Health NZ Counties Manukau Health runs a 24/7 Crisis Resolution Service for adults needing urgent mental health care (65)
- Urgent Adult Services in the Health NZ Canterbury region provide a mobile response to adults in acute distress, often referred from EDs (66, 67).

Te Toka Tumai Auckland operates a Psychiatric Decision Unit (PDU) located adjacent to the ED. This low stimulation unit allows tāngata whaiora to stay for up to 48 hours while receiving psychiatric assessment and support in a calmer environment offering a viable alternative to full inpatient admission (68).

**Comparisons:** Internationally, crisis response models are trending toward system-wide investment in rapid, non-coercive alternatives that reduce ED wait times, lower inpatient admissions, and divert people from police involvement (14, 61, 69–71). Many jurisdictions are also embedding culturally responsive and youth-specific approaches, such as Canada’s Indigenous-led *MKO Mobile Crisis Response Team* (72) and Australia’s *I3YARN* helpline (73), to ensure equity and relational safety.

In Aotearoa, rapid response services like ACITs, Crisis Resolution Teams, and PDUs remain regionally variable, but there are notable strengths. Alternatives such as *Tupu Ake* (10), *Piri Pono* (Appendix 2; 20), and *Te Ao Mārama* (74) provide acute, voluntary,

culturally grounded environments that reduce reliance on EDs and coercive interventions. The challenge is achieving the national consistency and infrastructure seen overseas, while scaling culturally grounded and relational innovations into a coordinated system that recognise the context in Aotearoa.

### 3.2.5. Equitable geographic reach

Ensuring equitable access to crisis support is essential, particularly for underserved and rural communities, who often face barriers such as limited local mental health and addictions services, long wait times, and reliance on EDs for acute care (14). These challenges are exacerbated by the large geographical areas that regional crisis response services need to reach. These inequities can lead to avoidable hospital admissions and missed opportunities for early intervention. Innovations such as digital health solutions and decentralised care models aim to bridge these gaps and bring support closer to the point of need (14).

**International practice:** Several models have been developed to improve mental health crisis care access in underserved regions. The *Emergency Psychiatric Assessment, Treatment and Healing (EMPATH)* model provides a specialised space within or near rural EDs for rapid mental health assessment and short-term support to reduce immediate distress. This approach has significantly improved outcomes for patients by reducing inpatient admission rates (from 57.1% to 27.3%), ED wait times (from 16 to 5 hours) and increasing follow up support within 30 days by 60% (14). Bringing services closer to the point of need, models like EMPATH promote more equitable and accessible mental health and substance use crisis support (14).

In addition, the *North Carolina Statewide Telepsychiatry Program* (NC STeP) connects rural EDs to psychiatric providers via video consultation, improving responsiveness and transitions to aftercare (75). Australia's *Better Access* initiative funds subsidised telehealth services for people in rural and remote areas, enhancing continuity of care and mitigating workforce shortages (76). These examples highlight how technology enabled and decentralised models can help ensure more equitable, responsive mental health crisis support across different geographies.

**New Zealand practice:** Rural communities continue to experience disparities in crisis service availability (77). While some regions have implemented telehealth based psychiatric consultations, access remains variable, with ongoing reliance on EDs for mental health and substance use crisis support. Telehealth is used sporadically, and rural communities still face service variability and access challenges (78).

**Comparisons:** International models highlight how digital innovation, dedicated crisis environments, and integrated community responses can address access inequities at scale. Programmes such as *EMPATH* and *NC STeP* demonstrate how technology-enabled and decentralised approaches can reduce wait times, improve continuity, and extend specialist reach (14, 75, 76).

In contrast, Aotearoa relies heavily on regionally delivered Health NZ crisis teams, with variable access and limited national infrastructure for specialised crisis environments like *EmPATH* units. While telehealth initiatives are emerging, their use is inconsistent,

and many rural services remain reliant on face-to-face daily clinical support to meet acute needs. Recent initiatives, such as the Mental Health Innovation Fund's (2025) support for Tend Health to expand telehealth services, signal early steps toward improving digital access (120). However, the literature indicates that these developments are still emergent, with uneven coverage and limited integration into the wider crisis response system (15).

### 3.2.6. Integrating services into community settings

Integrated crisis responses connect acute support with ongoing care by linking tāngata whaiora to community mental health teams, primary care, whānau, and social supports. This approach ensures continuity of care and reduces the likelihood of repeated crises. Key models include *Crisis Resolution Home Treatment (CRHT)* and home-based treatment, which provide intensive support in a person's home, avoiding inpatient admissions and promoting recovery in a familiar, culturally safe environment (7, 16, 79).

