NSW Ministry of Health Guidance – Establishing Alternatives to Emergency Department Presentations Services

Description of initiative

Under the Towards Zero Suicides investment in NSW, funding of $25.1 million is dedicated to the Alternatives to Emergency Department Presentations initiative over three years. This initiative will deliver new twenty services across NSW that provide an alternative to emergency department presentations for people experiencing a suicidal crisis, especially outside of hours.

For many people experiencing a suicidal crisis, emergency departments are the most immediately accessed or only form of support. However, busy emergency departments are not ideal locations for people who are in acute psychological distress.

The Alternatives to Emergency Department Presentations services will provide a warm welcoming space for people experiencing a suicidal crisis where compassionate care will be provided by peer workers with a lived experience of suicidality in a non-clinical environment.

People can access information about a wide range of other community based services such as housing, relationship counselling or financial assistance, to help address the causes of distress, and will be warmly connected to these.

People will not require a formal referral to the service.

Project objectives

The objectives for this project are to:

- Reduce deaths by suicide, suicide attempts and self-harm.
- Provide immediate, person centred and compassionate care to people at risk of suicide.
- Connect people to support services to address the underlying factors contributing to their distress.
- Reduce pressure on emergency departments and provide a genuine alternative to traditional clinical services

Values which inform the model

A range of stakeholders, including people with lived experience of suicide, have highlighted the following values as key in this model:

- Person-centred
- Risk tolerant
- Non-judgmental
- Welcoming
- Responsive
- Compassionate
- Strengths focused
- Hopeful
- Holistic
- Self determination
- Empowerment
- Human connection

- Collaboration
- Integration
- Respectful
- Evidence based
- Dignity
- Inclusion
- Choice

State-wide support

The Mental Health Branch, Ministry of Health will provide the following support:

- Funding to establish and staff the services in twenty locations across NSW
- Engagement of a co-design consultancy to lead the local co-design process and to establish local lived experience advisory groups
- Facilitation of a state-wide communities of practice
- Support for the Suicide Prevention Peer Workforce development
- Support for communication and promotion of the services
- Commissioning of an independent evaluation and research project
- Support to develop appropriately sensitive outcome reporting in conjunction with people with lived experience of suicidality and the independent evaluators

Local implementation

- Each local health district will develop its own implementation plan to establish and run the service, informed by a local co-design process.
- It is expected that local implementation planning will reflect the needs and wants of the local community, and involve genuine collaboration across a range of disciplines, services and sectors collaborating.
- Scoping of potential sites for the services can progress independently of the local co-design process
- Recruitment of the services' peer worker roles is required to be undertaken in line with the Ministry of Health Suicide Prevention Peer Workforce Guidelines
- Co-design will include (but not be limited to) the physical environment, the hours of operation, the nature of services and supports provided, supporting safety and access to additional support, how data will be collected.
- A template local implementation plan is at **Appendix 1 – Local Implementation Plan**, which districts are asked to complete and provide to the Ministry of Health for approval.

Essential elements

These elements are required in each service in NSW:

Leadership by people with lived experience of suicide

- The service is co-designed with people with lived experience of suicidal crisis and/or experience of caring for someone in crisis.
- There are ongoing opportunities for people with lived experience of suicidal crisis to have input into the operation of the service.
- Peer Workers with lived experience of suicide are employed, and provided training and support as outlined in the Ministry of Health Suicide Prevention Peer Workforce Guidelines

Safety and accessibility

- There is no requirement for people to present to an emergency department prior to accessing the service.
- The service can be located on or off hospital/health grounds, but is within proximity to the Emergency Department, not requiring people to travel a long distance. Ideally, as a non-clinical service, the service will represent a genuine alternative to accessing the hospital.
- The service is accessible outside of business hours.
- There is a 'no wrong door' approach with the service welcoming everybody. In the event that a person presents a clear and immediate risk to the safety of staff or other people in the service, they will be connected with other, more appropriate support to assist them.
- Clear protocols will be in place to support staff to make decisions about safety and access. This includes having the capacity to respond to drug and alcohol issues and provide access to medical or other support, where this is needed.
- People will be actively supported to determine for themselves how best to stay safe, and supported to access additional services of their choice.
- Guests attending the service are not required to undertake any assessments or meet eligibility criteria.
- The environment is welcoming, safe and calm. This includes cultural, spiritual and emotional safety, and the provision of trauma informed care.
- The services are promoted in the local community so that people are aware of the services, what it can provide and when.

A non-clinical model

- Clinical services are not provided. What is delivered in the service must be non-clinical.
- However, there is a clinical governance structure which provides a clear process to actively support the Suicide Prevention Peer Workers to identify in partnership with the person using the service, when and how additional clinical supports may be needed and accessed to best meet the individual needs and wants of the person.
- The service is connected closely, or jointly delivered with community organisations, including other support services and local businesses.

