Alternatives to Emergency Departments

Project Report September 2019

Consumers of Mental Health WA (Inc)

Consumers of Mental Health WA - Listening to, understanding and acting upon the voices of people with lived experience in Western Australia

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Acknowledgements

Consumers of Mental Health WA (CoMHWA) would like to acknowledge the traditional owners of country throughout Australia and recognises their continuing connection to land, waters and community. We pay our respects to them and their cultures, and to elders both past and present.

The project team at CoMHWA would particularly like to thank the many people with lived experience expertise who shared their knowledge and ideas. This has added depth and wisdom to the project.

CoMHWA is grateful for the active support and guidance of the Alcohol and other Drug Community and Consumer Coalition (AODCCC) throughout this project.

Information was also generously shared by individual service providers from multiple agencies and organisations. In particular, assistance was generously offered by Fran Timmins who has overseen the introduction of the Safe Haven Café at St Vincent's Hospital in Melbourne, and by Helen Glover and Kate Gill who are supporting the trial of Living EDge, a peer delivered alternative to Emergency Department (ED) at Redlands Hospital in Brisbane.

Other organisations and peak bodies have also assisted through their promotion of, and participation in, engagement opportunities. Our thanks for this support goes to the Aboriginal Health Council of WA, Multicultural Futures, The Freedom Centre, HelpingMinds, Carers WA, Richmond Wellbeing, The Mental Illness Fellowship of Western Australia (MIFWA), the Health Consumers Council and the Western Australian Association for Mental Health (WAAMH).

CoMHWA acknowledges the funding from the Western Australian Mental Health Commission (MHC) to undertake this project and appreciates the supportive interactions with MHC staff throughout.

Findings and recommendations

Findings

Diverse needs and settings have generated a diversity of service delivery models as described in the table below.

Table S.1. Psychosocial crisis support service delivery models: safe spaces and ED diversion services, where there is a peer component

Location	Service delivery model	Examples
In-hospital or on the hospital campus	An alternative ED waiting room that functions as a café in a communal space. Engagement with peer workers is available but optional. Referrals from ED and walk ins. Approx 1:4 staff client ratio. Open out of hours 18 hours per week	Safe Haven Café, St Vincent's Hospital Melbourne
	Peer supported transition programs. ED to home.	Choices and Peer2Peer, Perth
	Alternative waiting rooms providing with one to one peer support.	Living EDge, Brisbane The Living Room, Springfield, USA
Community based	Walk in respite centres (clinician triage followed by one on one peer support)	The Living Room, Chicago, USA
	Crisis stabilisation centres. Multidisciplinary clinical and peer team providing psychiatric, medical and psychosocial support. Walk ins and referrals -24/7	Exodus Centre, LA, USA Crisis Stabilisation Centre, San Bernadino, USA
	Crisis houses offering one to one peer support in a residential setting with varying lengths of stay (hours to days)	The Sanctuary, Bristol, UK
	Drop in space offering peer support and access to clinical assessment	Safe Haven Cafes, UK
	Crisis cafes offering small group or one to one peer delivered psychosocial support in a social setting	The Well-Bean Cafes, Leeds, UK
In-home	Outreach from community or hospital based peer support	Some peer transition programs Some crisis cafes
Mobile services	Street health teams, accompanied by food vans, housing support staff, laundry services	RPH Homelessness Street Health
Virtual	Warm lines, online and text chat services	Distress Centres, Canada, Carer Warm Line, Queensland

Effectiveness and outcomes

As psychosocial crisis support services vary considerably in their design and delivery models, they also vary in the outcomes expected and achieved and in how these are measured. Those that have been evaluated have made some impact in the following areas of need experienced by people with mental health issues and/or alcohol/other drug issues.

Measured at the system or area level

- diversion from ED to a more appropriate service
- reduced inpatient length of stay
- reduced hospital admissions
- reduced engagement with police
- reduced rates of incarceration

Measured at the individual level

- Re-established social connections/maintenance of social connections
- Reduced suicidality
- Improved experience of service
- Reductions in scores on the Subjective Units of Distress Scale
- Increased confidence to pursue housing, education and employment options and address financial concerns
- Increased self-advocacy skills
- Increased access to health and other services
- Improved ability to self-recognise levels of wellbeing and to implement self-management strategies

However, some groups of people who experience a need for support were frequently ineligible for services or there was limited information about how their needs would be met by the service. This includes:

- people currently or visibly substance affected
- people whose behaviour was considered aggressive or violent
- children and young people aged under 18, in particular, those aged under 14
- people currently under a mental health order
- people without a home
- people who don’t comfortably speak the mainstream language
- people with intellectual disability and mental health issues
- people experiencing AOD issues in addition to mental health issues
- people with dementia and mental health issues
- parents of dependent children without alternative means of childcare
- people from culturally diverse backgrounds
- people who are accompanied by several family members and prefer to remain with those family members

What did people need from an alternative to ED?