**International practice:** Internationally, CRHT and home-based models are widely used to reduce hospitalisation and support recovery in community settings. In Amsterdam, CRHT interventions led to a 33% reduction in hospitalisation days over 12 months compared with inpatient support, with higher satisfaction from service users and families (80). In Germany, the Inpatient Equivalent Home Treatment (IEHT) model delivers multidisciplinary care in people's homes with equivalent staffing to hospital units (70).

In the United Kingdom, NHS England's *Five Year Forward View for Mental Health* outlines a national commitment to shifting acute and crisis care out of hospitals and into the community. This includes investment in 24/7 community crisis teams, crisis cafés, which provide drop-in, non-clinical support in safe, calming environments. Crisis cafés typically operate extended hours, are staffed by peers alongside professionals, and connect people directly to ongoing services rather than providing standalone care (81).

These models are valued for preserving routines, strengthening family involvement, and reducing the trauma associated with hospitalisation (82, 71).

**New Zealand practice:** Several districts operate home based crisis support through Crisis Resolution Services and Acute Community Intervention Teams (ACITs). These services provide short term intensive support, often as an alternative to inpatient care, and can be delivered in people's homes or community settings. Key examples include:

- Health NZ Counties Manukau offers a home-based crisis service for adults needing urgent support (83)
- Health NZ Waitematā ACIT delivers mobile outreach to tāngata whaiora in acute distress (83)
- Health NZ Canterbury operates mobile crisis teams that provide urgent support, including clinical assessment and coordination with whānau, similar to models used in Hawke's Bay/Tairāwhiti (83).

**Comparisons:** Both internationally and in Aotearoa, there is a clear shift toward integrating crisis response into community settings as an alternative to hospital-based care. The literature shows that internationally, the focus is primarily on clinical effectiveness, service efficiency, and system impact. Models like *Crisis Resolution Home Treatment (CRHT)* in the UK and *Inpatient Equivalent Home Treatment (IEHT)* in Germany are well evaluated, demonstrating reduced hospitalisation days, improved throughput, and higher service user satisfaction (71, 80, 82).

Internationally, long term system planning involving whole of system integration across acute care, community supports, and peer led alternatives has proven critical to success. Key examples include *Trieste* and *Ireland*. In Aotearoa, while approaches are more locally led and variable across regions, there are strong values in practice, including peer integration within community-based crisis alternatives such as *Tupu Ake*, *Piri Pono*, and *Te Ao Mārama*. These services demonstrate how peer-led support can complement clinical and whānau involvement to provide culturally grounded, relational care.

The key distinction is that international models emphasise system consistency, while approaches in Aotearoa prioritise local responsiveness and cultural connection.

### 3.2.7. Workforce wellbeing

While not the focus of this literature scan, staff wellbeing is widely recognised as essential for sustainable and effective crisis responses. Burnout and stress can undermine safe and compassionate care, while supportive environments foster trust, empathy, and resilience (5, 7).

**Comparisons:** Evidence across both international and Aotearoa contexts highlights the importance of embedding wellbeing supports for crisis teams. International models emphasise structured training, peer support, and wellness initiatives (84). In Aotearoa, peer support roles are an emerging part of the crisis response workforce. While most services are not fully peer-led and operate within broader organisational structures, initiatives such as *Tupu Ake* (10) have shown the potential of peer-informed approaches to create emotionally safe, non-hierarchical environments. Alongside collaborative, cross-agency models, these emerging peer contributions support the relational and therapeutic values central to crisis care.

## 4. WHAT WORKS WELL FOR INDIGENOUS POPULATIONS?

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The evidence on crisis responses for the general population highlights the importance of non-coercive, person-centred care; embedding peer and lived experience; co-response models that reduce police involvement; and trauma-responsive, relational approaches. International and Aotearoa-based evidence shows that these elements are also critical for Indigenous populations, but they are not sufficient on their own. For Indigenous communities, the most effective crisis responses go further — they are whānau and community-led, culturally grounded, and self-determined (85-88).

Shared themes across both groups include holistic models of wellbeing, de-escalation through relational care, and the integration of lived experience. The key differences lie in the centrality of cultural identity, tikanga, and community authority in Indigenous models. Internationally, Indigenous crisis responses are often embedded within national rights and policy frameworks, while in Aotearoa, kaupapa Māori initiatives are locally developed, relationally grounded, and variably resourced, reflecting both their strengths and their vulnerability (86, 87).

This section focuses on international and Aotearoa approaches and comparisons to understand more about the evidence relating to:

- Embedding whānau and community led approaches
- Embedding Indigenous leadership and self-determination
- Integrating cultural practices.