Recovery oriented support

- Support is person-centred, promoting hope, and responding holistically to the person's needs.
- There is a focus on responding to psychosocial reasons for the person's need for support, including loneliness and isolation.
- Collaborative relationships are established and maintained with other services to connect to, including, for example, other suicide prevention services, homelessness services or domestic and family violence support services.
- Family and friends are involved, wherever possible and in alignment with the wishes of the person using the service
- The service is staffed by Suicide Prevention Peer Workers with a lived experience of suicidal crisis and recovery.
- There is ongoing training, supervision, mentoring and group reflection opportunities to support the skill development and promote the personal recovery and professional growth of Suicide Prevention Peer Workers.

Transparency

- The service is transparent about all policies and procedures about the confidentiality and privacy of people using the service, the nature of support provided.
- A clear communication channel exists for people to provide feedback about the service and a process for prompt response and follow up.
- There is accountability and transparency about how effective the service is and whether it is meeting community expectations, including through outcome reporting and participation in independent evaluation.
- Outcome reporting is non-intrusive and does not present a barrier to people accessing the service.
- Outcome reporting to the Ministry of Health includes indicators of consumer experience, staffing, number of people using the service, issues, incidents, governance, partnerships, as well as and broad expenditure reporting.
- Any savings are reinvested into the service.
- There are clear governance and reporting lines within the health service, to provide oversight and support.
- The service is evidence based, or evidence-informed where there is emerging evidence.

Person centred language

- Language is person centred and appropriate to suicide prevention. For example:

Instead of	Consider saying
Patient	Person, participant, guest, visitor, attendee.
Facility	Space, building, location, haven, place, locale, venue, centre, safe space, hub, service, café.
Referral	Link, recommend, connect, offer ideas, options, pathway, invitation, support.
Exclusion criteria	Safety boundaries, mutual expectations, appropriateness, aim of the service, is this the best place for the person?
De-escalation	Addressing the person's need in that moment, conversation, relationship building, empathy, connection, calming, grounding, reducing distress, positive engagement.
Risk management	Safety plan, working with someone to stay safe, dignity of risk, recovery plan, keeping well.
Beds	Places, spaces, place to rest.
Recovery	Journey, discovery, healing, resilience, strengths, positivity, hopefulness.
Triage	Welcome, wellness check, prioritisation, what is important right now, planning, talking, listening.
Assessment	Discussion, what is needed right now, listening to full story, collaborating, understanding.

In addition, all communication about suicide should be consistent with the following guide:

Issue	Problematic	Preferred
Language that presents suicide as a desired outcome[51]	'successful suicide', 'unsuccessful suicide'	'took their own life', 'ended their own life', 'died by suicide'
Phrases that associate suicide with 'crime' or 'sin'[52]	'committed suicide', 'commit suicide'	'died by suicide', 'took their own life'
Language that glamourises a suicide attempt[53]	'failed suicide', 'suicide bid'	'made an attempt on his life', 'suicide attempt', 'non-fatal attempt'
Phrases that sensationalise suicide[54]	'suicide epidemic'	'higher rates', 'increasing rates', 'concerning rates'
Gratuitous use of the term 'suicide' out of context	'suicide mission', 'political suicide', 'suicide pass' (in sport)	refrain from using the term suicide out of context

Appendix 1 – Local Implementation Plan

Alternatives to Emergency Department Presentations initiative 2019/20

Please provide the information below, adding as much additional information as needed.

Local Health District	
Budget	$415,000 in 2019/20: ○ 1 FTE @ $150,000 ○ 2 FTE @ $120,000 ○ $50,000 establishment costs ○ $25,000 operating costs
Location of the service	• What is the address of the service? • Is it on the hospital grounds or in the community? • How close is the service to the Emergency Department?
Timeline	• What is the start date for operation?
Property tenure	• Is the property owned by the health district / leased from another organisation? • If leased, how long is the tenure? Is there a formal written lease agreement in place?
Co-design	• Who are the local stakeholders for co-design? • How have they/ will they be engaged? • What are the outcomes of the co-design process?
State-wide elements	• How will the state-wide elements, values and principles be reflected in the service model?
Partnerships	• Will the service be provided in partnership with any other organisations?
Staffing	• What is the proposed staffing model? • What is the estimated timeframe for recruitment? • How will the peer workforce be supported?
Governance	• How will management of the service be reflected in clinical and operational governance structures of the district? • What are the key risks in establishing the service, and how will they be managed? • What arrangements/ protocols will be put in place to support referrals to and from the Emergency Department?
Operation	• What will the opening hours be? • What will the style of the service be - café/ lounge/ meeting rooms/ other?

	• How will food and drink be provided? • How will carers, family or friends be supported? • Will information be provided in different languages? • How will people have the opportunity to provide feedback on the service?

Priority groups	• How will the service specifically address the needs of:
	  ○ Aboriginal people
	  ○ People from the LGBTQI+ community
	  ○ Men
	  ○ Young people
	  ○ Older people

Communication / engagement	• How will Emergency Department staff be supported with information and education about the service? Posters/ leaflets/ visits/ meetings/ peer worker in situ? • How will the service be promoted in the community, other health services and community organisations? • What support does the district need from the Ministry around communication/ promotion? • What partnerships will support local referrals or connections to services for consumers? • Are there media opportunities to promote the service?
Reporting	• How will outcome data be collected and reported? For example, consumer experience, staffing, number of people using the service, issues, incidents, governance, partnerships, referrals, expenditure reporting?