The aspects of the service delivery model most consistently desired by consumers, people close to them and service providers include the following:

- The service is available 24/7

- The service is staffed by peer workers
- The service is in a location that is safe at night
- There is provision for privacy for conversations and dignity
- The service is both a sanctuary and an active source of support and links to other services

Conditions for successful implementation and sustainability

Effective relationship building with existing crisis services, emergency response, community mental health and other services is necessary to achieve effective pathways to and from the alternative service, to ensure appropriateness of referrals and to ensure safe and effective operations.

Associated changes to those services are therefore likely. This suggests, as has occurred in other jurisdictions, that both a co-commissioning and a co-design approach will enhance the sustainability of the service.

Promotional material including short videos should be co-designed to ensure it addresses the informational needs of potential service users and potential referrers.

It may be necessary to implement strategies to ensure this initial individual service is not called upon to meet all current unmet demand.

It will be challenging to embed within one service all the features that will make the space safe for all potential users. Strategies exist to address this to an extent but specialised models may more successfully support different users, in particular, young people.

Attention should be given to creating a mentally healthy workplace.

Examine the suitability of current parental/guardian consent arrangements to ensuring the access of young people to psychosocial crisis support services.

The Safe Haven Café at St Vincent's Hospital Melbourne

The Safe Haven Café at St Vincent's Hospital commenced in April/May 2018 and operates as an afterhours Café for 18 hours per week within the hospital's existing Art Gallery. Integral to its operations are the links to ED where a peer worker is based who acts as a referrer to the Café. In the first twelve months of operation, approximately 1,100 visits were recorded. At full capacity, the Café could potentially support an estimated 1,800-2,000 visits annually. Based on analysis of ED data co-related to the opening times of the Café, it was estimated that the Cafe was diverting 10 visits per month from ED. In contrast, data from the Café guests suggested a reduction of about 30 ED presentations per month. It is not easy to attribute causality in this situation as no individual guest records are kept. Using the higher rate of ED diversion, it was estimated that the Café would achieve an annual saving to the hospital of $225,400, by virtue of reduced ED presentations. Given annual operating costs were estimated at $191,540, a surplus of $33,860 would remain.

Benefits were identified by individuals using the Café included increasing their social networks due to meeting new people in the Café and having increased confidence to pursue

new options in education, employment and housing. The Cafe service delivery model demonstrates the respect and peer support highly valued by respondents to our engagement processes. Being a communal social setting with no private rooms, it does not appear to have provision for private conversations. People whose behaviour is aggressive or who are visibly substance-affected will be asked to leave the Café. The café is for adults only. Recent conversations with the Café Project Manager indicate there is a demand for increased engagement of Café clients with support services and therefore a likely future direction for the Safe Haven Café will be the introduction of in reach by community organisations.

Recommendations

The recommendations, while informed by the engagement process and literature review, are based on the following conditions specified by the MHC:

- annual funding of approximately $700,000 per annum will be provided;
- the service must be delivered in a manner that ensures compliance with the National Standards for Mental Health Services;
- the service is for people with urgent psychosocial needs who do not require urgent medical assistance;
- the service will be located within the metropolitan area, within, or in close proximity to, an ED;
- the service should be operational in the first half of 2020.

Option 1. A hospital-based Café/Hub

Based within a hospital or on the hospital campus – closest existing examples – Redland Hospital's Living EDge and St Vincent's Safe Haven Café combined. If available, this could be integrated with a separately funded community-based peer worker program to provide ongoing support, a peer operated warm line and a phone/web chat service.

Option 2. A community based Café/Hub

A community-based Café service, open 15 hours weekly in the evenings, near public transport and nearby a hospital – closest existing service delivery model – Bradford NHS District Crisis Café.