### 4.1. Embedding whānau and community led approaches

Whānau and community-led crisis responses are highly effective for Indigenous populations, as they centre connection, cultural knowledge, and lived experience. These approaches prioritise long-term, intergenerational wellbeing over short-term clinical outcomes (87, 88). By drawing on collective strengths and whānau networks, they provide a strong foundation for recovery and healing (90, 91, 26, 89, 45, 85, 88).

**International practice:** Evidence demonstrates the effectiveness of community-led crisis responses for Indigenous populations. The *Fish Net Model* developed by the Eskasoni First Nation in Canada employs a “two-eyed seeing” approach, blending Indigenous and Western perspectives to provide holistic mental health support (92). In Zimbabwe, the *Friendship Bench* model trains trusted community members, often referred to as “grandmothers,” to deliver accessible talk therapy in local settings. This model addresses service gaps through relational, culturally grounded care and has been linked to significant improvements in mental wellbeing (93).

**New Zealand practice:** In Aotearoa, kaupapa Māori services highlight collective wellbeing and relational care. *Te Kuwatawata* (currently operating as He Waharoa



under Te Kupenga Trust) supports tāngata whaiora through connection, narrative, and whakapapa, rather than through diagnosis or rigid clinical entry criteria (94). An evaluation found that strengthening cultural identity and whānau connection was critical to improved recovery and engagement.

**Comparison:** International models emphasise expanding access to community-delivered supports, while in Aotearoa, whānau-led approaches like *Te Kuwatawata* are firmly grounded in kaupapa Māori frameworks, privileging whakapapa and collective recovery over short-term clinical outcomes.

## 4.2. Embedding indigenous leadership and self determination

For Indigenous communities, the most effective crisis responses are those that reflect self-determined priorities, cultural values, and lived experience. Whether in Aotearoa or internationally, evidence consistently shows that when Indigenous peoples lead or co-govern mental health services, outcomes improve. These approaches align with global Indigenous rights frameworks and emphasise the importance of cultural safety, community control, and relational care in achieving long-term wellbeing.

**International practice:** There is strong evidence that Indigenous-led and co-governed crisis responses result in more trusted, effective, and culturally safe services. In Canada, the *First Nations Health Authority (FNHA)* enables First Nations to design and deliver their own health services, strengthening community control and aligning care with cultural values (94, 95). In Australia, the *Gayaa Dhuwi (Proud Spirit) Declaration* calls for Aboriginal and Torres Strait Islander leadership across all levels of mental health systems, ensuring services are culturally relevant and responsive to Indigenous worldviews (96). These initiatives align with global rights instruments such as the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*, which affirms Indigenous peoples' rights to define and lead their own health priorities (97).

**New Zealand practice:** The strength of Indigenous crisis response in Aotearoa lies in kaupapa Māori approaches that centre mana motuhake, cultural identity, and whānau-led healing. Services such as *Te Puna Wai* and *Te Ao o Ngā Tāngata* were developed through community hui, peer-led consultation, and Māori partnership, ensuring tāngata whaiora and whānau define what wellness means and co-design services to meet their needs (46, 94, 11, 44). These approaches reflect the principles of *Te Tiriti o Waitangi* and are also aligned with the *Wharerātā Declaration*, which calls for Indigenous leadership, equity, and culturally grounded mental health responses. By drawing on collective strengths, cultural knowledge, and lived experience, kaupapa Māori models provide relational, safe, and holistic support that extends beyond clinical frameworks.



**Comparison:** International examples demonstrate the benefits of embedding Indigenous governance at a system-wide level. In Aotearoa, Indigenous self-determination is most visible in locally developed kaupapa Māori services, which are powerful in their cultural grounding but less consistently supported by national frameworks.

### 4.3. Integrating cultural practices

Crisis responses that integrate Indigenous healing with clinical models are increasingly recognised as essential for culturally safe care (92, 95). Evidence from Aotearoa and internationally shows that blending traditional knowledge with Western approaches can address intergenerational trauma, build trust, and improve outcomes. By centring cultural identity, whānau connection, and relational healing, these models are particularly effective in crisis situations.

**International practice:** Integrating traditional Indigenous healing with Western clinical models has been shown to strengthen engagement and outcomes. In Canada, Aboriginal communities have embedded healing approaches within the *Seeking Safety* programme to address trauma and substance use, ensuring that cultural identity remains central to recovery (98, 92). In Australia, the *Wungen Kartup Specialist Aboriginal Mental Health Service* combines Aboriginal healers with Western clinicians in a dual-practice model, offering whole-of-family, culturally safe care that builds trust and supports emotional healing.

**New Zealand practice:** Kaupapa Māori services embed cultural practices as the foundation of care. *Mahi a Atua* uses pūrākau, rongoā, mirimiri, and wānanga to restore mana, relational connection, and whānau wellbeing, challenging models that prioritise diagnosis over cultural identity (42, 26, 87, 98).

