NSW Ministry of Health Guidance – Establishing services for the Redirection from Emergency Departments initiative

Description of initiative

A key component of the NSW Government's Towards Zero Suicides investment, funding of $25.1 million over three years is dedicated to the Redirection from Emergency Departments initiative. This initiative will deliver twenty new 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 in acute psychological or emotional distress.

The Redirection from Emergency Department services will provide people with appropriate and customised suicide prevention support nearby to emergency departments, where rapid and compassionate care can be provided by mental health clinicians and peer workers in a non-clinical environment.

People can also be provided referral and information about a wide range of other community services such as housing, relationship counselling or financial assistance, to help address the causes of their distress.

On 29 November 2019, the Ministry of Health convened a launch and workshop of approximately 120 stakeholders including districts, non-government organisations and people with lived experience of suicide. At this event, participants contributed to the design of state-wide guidelines for the model of these services. The contents of this document reflect the advice provided by participants at that event.

Initiative objectives

The objectives for this initiative are to:

- Provide rapid, appropriate and compassionate care to people at risk of suicide.
- Link people to support services to address the cause of their distress.
- Reduce pressure on Emergency Departments.

Values which inform the model

The following values have been identified as key in this model:

- Person centred
- Risk tolerant
- Non-judgmental
- Welcoming
- Responsive
- Compassionate
- Strengths focussed
- 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 establish local lived experience groups and support local co-design processes
- Facilitation of a state-wide community of practice
- Support for 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.

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 conditions of the local community, and involve a range of disciplines, services and sectors collaborating.
- Recruitment of staff and establishment of sites for the service can progress independently of the local co-design process, as these need to be put in place as soon as possible.
- Peer workers should be recruited with reference to lived experience of suicide, noting that a program of support and development for the suicide prevention peer workforce is being produced by the Ministry.
- Co-design should include (but not be limited to) interface with emergency departments, the physical environment, hours of operation, the nature of services and support provided, access to additional support, how data will be collected and other issues.
- 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.
- **Appendix 2 – Considering Different Perspectives** provides some guidance on considering the perspectives of different stakeholders. This was developed by participants at the launch of the Redirection from Emergency Departments initiative.

Essential elements

These elements are required in each service in NSW:

Leadership by people with lived experience of suicide

- The service must be co-designed by people with lived experience of suicide.
- There should be ongoing opportunities for people with lived experience of suicide to have input into the operation of the service through for example, an ongoing steering group.
- Peer workers with lived experience of suicide should be employed to deliver the service, and there is training and support for peer workers.

Safety and accessibility

- The service can be located on or off hospital/health grounds, but should be within proximity to the Emergency Department, not requiring people to travel a long distance.
- Locating a peer worker within the Emergency Department while the service is open can ensure people can be safely accompanied to the service and increase links with Emergency staff.
- The service should be accessible outside of business hours. Districts should take advice from people with lived experience and also analyse data to determine the best times for services to be open.
- There is no requirement for people to present to an Emergency Department prior to accessing the service.
- There is a 'no wrong door' approach with the service aiming to accept everybody, other than when there are clear risks to the safety of staff or other service users. If the service is not appropriate for someone, they should be linked with other, more appropriate support to assist them.
- A risk management and access policy/process supports 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. There should be guidelines for when someone should preferably access the Emergency Department, mental health or other support services.
- People 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 psychological safety, and the provision of trauma informed care.
- Peer workers are trained with specific suicide prevention training.
- The services are promoted in the local community so that people are aware of the service, what it can provide and when.
- Emergency Department staff are supported to understand and refer to the service, for example with written information, staff visits and other strategies. This will be a critical component for the success of the services. Emergency Department staff should be engaged early, not only when the service is opened, and should be involved in co-design processes.

A non-clinical model

- Clinical care is not provided in these services.
- However, there is a clinical governance structure which provides a clear risk management process. This process should support staff to identify when and how additional clinical care can be accessed, and when it is needed.
- Management of the service by a clinician, although clinical services are not provided in the service itself, is recommended. This will help to ensure that access to clinical care is provided in the event it is required.
- Services should be closely linked with community organisations, including other support services that can contribute to increased community connections, resolution of issues causing distress and ongoing support for people at risk.

Recovery oriented support

- Support should always be person-centred, promoting hope, and responding holistically to the person's needs.
- There will be a focus on responding to psychosocial reasons for the person in need of support, including loneliness and isolation.