Option 3. A community-based Sanctuary

Closest existing service – The Sanctuary in Bristol. A residential type setting staffed by peer counsellors who assist with de-escalation, self-management and problem solving and other calming activities. Available in the late afternoons until early morning hours. Accessed by phone through a separately funded crisis line triage and referral service.

Section 1. The establishment of a Safe Haven Café or similar in Western Australia

The Sustainable Health Review identified that people experiencing an urgent need for psychosocial support should be able to access this support outside of Emergency Departments and suggested safe haven cafes as an option.

> *'Further work will be needed to develop care pathways that will better support their needs out of emergency departments and help vulnerable people access the right care as early as possible, in the right place within the community. Mental health safe haven cafés work alongside EDs to provide a safe environment for respite and peer support for people seeking assistance after-hours but do not need acute care. Mental health safe haven cafés also help people learn more about their own needs and find options available for them locally to get further support.'*[1]

The Mental Health Commission described safe haven cafes as providing 'a peer based, non-clinical service for people with mental health issues … who may otherwise attend Emergency departments after hours'. [2] The need for an alternative to ED was strongly supported by the community members who responded to and engaged with this project.

People experiencing a crisis in their mental wellbeing describe utilising multiple strategies before they attend ED. They may talk with friends and family, seek urgent appointments from GPs and other providers, use social media and other communication platforms and employ a range of different self-calming techniques.

Table 1. 1 When you've needed urgent support, what strategies have you used that helped? Please tick all that apply.

Used techniques that calmed me	75%
Talked to family and friends	67%
Gone to an Emergency Department	63%
Made an urgent appointment with a service I trust	53%
Phoned a crisis support line	49%
Searched for new information and ideas	42%
Used social media to link with other people who have had similar experiences	35%
Called my peer support group (e.g. 12 step fellowship)	16%
Used an online chat service (e.g. Lifeline Crisis Support Chat)	14%

[1] Sustainable Health Review. (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia, p. 65.
[2] Mental Health Commission. (2019). Establishment of a Safe Haven Café in Western Australia.

When these self-management strategies are not sufficient, people have few alternatives but to attend ED. This pathway to ED is reinforced through multiple channels including crisis lines, GPs, and emergency services. However, once in ED, waiting to be triaged or attended to, the environment generally works against the utilisation of self-management resources. In the noise, brightness and pace of an ED, it is difficult to talk privately, to self soothe, and to de-escalate.

It has been widely acknowledged that EDs experience multiple challenges in attempting to provide the non-medical but urgent support that people experiencing a mental health challenge require.[3] This has been further highlighted by the increasing number of people presenting to EDs seeking support for their mental health.[4] In Western Australia, mental health related presentations to EDs have increased in absolute number and as a percentage of all presentations. Using data from Australian Institute of Health and Welfare (AIHW) [5] in 2017-18, 35,634 mental health related presentations were made to Western Australian public hospital EDs, comprising 4.2 per cent of all presentations. Five years ago, in 2012-13, the comparable figures were 21,372 and 3.0 per cent.[6] Of the people who did present in 2017-18, over 60 per cent (21,525) were neither admitted nor referred. Additionally, in 2017-18, at least 840 people left ED at their own risk or did not wait to be seen. Analysis of mental health presentations Australia wide identified the unsuitability of the ED environment and lengthy wait times for assistance as likely contributing factors.[7]

In May 2019, the Australian College of Emergency Medicine (ACEM) and RANZCP released a consensus statement that included a recommendation for engagement with people with lived experience as part of a process of reforming EDs.[8] Investments to improve the ability of EDs to respond to people in mental health crisis are underway. As examples, short stay Mental Health Observation areas (MHOA's) have been established in two Western Australian hospitals. In addition a Mental Health Emergency Centre opened at Royal Perth Hospital in October 2019 with another planned for Midland Hospital. MHOA's and MHECS are specialised areas for people presenting to ED experiencing mental health issues who require close observation and intervention in a more clinically capable and appropriate environment. [9] the successfully trialled VIP program at Calvary Mater Newcastle introduced

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[3] Australian College for Emergency Medicine. (2018). The long wait: An analysis of mental health presentations to Australian Emergency Departments. ACEM, Melbourne.