Workforce initiatives such as the postgraduate diploma at *Te Whare Wānanga o Awanuiārangi* integrate tikanga Māori and āhuetanga Māori into modern mental health training, developing a culturally competent workforce (98). Similarly, *Mahi a Atua* offers a kaupapa Māori framework grounded in pūrākau, rongoā, mirimiri, and wānanga—centering whakapapa and relational restoration over diagnostic labelling (99, 26, 87, 98). These models foster healing, restore mana, and create culturally meaningful experiences of care.

**Comparisons:** Across both international and Aotearoa contexts, the evidence affirms that Indigenous-led, culturally grounded healing approaches significantly enhance the quality and outcomes of crisis response. International models such as *Seeking Safety* and *Wungen Kartup* show how traditional practices can be formally embedded alongside clinical models, supported by system infrastructure and workforce integration. In Aotearoa, the strength lies in kaupapa Māori approaches that holistically weave together cultural identity, whānau involvement, and relational healing. Together, these examples reinforce that the integration of Indigenous healing methods is not only a cultural imperative, but a practical foundation for effective, transformative crisis care.

## 5. WHAT WORKS WELL FOR YOUTH?

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Evidence shows that many of the principles that support effective crisis responses for the general population — non-coercive, trauma-informed, and relational approaches — are also essential for youth. However, youth-specific responses also emphasise the importance of whānau involvement, age-appropriate environments, and accessible, non-clinical settings. These differences reflect the unique developmental, cultural, and social needs of young people, making youth-centred design a critical factor in effective crisis care (100-102).

### 5.1. Engaging with family/whānau

Family/whānau engagement is a critical element of effective crisis responses for young people experiencing mental distress or substance use harm. Involving families not only strengthens emotional and cultural safety but also contributes to better recovery, increased connection, and long-term resilience. Both international and Aotearoa-based evidence supports family inclusion as a protective factor—though the ways it is operationalised differ by context (100, 101).

**International practice:** Family engagement is widely recognised as a cornerstone of youth mental health crisis care. In the UK, crisis services follow *NICE guidelines*, which promote shared decision-making and family-inclusive planning (103, 104). In Australia, services like *Headspace Early Psychosis* and *Orygen Youth Health* formally embed family involvement through structured interventions, education, and relapse prevention efforts (105-107). These services treat families as partners in recovery and equip them with tools to support young people effectively.

In the United States, the *SAMHSA National Guidelines for Child and Youth Behavioral Health Crisis Care* identify family engagement as a core pillar of crisis response. These guidelines recommend embedding family peer support workers within multidisciplinary teams to ensure meaningful, culturally responsive family involvement throughout the crisis care continuum (108).

**New Zealand practice:** Whānau engagement is deeply rooted in relational and cultural values in Aotearoa. Services like Purapura Whetu in Ōtautahi (Christchurch) offer youth-focused, kaupapa Māori mental health and addiction support that integrates *mātauranga Māori*, traditional healing, and community-based services. Their approach strengthens identity and connection through whānau-centred wellbeing and culturally safe practice (109).

Emerging evidence shows that including whānau improves outcomes, safety, and relational support for young people in crisis (7, 84, 100), with particular resonance for rangatahi and young people, where cultural and whānau connections are central to wellbeing. The emphasis on *whanaungatanga*, cultural safety, and collective healing offers a strengths-based alternative to more formalised therapeutic family interventions.

**Comparisons:** Both international and Aotearoa-based models recognise the value of engaging family and whānau in youth crisis responses. International models often rely on formal mechanisms—such as structured family therapy, care coordination roles, and national guidelines—to embed family engagement into service delivery. These structures support consistency and scalability across systems.

In Aotearoa, whānau engagement is already a core feature of many youth mental health and addiction services, delivered in ways that reflect cultural values of whanaungatanga and collective support. The evidence confirms that both internationally and in Aotearoa, actively engaging families supports safety, trust, and recovery for young people.

## 5.2. Youth focused community settings

Youth-friendly crisis responses are most effective when they are accessible, non-clinical, and integrated into environments that reflect the preferences and needs of young people. Both international and Aotearoa-based models are increasingly shifting away from hospital-based care toward early intervention and community-led approaches.

**International practice:** International models are leading a shift toward decentralised, non-institutional youth crisis responses. In the UK, the *Best for You* model in London includes *The Arc*, a youth-centred day facility offering four weeks of therapeutic support for adolescents and their families. This model is associated with reduced hospital use and improved satisfaction among both young people and whānau (110).

In Germany, the *Inpatient Equivalent Home Treatment (IEHT)* model brings hospital-level mental health care into the home, including for adolescents. This approach supports continuity in school and family life, with evaluations showing higher patient satisfaction, stronger decision-making involvement, and reduced readmissions compared with traditional inpatient care—despite slightly longer treatment durations (12, 112).

