NSW Ministry of Health
Statewide Requirements

Towards Zero Suicides –
Suicide Prevention Outreach Teams

NSW
GOVERNMENT

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.

Further copies of this document can be downloaded from the NSW Health webpage www.health.nsw.gov.au

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Description of initiative

Under the Towards Zero Suicides investment in NSW, $21.35 million is being provided for Suicide Prevention Outreach Teams (the teams) over three years from 2019-20 to 2021-22. This initiative will expand the local suicide prevention workforce in each local health district so more people will receive support more quickly.

Many people in a suicidal crisis struggle to find timely appropriate care. The teams can provide proactive care to where people live their lives and feel comfortable.

The teams will be able to offer support and care to those who need it. They will also provide care pathways to other services and be able to reduce the time people spend in Emergency Departments by coordinating admissions to appropriate wards.

Objectives

The objectives for this initiative are to:

- Reduce deaths by suicide, suicide attempts and self-harm.
- Engage people where they live their lives.
- Be open to all those who need it with a focus on those not engaged in traditional community mental health settings.
- Link people to support services to address the causes of their distress.
- Keep people in the community with their existing support systems, when it is safe to do so.

Statewide support

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

- Funding to establish and staff the services across local health districts.
- Engagement of a co-design consultancy to establish local lived experience groups and support local co-design processes.
- Facilitation of a statewide community 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.

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. A template local implementation plan is attached, to guide the process.
- Clinical positions can be multi-disciplinary, the staff need to be registered with AHPRA or fulfil eligibility criteria for registration with AASW.
- 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 together.
- Recruitment of staff and establishment of sites for the service 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.
- 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.

Requirements for the co-design

- Co-design will include the physical location of the teams, the hours of operation, the nature of services and supports provided, supporting safety and access to additional support as well as how and what data will be collected.
- Involve local stakeholders like the Emergency Department(s) and community teams.
- Include people with lived experience of suicide.

Essential elements

These elements are required in each service in NSW:

An integrated service

- The team is to be integrated with current care services to increase coverage for suicide prevention.
- The team is not limited to the mental health system and will be linked with existing community based health services. The teams need to be linked in with the existing non-government agencies that provide care to people in distress and suicidal crisis.
- Teams can be embedded within current community teams, but must maintain a suicide prevention focus and not be absorbed into them.

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 suicide to have input into the operation of the service.
- Suicide Prevention Peer Workers with lived experience of suicidal crisis are employed, and provided training and support as outlined in the Ministry of Health Suicide Prevention Peer Workforce Guidelines.

Collaborative peer and clinical staffing

- There will be a two-person proactive response, one peer worker and one clinician.
- The staff are grouped in to partners, one clinician and one peer worker per response.
- The peer worker does not work under the clinician.
- The staff will be de-identified as health workers in their dress regulations, vehicles provided etc.
- There will be a minimum 50 per cent FTE of peer workers, noting that it is likely that peer workers will be employed on a part time basis there may be more peer workers than clinicians.

Safety for staff and people using the service

- The service can be based on or off hospital/ health grounds or community mental health buildings, noting that the teams will be mobile.
- A risk management and access policy/process supports staff to make decisions about safety. This includes having the capacity to respond to drug and alcohol issues and provide access to medical or other support, where this is needed.
- Guidelines are required for when staff need to access the Emergency Department.
- The team works within all current NSW Health policies.

Make the teams accessible

- The service is accessible out of business hours.
- People do not need to present to an Emergency Department or community centre before accessing the service.
- There is a 'no wrong door' approach. The team will accept everybody with self-harm and suicidality, except when there are clear risks to safety.

- The team is promoted in the local community so that people are aware of how to contact them, what they can provide and when.
- CMO staff are supported to understand and refer to the service, for example with posters, leaflets or staff visits.
- Referrals can be made by anyone; the consumer does not need to be responsible for engagement.
- There needs to be links with services responsible for people released from gaol, Domestic Violence, Aboriginal Controlled Community Health Organisations and Women's and family services. Local Men's Sheds and other services for men should also be a focus for information.
- The local Police command, Ambulance and GPs are to be made aware of the team. They will be encouraged to make contact prior to hospitalisation in a suicidal crisis, where there is no risk to self or others.