[4] Vandyk, A., Kaluzienski, M., Goldie, C., Stokes, Y., Ross-White, A., Kronick, J., Gilmour, M., MacPhee, C. & Graham, D. (2019). Interventions to improve emergency department use for mental health reasons: protocol for a mixed-methods systematic review. *Systematic Reviews*, 8:84 https://doi.org/10.1186/s13643-019-1008-6

[5] Please note a difference in coding methodology means the AIHW figures are significantly lower than those produced by WA Department of Health.

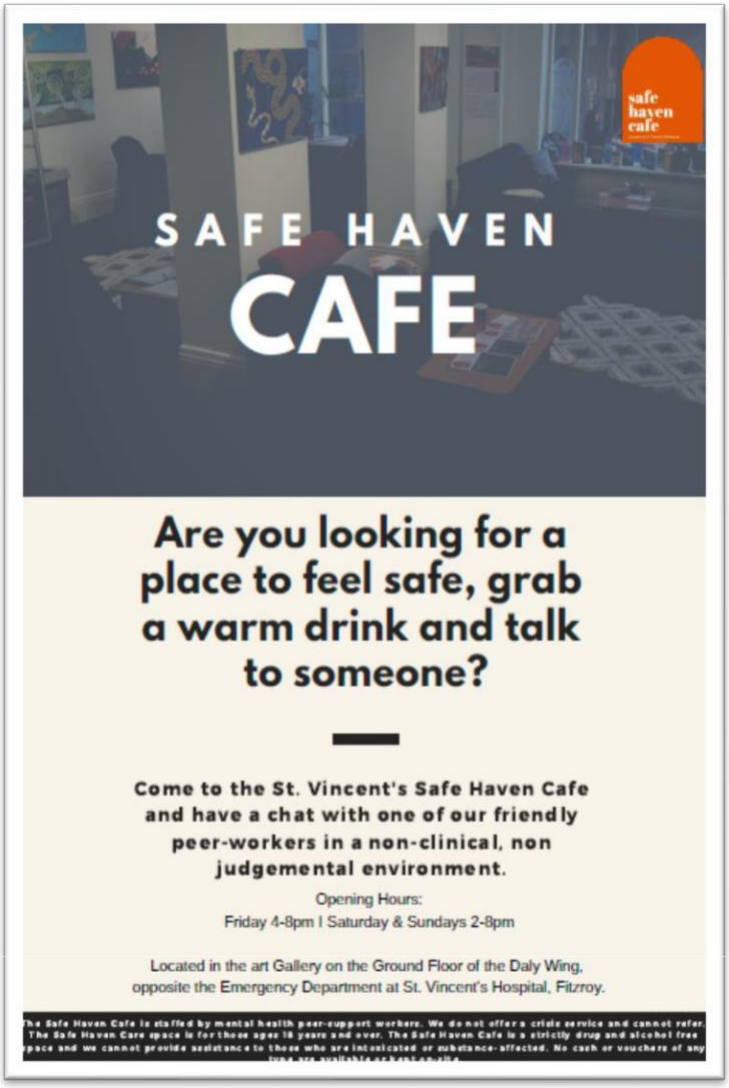
[6] AIHW (2019). Mental health services in Australia. Services provided in public hospital emergency departments. Tables ED. 1 and ED. 11.

[7] Australian College for Emergency Medicine. 2018. The long wait: An analysis of mental health presentations to Australian Emergency Departments. ACEM, Melbourne.

[8] ACEM. (2019). Mental health in the Emergency Department Consensus Statement. ACEM and RANZCP.

[9] https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/02/New-7-point-1-million-dollar-Mental-Health-Observation-Area-opens-at-Joondalup-Health-Campus.aspx

a social determinants of health approach to triage[10]; the Victorian Government has announced the introduction of six Mental Health Crisis Hubs to be based in hospital EDs[11] and, back in WA, the Mental Health Emergency Centre is scheduled opened in October 2019 at Royal Perth Hospital with another planned for Midland.[12]



Advertising of the Safe Haven Café at St Vincent's Hospital in Melbourne.