In Canada, *Kids Help Phone*, a 24/7 national e-mental health service, provides immediate, confidential crisis support through phone, text, and online platforms, reaching a wide range of young people, including those in rural and underserved communities. Its scalability and accessibility make it a critical complement to in-person youth crisis services (113).

**New Zealand practice:** *Child and Adolescent Acute Response Teams (CAARTs)* integrate mental health, physical health, substance use, peer, and social supports within one service hub (119). Well-implemented CAARTs have reduced ED presentations by 15% and re-presentations by nearly 32%, highlighting their impact (102). Alongside these, helplines such as *Youthline* (114), *Peer Warmline* (115), and *1737* (116) provide immediate, anonymous support. While *Youthline* does not position itself as a crisis service, evidence and practice indicate that many young people turn to it during times of immediate need. These services are particularly important for rural

and isolated youth, even though integration with in-person crisis responses remains inconsistent (117).

**Comparisons:** Internationally, youth crisis responses are moving toward structured, therapeutic day services and home-based care embedded within national frameworks (118).

In Aotearoa, the strength lies in integrated, community-led services like CAARTs, and widely accessible helplines that lower barriers for diverse youth populations, although integration across the system remains variable.

## 6. OVERVIEW OF KEY THEMES

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This literature scan draws together international and Aotearoa evidence on crisis responses for the general population, Indigenous communities, and youth. Looking across these groups, several unifying themes emerge, alongside clear contrasts between international system-wide approaches and regionally driven, culturally grounded responses in Aotearoa.

**International literature** emphasises system-level design and sustained investment as critical to effective crisis response. Common features include:

- **Integrated, 24/7 coverage:** Mobile crisis teams, crisis stabilisation units (e.g. *EmPATH* in the US, Gold Coast CSU in Australia), and crisis cafés ensure immediate and continuous access.
- **System-wide coordination:** National strategies and evaluation frameworks (e.g. UK's CRHT teams, Ireland's *Sharing the Vision*) provide consistency, accountability, and equity of access.
- **Non-coercive, trauma-responsive care:** Many models intentionally move away from police-led or coercive interventions, instead embedding peer and lived experience roles, therapeutic spaces, and family inclusion.
- **Equity and rights frameworks:** *UNDRIP* and *CRPD* principles underpin Indigenous and minority-focused services in countries such as Canada and Australia, embedding cultural safety and self-determination.
- **Youth-specific responses:** Purpose-built, age-appropriate hubs (e.g. *Best for You* in the UK) and digital platforms (e.g. *Kids Help Phone* in Canada) deliver youth-friendly, stigma-reducing support.

**New Zealand literature** identifies the strength of innovative approaches, though largely at local or regional levels. Key themes include:

- **Cultural grounding and whānau-centred care:** Kaupapa Māori services (e.g. *Te Kuwatawata*, *Te Puna Wai*) embed tikanga, whakapapa, and collective wellbeing as the foundation of crisis support.
- **Peer leadership and lived experience:** Services such as *Tupu Ake* and *Piri Pono* demonstrate the value of peer-led, voluntary alternatives to ED-based care, with Aotearoa beginning to embed peers into EDs nationwide.
- **Relational and trauma-responsive practice:** Locally led safe havens, respite services, and community outreach focus on creating emotionally safe, voluntary, and non-stigmatising environments.
- **Patchwork access and fragmentation:** While individual services show positive outcomes, national cohesion is limited, with variable access to 24/7 support, inconsistent use of telehealth, and reliance on EDs and police in many regions.
- **Youth and family inclusion:** *Child and Adolescent Acute Response Teams (CAARTs)* and helplines like *Youthline* provide different options for young people, though integration into a national framework remains limited.

Overall, the literature shows that crisis responses are most effective when they are timely, non-coercive, culturally safe, and connected to wider systems of care. Internationally, outcomes are strongest where services are part of cohesive, nationally coordinated systems with 24/7 coverage, consistent standards, and robust evaluation.

In Aotearoa, the standout strengths are locally led, kaupapa Māori and peer-informed approaches that build trust, uphold mana, and provide safe, voluntary alternatives to EDs. However, access remains uneven and fragmented, with many services regionally driven rather than nationally integrated.

The shared message is clear: across general, Indigenous, and youth populations, crisis responses that centre relationships, cultural identity, and lived experience deliver the most meaningful support. The difference lies in scale — international systems achieve this through national frameworks, while Aotearoa relies on innovative but localised approaches.

## **Limitations and information gaps**

While the evidence base on crisis response is growing, important gaps remain that constrain our understanding of what works best across diverse populations and settings.