Holistic care

- Clinical services are not the sole focus of the team and should be coupled with appropriate non-clinical support.
- Services are linked closely, or delivered jointly, with community organisations where possible.
- Early contact is to be focused on stabilization, safety planning and distress recognition. Linkage with outpatient or community services working in a holistic approach with family and other support providers is required.
- Family are supported and other education is provided as needed.
- All interventions need to balance safety with cultural needs and expectations.

Recovery oriented support

- Support is person-centred, promoting hope and responding holistically to the person's needs.
- There is a focus on responding to the psychosocial reasons for the person need for support, including loneliness and isolation, linking with support services for this to be managed by CMOs, if there are appropriate transfer protocols.
- There are relationships with service providers to connect with and refer to. Other providers need to represent suicide prevention services, homelessness services and domestic violence support services.
- Family and friends are engaged, wherever possible, to create and support safety plans.

- There is consistent staffing, including employment of Suicide Prevention Peer Workers with 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

- There is accountability and transparency about how effective the service is and whether it is meeting stakeholder expectations, including through outcome reporting and participation in independent evaluation.
- There are clear governance and reporting lines within the health service, to provide oversight and support.
- Services are evidence based, or evidence informed where there is emerging evidence.
- Any savings are reinvested into the service.

Co-design support to districts

- 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.
- Inside Out has been contracted to provide co-design services to districts in the Suicide Prevention Outreach Teams initiative.
- Roses in the Ocean has been contracted 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

Appendix 1 – Local Implementation Plan

Suicide Prevention Outreach Teams 2020/21

Please fill in the details below, adding as much additional information as needed.

Local Health District	
Budget	• $510,000 per annum • Minimum of 4 FTE • Minimum of 50 per cent FTE peer workers
Location of the service	• Where will the teams be based?
Timeline	• What date will the team start operations?
Co-design	• Who are the local stakeholders for the co-design? • What are the outcomes of the co-design process?
Statewide elements	• How will the statewide elements and principles be reflected in the service model? • How will the team support the Toward Zero Suicides Premier's Priority?
Partnerships	• How will this team partner with existing services both government and CMO? • How will information be transferred between services? • Has the team been discussed with the local Emergency Department(s)? Are there agreements in place for the transfer of care to ED?
Staffing	• What is the proposed staffing model? • What is the estimated timeframe for recruitment? • How will you support peer workers? • How will staff be supported in the event of a traumatic event? • How will equality be maintained within the teams?
Governance	• How will the management of the team align with clinical and operational governance structures of the district? • What are the key risks in establishing the team, and how will they be managed? • What policies and procedures are in place to support referrals? • What are policies currently in place for the teams to function safely? • What changes, if any, need to be made to local policies and procedures to allow for direct admissions to the in-patient unit(s) if it is safe to do so?

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

Operation	• What will the focus of care be for the team? (after care, assertive preventative, etc.).
	• How will you ensure there is not a replication of existing services?
	• What are the hours of operation?
	• How will support be given to carers?
	• How will you provide information in a culturally appropriate way?
	• How will consumers provide feedback?
	• What communication devices will be the team receive?
	• What type of vehicle will the team utilise?
	• How will you ensure safety for the team?
	• What change management support is required to commence the team?
	• How will you ensure the teams remain de-identified as health workers, to remove stigma and possible barriers to people seeking care?
	• How will you engage people without current MH diagnosis' or who have not received care from MH services previously?
	• What is the business continuity plan in the case of pandemic or mass events impacting the public?
Communication / engagement	• How will you provide the Emergency Department, Police, Ambulance and GPs information and education about the team? Posters/leaflets/visits/meetings/peer worker in situ?
	• How will you communicate to custody services, housing, domestic violence services, sexual assault services regarding the teams?
	• How will you promote the team 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/links to services, for people attending?
	• What are there media opportunities?
Reporting	• What kind of outcome reporting will be provided to the Ministry of Health – Occasions of service numbers, service delivery issues, critical incidents, transfers of care to partner agencies, user satisfaction, time in service, time in contact, collateral contacts (GP's, Private providers, carer support, etc.)?
	• How will data be collected in a way which is non-intrusive/not a barrier to consumers of the team?
	• Expenditure reporting (staffing, operational)