Some of the recent initiatives in ED incorporate greater provision of psychosocial supports delivered by peer workers. For example, the current (2019) project to pilot a peer staffed space, described as an alternative waiting room, on the campus of Redlands Hospital in Brisbane.[13] The Safe Haven Café at St Vincent's Hospital in Melbourne is a quite different example of an alternative waiting room. It is a Café space staffed by peers and clinicians and

10 https://www.calvarycare.org.au/blog/2017/12/19/calvary-mater-newcastle-receives-worldwide-recognition/
11 https://www.dhhs.vic.gov.au/mental-health
12 https://rph.health.wa.gov.au/Our-services/Mental-Health
13 https://www.qmhc.qld.gov.au/media-events/news/ed-alternative-trial-underway?fbclid=IwAR2aP6A0ZWHSp9EX-qF-PCIK-k4FKESD9cw5rqqBvrhl8NYnhajOgbx6LC4.

available to people in ED who are invited through by an ED-based peer worker, as well as being accessible on a walk in basis by members of the public seeking a friendly non-judgemental person to talk to or a safe space to sit. Peer workers are now based in the Emergency Departments of three Western Australian hospitals and are able to support people who will not be admitted to hospital by offering them community based support in the weeks following their ED presentation.

Outside of hospitals, alternatives to ED and variously named safe havens have emerged over recent years, designed to provide a welcoming setting, often with reference to a café, home or living room arrangement. Many of these, more or less explicitly, adopt a recovery-oriented approach, supporting the individual to recognise their strengths, to build hope and resilience and to make plans in order to meet practical needs.

Both the MHC and the Sustainable Health Review have mentioned the role to be played by peer workers in the safe haven. Peer workers feature in many of the services reviewed later in this report. A peer worker is a person with expertise gained through lived experience and, depending on the workplace and role requirements, may additionally have formal peer worker qualifications. Their lived experience may relate to mental health challenges and/or substance use (consumer peer worker), or they may have played an ongoing role in supporting someone close to them who experiences these issues (carer peer worker).[14] The sharing of this identify and experience is essential to their role.

Recent Western Australian research highlighted that people supported by peer workers reported the experience as positive.[15] People providing input to this this project similarly viewed peer workers as 'a living example, a beacon of light, actions speak louder than words'.[16] Reasons given for this included that peers '…support each other and engage respectfully. No power structure, humans sharing emotions in a way that doesn't undermine…'.[17]

There have been debates in the academic literature regarding the outcomes achieved through the introduction of peer workers. Many of the differences in findings relate to the wide variety of roles in which peer workers are employed, and the organisational structures they are employed within. In some situations, peer workers have been required to undertake roles that were inconsistent with the original program intent and with the peer philosophy of

[14] MHC NSW. (2016). Employers Guide to Implementing a Peer Workforce.
[15] WA Peer Supporters' Network. (2018). The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services. http://www.comhwa.org.au/wapsn
[16] Consumer interview.
[17] Consumer interview.

mutual support.[18] However, a recent review of the literature concluded that when peer workers are evaluated for the outcomes intended of peer work, the advantages to people using those programs are clearly demonstrated.

> *'…multiple studies have found that peer staff who are working in peer-specific roles are better able to engage people in caring relationships; improve relationships between clients and outpatient providers, thus increasing engagement in non-acute and less costly care; decrease substance use, unmet needs, and demoralization; and increase hope, empowerment, self-efficacy, social functioning, quality of and satisfaction with life, and activation for self-care.'*[19]

Psychosocial support can be used to describe any non-therapeutic support that helps a person cope with daily life. It acknowledges that there are psychological impacts from difficult life circumstances. Peer workers focus on the strengths of the person and the challenges they are facing, and work with them to identify strategies to address them. It may be that at the point the person accesses the safe haven, they may not be able to plan for the future, but part of the evidence of the impact of peer work is that people, having engaged with a peer worker, are more likely to feel hopeful and valued.

Involving the community in developing the safe haven model for WA

The MHC contracted CoMHWA to undertake engagement with a broad range of stakeholders for the purpose of assisting with the development of a model of service. Elements of a co-design approach were adopted and built into each stage of the project design and each form of engagement.[20] One of the most important aspects of co-design is explicitly addressing power imbalances amongst stakeholders.[21] This can occur when engagement processes favour a particular type of knowledge above others, or favours different ways of working together. To address these potential barriers to co-design, the engagement methods were varied to suit people's preferences.

Initial interviews were undertaken with people with lived experience who were willing to reflect on their experiences of accessing ED and who then imagined what the alternative service should look like. Their knowledge was then used to design the survey. The survey was constructed collaboratively across two peak bodies, CoMHWA and the AODCCC with lived experience input from service users and service providers.