There is limited evaluation of holistic, culturally grounded, and peer-led models. These approaches are widely recognised as promising, but more comparative evidence is needed to assess their effectiveness, scalability, and long-term outcomes. Similarly, few studies follow the long-term impacts of crisis interventions on recovery and sustained wellbeing.

The evidence base on youth-specific crisis responses remains underdeveloped, particularly for Pacific, Rainbow, disabled, and rural rangatahi and young people, and there is an ongoing underrepresentation of lived experience research on coercion, use of the Mental Health Act, and cultural safety. In addition, there has been little assessment of the cultural safety of co-response models, and substance use crises remain far less studied than mental health crises.

Even with these gaps, the evidence reviewed provides strong indicators of effectiveness. Peer-led and kaupapa Māori approaches show improved engagement and whānau involvement, while co-response and community-based alternatives are reducing reliance on EDs and coercive interventions. Together, these findings give confidence in the elements of crisis response systems that are supporting positive influences in terms of accessibility, safety, and uptake.

# APPENDIX 1: SEARCH STRATEGY

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The search strategy was designed to identify and compare crisis response models for tāngata whaiora and whānau experiencing mental distress and/or substance use harm in Aotearoa and international contexts. Emphasis was given to models specifically developed for Indigenous populations and youth.

A structured search was undertaken to gather academic and grey literature related to crisis response models. This included:

- **Databases searched:** Academic databases (e.g., PubMed, Scopus, Web of Science, and Google Scholar) to identify peer reviewed literature.
- **Grey literature sources:** Organisation websites, Government publications, evaluation reports, and trusted mental health and addiction sector portals from both New Zealand and international jurisdictions were manually scanned.
- **Search terms:** Keywords included combinations of "crisis response", "mental health", "substance use", "addiction", "co response", "crisis intervention", "Indigenous", "Māori", "youth", "co design", and "emergency services".

The initial search identified a total of 176 references, of which:

- 130 were academic articles
- 46 were grey literature reports, evaluations, or programme descriptions

A total of 119 sources were included in this literature scan; 81 academic articles and 40 grey literature references. Exclusions were based on relevance to the research focus, strength of evidence, alignment with inclusion criteria, and avoidance of duplication. Additionally, due to time and resource constraints, we prioritised articles that provided the most relevant and practice-oriented insights, particularly those grounded in Indigenous perspectives, equity-based crisis responses, and least restrictive models of care.

## APPENDIX 2: AOTEAROA CRISIS RESPONSE EXAMPLES

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### Piri Pono

**About the service:** Piri Pono is a peer led residential service located in Silverdale, Auckland, offering an alternative to hospital admission for tāngata whaiora experiencing mental distress and substance use crisis. Established in September 2013, the service provides a supportive, home like environment where tāngata whaiora can stay for up to 10 days (20). The name "Piri Pono" translates to being loyal, faithful, and devoted, reflecting the service's commitment to fostering relationships and promoting independent living.

Intentional Peer Support (IPS) is the key framework for service delivery within Piri Pono and all staff are IPS trained.

**Referral criteria:** Piri Pono is available to tāngata whaiora who have been assessed by the Rodney Adult Mental Health Services and are experiencing mental distress or substance use crisis requiring 24-hour intensive support and treatment (20).

**Workforce involved:** Piri Pono operates with a dedicated team of peer support staff who work 24/7 in rostered shifts. Additionally, a registered nurse is on site for 12 hours each day. All staff are trained in Intentional Peer Support (IPS), a framework that emphasises mutual relationships and empowerment.

**Evaluation status:** An evaluation conducted in 2017 highlighted the effectiveness of Piri Pono as a community-based alternative to inpatient admission. In the first 18 months of operation, 84% of tāngata whaiora reported a reduction in distress levels. The evaluation also emphasised the importance of mutual relationships and the IPS framework in fostering recovery (21).

The evaluation found that 80% of tāngata whaiora expressed high agreement with the statement, "staff and service is inspiring and encouraging," indicating a positive response from the peer led support model (20,21).



## Te Puna Wai

**About the Service:** Te Puna Wai is an after-hours, peer led Safe Haven Café in Palmerston North, operated by Mana o te Tangata Trust since June 2022 (10). It was established as part of Te Mātāpuna o te Ora Mid Central's integrated model of support aiming to improve access to mental health and addiction support by offering services closer to home. The café is open Fridays from 5pm–10pm and weekends from 3pm–10pm, providing an accessible, culturally safe environment for tāngata whaiora experiencing emotional distress (11).

The name 'Te Puna Wai' refers to a water spring, a precious taonga (treasure) and a vital source of life, both physically and spiritually. In this context it represents a place of safety that can help look after those who require support. The name was chosen by the kaimahi at Mana o te Tangata Trust. Pou Tautoko Kaupapa Māori Whānau Support at Mana o te Tangata Trust said that the name was likened to a safe place or somewhere where you feel rested but can restore and reset (11).

