

NSW Ministry of Health
Statewide Requirements

Towards Zero Suicides – Alternatives to Emergency Department Presentations



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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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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 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 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.

Initiative objectives

The objectives for this initiative 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

Statewide 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 statewide 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' Suicide Prevention 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.
- Suicide Prevention Peer Workers with lived experience of suicidal crisis are 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 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 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.
- 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.

Translation of co-design outputs to service delivery

- Local people with lived experience of suicide will play an active role in ensuring the co-design outputs translate into service delivery and the ongoing iterative re-design of the service.
- Roses in the Ocean has been contracted to provide co-design services for the Alternative to Emergency Department Presentations initiative and to support districts with implementation, as well as to train local people with lived experience of suicide to participate in advisory groups, other governance structures, co-design processes and other local activities supporting the services.

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	'successful suicide', 'unsuccessful suicide'	'took their own life', 'ended their own life', 'died by suicide'
Phrases that associate suicide with 'crime' or 'sin'	'committed suicide', 'commit suicide'	'died by suicide', 'took their own life'
Language that glamourises a suicide attempt	'failed suicide', 'suicide bid'	'made an attempt on his life', 'suicide attempt', 'non-fatal attempt'
Phrases that sensationalise suicide	'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