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[18] King, A. & Simmons, M. (2018). A Systematic Review of the Attributes and Outcomes of Peer Work and Guidelines for Reporting Studies of Peer Interventions. Psychiatric Services, vol. 69, issue 9, pp. 961-977.

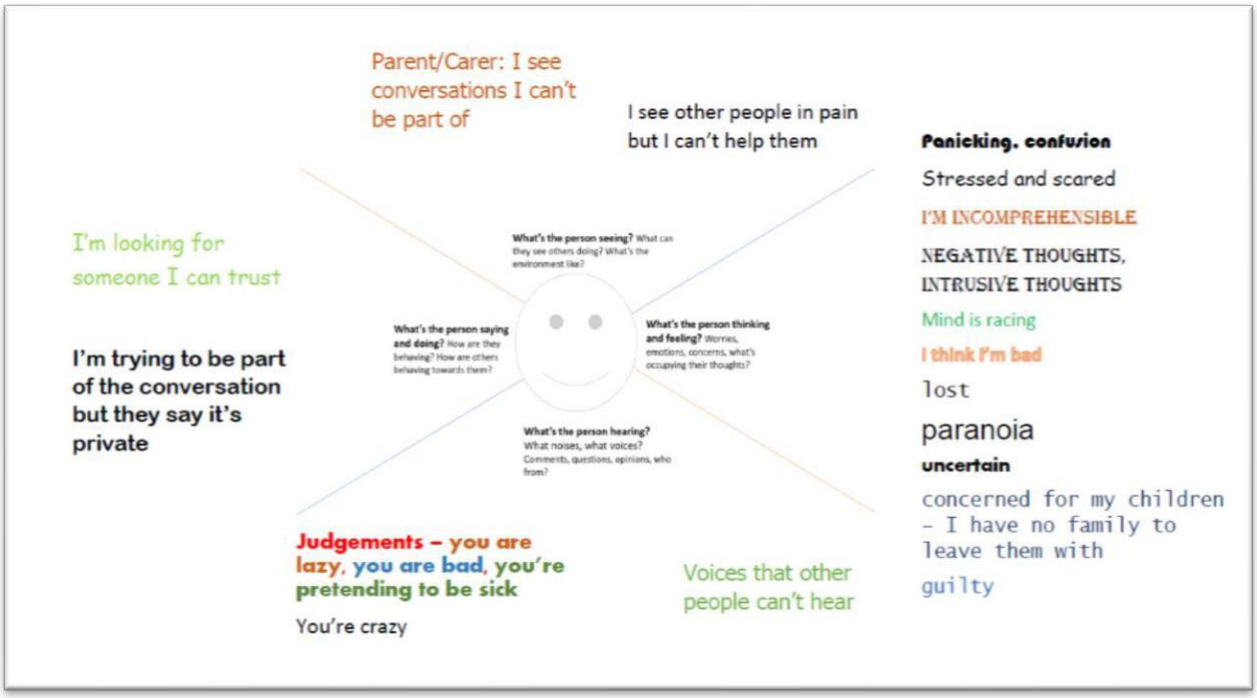
[19] Davidson, L., Bellamy, C., Chinman, M., Farkas, M., Ostrow, L., Cook, J., Jonikas, J., Rosenthal, H., Bergeson, S., Daniels, A. & Salzer, M. (2018). Revisiting the rationale and evidence for peer support. *Psychiatric Times*, volume 35, Issue: 6

[20] Burkett, I. (n.d.). An Introduction to Co-design. Centre for Social Impact.

[21] WACOSS. (n.d.) Co-Design Toolkit.

In forums, the facilitator identified as having lived experience and explained how that experience was relevant and valuable to the project, while at the same time acknowledging that talking about some of the topics was challenging. To assist people to feel more confident about their level of understanding of the topic, focus groups commenced with a presentation about the project and the topic, reframing it in everyday language and human experiences. Photos accompanied text wherever possible. Empathy mapping was utilised to create a vehicle to share understandings and difficult experiences but without exposing individuals or requiring any one to share personal stories.