"Many Puna Wai are hot pool or springs, so in terms of Te Puna Wai, it holds a space to talk or navigate a person through a pathway towards wellbeing." Pou Tautoko Kaupapa Māori Whānau Support at Mana o te Tangata Trust

The café provides an alternative to EDs and was designed to improve earlier access with more socially connected forms of support. It provides a culturally safe, peer led welcoming environment for tāngata whaiora and whānau experiencing mental distress and substance use crisis outside of normal clinic hours. It was designed to support the lack of after-hours and non-clinical support options in Palmerston North, particularly for Māori communities. Te Puna Wai is grounded in Kaupapa Māori models, specifically Te Whare Tapa Whā which emphasises the balance of spiritual, mental, physical and family health. This framework ensures that the service aligns best with Māori cultural practices and holistic wellbeing approaches (11).

**Referral criteria:** There is no referral required. Anyone who is experiencing mental distress and substance use can access Te Puna Wai by visiting them on Fridays from 5pm 10pm and weekend hours from 3pm 10pm (11).

**Workforce involved:** Te Puna Wai Café is operated by peer support workers. They provide tāngata whaiora and whānau with kai and drinks in a soothing and welcoming environment. Peer support workers engage in conversations aimed to de-escalate crisis situations and promote wellbeing. Mental health crisis teams can, however, be contacted if necessary (11).

**Evaluation status:** An evaluation of Te Puna Wai was conducted over its first four months of operation (June–September 2022). The findings provide strong evidence that the café is delivering on its intended purpose, offering a culturally safe, peer led alternative to emergency services for those experiencing mental health distress after hours. It was estimated 5% of visitors would have otherwise presented to ED, cost savings over 6 months estimated at \$53,430. There were high levels of tāngata whaiora and whānau satisfaction with the most valued components of the service being peer support from those with lived experience and offering a safe and friendly environment.

*"I've been here in crisis before. I left with a plan and felt much lighter, I could also come back during the weekend for support. I always feel listened too and sometimes that's all I need, is to be listened too and know I matter and that I have support. I have rung the Crisis Line and been in E.D. many times and I always feel like a burden, rushed and embarrassed. They have conversations in the waiting room. Here I feel like they really care, and they never judge. The staff are amazing." – Tāngata whaiora*

## Wellington Co Response Team

**About the service:** The Wellington Co Response Team (Wellington CRT) is a collaborative crisis response model operating in the Wellington region of Aotearoa. Established in March 2020, Wellington CRT combines the expertise of Wellington District Police, Wellington Free Ambulance, and the Mental Health, Addiction, and Intellectual Disability Service (MHAIDS) from Te Whatu Ora Health NZ to respond to mental health and substance use crises (6). The model was designed to address increasing demand for more appropriate and compassionate crisis responses, particularly in situations where tāngata whaiora are experiencing distress in public spaces or may pose a risk to themselves or others (6).

Wellington CRT operates by dispatching a multi-disciplinary response team to emergency mental health and substance use callouts. The team includes a police officer, a paramedic, and a mental health clinician. This collaborative approach aims to de-escalate situations, provide immediate medical and psychological assessments, and determine appropriate support pathways, thereby reducing unnecessary hospital admissions and interactions with the criminal justice system (6).

**Referral criteria:** Referrals to Wellington CRT are initiated through emergency 111 calls where mental health and substance use needs are identified. Emergency services personnel assess the situation, and if deemed appropriate, the Wellington CRT is dispatched to provide specialised intervention. The focus is on people experiencing mental distress and substance use crisis who require immediate, comprehensive support (4, 6).

**Workforce involved:** Wellington CRT involves professionals from three key sectors:

- Police officers: Ensure safety and provide law enforcement expertise.
- Paramedics: Address any immediate physical health concerns and provide medical assessments.
- Mental health clinicians: Offer psychological evaluations, crisis intervention, and facilitate access to appropriate mental health services.

Involvement of whānau in crisis resolution is supported where possible, with clinicians and paramedics working alongside whānau or support people present. However, whānau engagement depends on the situation and immediate safety considerations, and there is room to strengthen this aspect of support.

**Evaluation findings:** An independent evaluation of Wellington CRT, conducted by the University of Otago over a 12-month period (March 2020 – March 2021), found the initiative to be a highly effective and culturally safe model for mental health and substance crisis response. The evaluation revealed that on days when Wellington CRT was operational, only 29% of tāngata whaiora experiencing mental distress and substance use crisis were taken to the ED, compared to 51% on days when the team was not available. This represents a significant reduction in ED utilisation, helping to relieve pressure on hospital services while offering more appropriate support in community settings (6).