- There should be good relationships with other services to connect and refer to, including other suicide prevention services, homelessness services or domestic violence support services.
- Family and friends should be engaged in a person's support, wherever possible and where people consent to this.
- There should be consistent staffing, including in employment of peer workers with lived experience of suicide.

Transparency

- There must be accountability and transparency about how effective the service is and whether it is meeting expectations, including through outcome reporting and participation in independent evaluation.
- Outcome reporting should be non-intrusive and not present a barrier to people accessing the service.
- Outcome reporting to the Ministry of Health will include indicators of consumer experience, staffing, number of people using the service, issues, incidents, governance, partnerships, and referrals, as well as expenditure reporting.
- Any unspent funds must be reinvested into the service.
- There should be clear governance and reporting lines for the service to provide oversight and support, including people with lived experience of suicide contributing through a reference or steering committee.
- Services should be evidence based, or evidence-informed where there is emerging evidence.

Person centred language

- Language should be 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, asking if this is 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, recovery plan, keeping well, staying safe.
Beds	Places, spaces, place to rest.
Recovery	Journey, discovery, healing, resilience, strengths, positivity, hopefulness.
Triage	Welcome, wellness check, prioritisation, working out what is important right now, planning, talking, listening.
Assessment	Discussion, what is needed right now, listening to the full story, collaborating, understanding.

In addition, all communication about suicide should be consistent with the following table from the Mindframe guidelines produced by Everymind:

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

Redirection from Emergency Departments initiative

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 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 been engaged? • What has the co-design process been? • How have people with lived experience of suicide been involved in the co-design process? • How has Emergency Department staff been involved in the co-design process? • 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 district governance structure is in place to ensure that stakeholders including people with lived experience of suicide can have ongoing input into the delivery of the service?

	• What arrangements/protocols are 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 (eg. 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 the following groups (including community engagement, referrals, culturally relevant service etc.):
	  ○ Aboriginal people
	  ○ People from the LGBTQI+ community
	  ○ Young people
	  ○ Men

Communication / engagement	• How will Emergency Department staff be supported with information and education about the service? (eg. 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 on 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? • What strategies will be in place to ensure that outcome data is not collected in ways that present barriers to people receiving support?

Appendix 2 – Considering Different Perspectives

The following information is drawn from an activity at the launch and workshop that considered the perspectives of different stakeholders in relation to these services. It is provided to assist districts and other local stakeholders during co-design processes.

Person seeking support

- To be listened to and offered comfort
- To be treated with kindness, dignity and respect
- For the service to be easy to access
- To be served coffee and tea, including non-caffeinated options
- A welcoming, quiet space
- An understandable process
- To feel like there are no strings attached
- To be accompanied by friends, family or a support person as needed

Carer/family/friend

- To be recognised, involved, consulted and supported
- To be empathised with, and for carer stress and burden to be recognised
- To have information in relevant languages available
- Something to drink - tea, coffee, water
- To know what to expect, what the service does and to know it is ok for them to stay
- To know the service is safe for the person receiving care
- To know who can help – including options for support outside the service, for both the person seeking support and for carers
- To have support and education as a carer, including on mental health and suicide prevention
- To have clear information through a peer worker
- To be asked for feedback

Manager or staff

- For the service to be co-designed
- For people with lived experience of suicide to be supported to participate in the co-design process, including through paid participation
- To have a best practice service which is evaluated
- To have adequate budget and resourcing for the hours of operation being provided
- For the purpose of the service to be clear, including what distinguishes the service from others
- For staff to be safe, trained and supervised
- To involve the local Emergency Department in the co-design of the service
- To promote the service to Emergency Department staff and in the community
- To have clear pathways and partnerships with rest of the suicide prevention system and other community based supports
- To have a clear policy about access and managing safety

Funders

- Strong clinical and operational governance
- For the service to be evidence based
- Reporting of measurable outcomes and evaluation of impact

- For stakeholders to be engaged collaboratively, for local communities to be involved, and for the service to be locally relevant
- Integration of the service with a diverse range of services
- Co-design by people with lived experience of suicide
- For the service to be well utilised
- For the service to be innovative and draw on the latest approaches in the suicide prevention field
- For the service to be cost-effective and provide a return on investment