Multiple forms of engagement with stakeholders were built into the project to ensure people with different communication preferences could participate in their preferred way. For example, people who preferred one on one communication were interviewed in their preferred space rather than joining a focus group. Most focus groups were small (5-8 people) and held in spaces identified as safe by participants. Co-facilitation occurred where ever possible with the co-facilitator being someone known to the group. The CoMHWA consultant sought advice from the co-facilitator on how to work consistently with the group's existing ways of keeping the conversation safe. Interpreters were offered and provided. People who participated in focus groups on the basis of their lived experience were paid for their time consistently with CoMHWA's Paid Participation Policy. This is another means of demonstrating respect for the knowledge being shared. People could also share knowledge



through different means – talking one on one, in person, over the phone or via Zoom; talking in a group; writing individually; responding to surveys and drawing.

During the period of engagement, the team reflected on who was participating and who was less likely to do so. This identified gaps that were then addressed through additional engagement options, including follow up interviews and personal invitations. Below is a summary of engagement activities and the number of responses from each stakeholder group.

Table 1.2 Summary of engagement types and responses

Type of engagement	Lived experience - consumer	Lived experience – family member, carer, friend	Service providers and other stakeholders	Total
Survey	58	34	77	169
Interviews	10	4	20	34
Lived experience focus groups x 4	38	9	-	47
Total number	106	47	97	250
Public forum – people were not asked to identify their experience				48
				298

All of the people with personal lived expertise who responded to the survey were adults, mainly under 65, and the majority were based in the great Perth metropolitan area. All respondents had experienced a mental health crisis of some kind with approximately 63 per cent of these presenting to an ED to seek support during the crisis. Almost 60 per cent of respondents experience both alcohol and other drug use in addition to a mental health challenge. Around 30 per cent experience disability of some kind. Almost seven per cent of respondents identified as Aboriginal and just over ten per cent were from culturally diverse backgrounds. Almost 30 per cent identified as LGBTIQA+. Other relevant aspects of identity raised by consumers included being a single parent of dependent children, experiencing a mental health while also caring for another person with mental health issues, and being an older people experiencing issues related to ageing in addition to mental health issues.

Family members and friends who responded to the survey were a similar age profile to consumers and were also mainly from the greater Perth metropolitan area. Around 12 per cent were from diverse cultural backgrounds; six per cent identified as Aboriginal; six per cent experience disability of some kind. Other relevant aspects of identity raised by carers relevant to their needs included the impacts of ageing and experiencing chronic health conditions, experiencing mental health issues, being a young carer and being a parent.

The majority of service providers who responded were from non-government organisations (36%), first responders (26%) and from government community mental health services (22%). A further ten per cent were hospital providers. There were also responses from peak bodies and advocacy organisations.

Focus groups were held with people with lived experience expertise as both consumers and as family members or friends providing care. In total, 47 people participated in four separate focus groups. Empathy mapping was undertaken

Individual interviews were held with people who were less likely to engage with a survey or attend a public forum. This included young people, people who are homeless, people who are not comfortable using English language, and people with particular communication preferences and challenges, including people hard of hearing, people who identify as Autistic and people more comfortable in one to one situations that in groups.

Additionally, the CEO of CoMHWA directly emailed organisational stakeholders, informing them of the project, inviting their participation in the project and their attendance at the public forum and asking their support in sharing links to surveys with their members and the wider community.

The consultant was invited to participate in a recently formed National Community of Practice for non-clinical alternatives to the Emergency Department for people in suicidal distress. This provided insight into the ongoing trial of the Safe Haven Café at St Vincent's Hospital in Melbourne along with updates to the development of safe havens in NSW and QLD. Additionally the consultant was able to link with a number of current projects underway in Perth and other states.

Our engagement activities approximately equate to the first two stages of co-design – empathising and defining. In these stages, we sought to move away from clinical and organisational descriptions of the need for alternatives to ED and instead develop a plain language, lived experience expression of the need for support and the types of services that would be valued. We explored existing service models and indicated preferences for various features of a model. However, co-designing the exact service delivery model will require more detailed knowledge of the specific environment in which the service will be expected to operate. The recommendations from this project offer a number of evidence based options that can be considered in more detail by the advisory group to be convened by the MHC.

Limitations on the data

We did not attract survey responses from people aged under 18. Focus groups with young people were held in anticipation of this outcome in order to provide a more suitable mechanism for their input. Providers of youth services were also interviewed to gain a better understanding of successful initiatives and unmet needs. However further consultation with young people will be important at the co-design stage and should also address the issues of how young people in a caring role for their parents will be supported by this service.

Other gaps in our knowledge base include how best to deliver a service that supports people with intellectual disability or other cognitive challenges who also experience mental health challenges. It will be important that these needs be addressed in the next stages of co-design.