The evaluation attributed the model's cultural safety to staff trained in culturally responsive practice, a focus on de-escalation, and efforts to involve whānau. Tāngata whaiora and whānau reported feeling seen and respected contrasting with past experiences of impersonal or coercive crisis responses. These findings align with wider evidence that culturally safe approaches build trust, enable earlier engagement, and improve outcomes, particularly for Māori and other historically underserved groups (6).

Additionally, the use of the Mental Health Act Section 109 powers (detaining tāngata whaiora experiencing mental distress and substance use crisis) was markedly lower when Wellington CRT was deployed 13% of cases, compared to 21% on non-CRT days demonstrating the team's effectiveness in de-escalating crises without resorting to coercive interventions. The evaluation also highlighted that over half of all interactions were resolved at the scene, with tāngata whaiora either remaining safely at home or supported through voluntary engagement with services. These findings underscore the CRT's impact in improving service user experiences, reducing unnecessary hospital presentations, and fostering stronger, more coordinated inter agency responses to mental health crises (6).

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# Rārangi Kupu | Glossary

**Note:** The meanings of te reo Māori (Māori language) terms in this glossary relate directly to the context of the literature scan. We respectfully acknowledge there may be other interpretations and differences.

Āhuatanga Māori	Māori characteristics, aspects, or features.
Kai	Food.
Kaimahi	A worker, also often referred to as staff or employee.
Kaitiakitanga	Guardianship, stewardship, and trust.
Karakia	Incantation.
Kaupapa Māori	Māori approach, Māori ideology.
Mana	A person's status and power accrued through leadership abilities.
Manaakitanga	The process of showing care, respect, and generosity to others.
Mana motuhake	Māori self-determination, tribal governance, or more simply, autonomy over one's affairs and destiny.
Mātauranga Māori	An indigenous knowledge system originating from Māori ancestors that incorporates Māori worldview, philosophical thought, perspectives, and cultural practice.
Mirimiri	A traditional Māori healing practice that seeks to restore energetic flow, balance function, and wellness.
Pūrākau	Ancient stories that are a fundamental part of Māori culture and oral history.
Rangatahi	Young Māori person.
Rongoā	The many Māori healing remedies and practices of a physical and spiritual nature in achieving a status of health and wellbeing.
Tāngata whaiora	People of any age or ethnicity seeking wellbeing or support, including people who have recent or current experience of

	distress, harm from substance use, or harm from gambling (or a combination of these).
Tangata Whenua	Local people, hosts, or indigenous people of a particular area of the country or of the whole country. Māori are the tangata whenua of Aotearoa.
Taonga	Treasure.
Te ao Māori	Māori world view.
Te reo Māori	The Māori language.
Te Whare Tapa Whā	A model developed by leading Māori health advocate Sir Mason Durie in 1984. The model describes health and wellbeing as a wharenui (meeting house) with four walls. These walls represent taha wairua (spiritual wellbeing), taha hinengaro (mental and emotional wellbeing), taha tinana (physical wellbeing) and taha whānau (family and social wellbeing). The connection with the whenua (land) forms the foundation. When all these things are in balance, we thrive. <sup>1</sup>
Te Tiriti o Waitangi	In English, Te Tiriti o Waitangi means the Treaty of Waitangi. Te Tiriti o Waitangi is an agreement that was signed in 1840 by representatives of the British crown and Māori chiefs.  Te Tiriti o Waitangi is the legal document that allows Government to exercise kāwanatanga (governorship) in Aotearoa. In this document, when referring to Te Tiriti o Waitangi, we are referring to the Māori translation of the Treaty of Waitangi.
Tikanga	A Māori concept based on custom.
Wairua	Soul, spirit.

<sup>1</sup> Durie, M. 2004. **An indigenous model of health promotion.** Health Promotion Journal of Australia 15(3): 181–5.



Wairuatanga	Spirituality.
Wānanga	To meet and discuss, consider, deliberate issues of importance and relevance to whānau, hapū and Iwi.
Whānau	<p>Whānau has its whakapapa (history) and origins located in te ao Māori (Māori worldview) and refers specifically to blood connections that exist between generations of lineage that descend from atua Māori (Māori gods).</p> <p>In present times, whānau is also commonly used to include people who have close relationships and/or who come together for a common purpose. Tāngata whaiora can determine who their whānau and/or kaupapa whānau are when they are seeking or receiving support.</p>
Whakapapa	A lineage of descent that gives history of one's genealogy of the human nature, but also to the kinship relationship to the natural elements and environment of ao Māori (Māori world).
Whakataukī	Proverb.
Whakawhanaungatanga	The process of establishing relationships and giving people a sense of belonging.