The review of safe havens and alternative to ED is broad but not exhaustive. Many are currently emerging and so limited information is available. Systematic reviews are the gold standard in assessing an evidence base but the majority of these are forced to conclude that a lack of standardised implementation makes it difficult to evaluate services against an agreed set of standards.

Section 2. Who might use a safe haven and what do they need it to provide?

This section discusses various ways of determining the demand for the service, at the state wide and individual service levels, and discusses the needs people have of the service, as identified in responses to the consultation processes.

Who might use a safe haven?

Anyone in the population can experience a situation that is beyond their current ability to cope with and require urgent support. The following are groups of people who might want to access an alternative to ED for psychosocial support:

- people who have presented to ED with a mental health and/or alcohol/other drug related issue, but were not admitted
- people who were referred to Community Mental Health Services but whose referral was not activated
- people in distress who have experienced barriers to accessing support
- people in distress who have never sought support
- family members and friends who provide care and support to people close to them who are experiencing distress and require urgent support

Table 2.1 describes the characteristics of people who accessed a public hospital ED in WA for support for a mental health related issue in 2017-18.[22] Approximately 22,000 presentations did not result in an admission. These are people most likely to be eligible to access psychosocial support from an alternative crisis service, as long as that service is available when and where they need it.

A recent analysis of the growth in ED presentations in WA over the past 15 years indicates two factors accounting for the majority of the increase.[23] The most significant contribution is from males experiencing mental health issues that co-occur with problematic alcohol and other drug use, and secondly, from younger females experiencing anxiety related conditions.

The majority of people using ED are adults. However, ED use by children and younger people experiencing mental health issues is growing.[24] They differ from adults in both their needs for support and in their ability to access support, which is constrained by legal and

[22] AIHW. (2019). Mental health services in Emergency Departments. Australia.

[23] Yap, M., Tuson, M., Whyatt, D. & Vickery, A. (2019). Anxiety and alcohol in the working-age population are driving a rise in mental health-related emergency department presentations in Western Australia. *Emergency Medicine Australasia*. doi: 10.1111/1742-6723.13342

[24] Tran, Q.N., Lambeth, L., Sanderson, K., De Graaff, B., Breslin, M., Tran, V., Huckerby, E. & Neil. A. (2019). Trends of emergency department presentations with a mental health diagnosis by age, Australia, 2004–05 to 2016–17: A secondary data analysis. *Emergency Medicine Australasia*, doi: 10.1111/1742-6723.13323

practice considerations as well as practicalities around access to transport. This needs to be considered in the design of an alternative to ED.

Table 2.1 Characteristics of people presenting at public hospital EDs Mental health related presentations: Western Australia 2017-18		
Person	*Number*	*Per cent*
Age		
0-17*	4,101	12.5
18-64*	25,227	76.5
65 and older*	3,668	11
Episode end status		
Admitted	10,887	31
Departed without being admitted or referred to another hospital for admission	21,525	61
Referred to another hospital for admission	2,325	7
Did not wait to be attended	145	-
Left at own risk	699	2
Aboriginal and/or Torres Strait Islander people	4,349	12
Main principal diagnosis		
Neurotic, stress related & somato form disorders	13,179	37
Mental and behavioural disorders due to psychoactive substance use	9,338	26
Schizophrenia	3,746	10
Mood affective disorders	3,167	8
Organic including symptomatic mental disorders	2890	8
Disorders of adult personality and behaviour	1302	4
Behavioural and emotional disorders with onset usually occurring in childhood & adolescence	907	3
Mental disorder not elsewhere specified	682	2
Triage category		
Resuscitation	315	0.9
Emergency	4,604	12.9
Urgent	17,995	50.5
Semi urgent	11,696	32.8
Non-urgent	1,024	2.9
DVA status	226	1
Metro (Perth North and Perth South PHN)*	25,440	77.1
Non metro (Country WA PHN)*	7,556	22.9
How arrived at ED		
Ambulance etc	12,537	35
Police	4,295	12
Other	18,794	53
Average cost of ED presentation 2016/17 (IHPA)	$838	
TOTAL ED mental health presentations	35,634	100

Sources: AIHW. (2019). Mental health services in Australia. Please note that AIHW figures are coded differently to WA Department of Health and are a relative undercount of all mental health related presentations. *PHN data differs slightly to AIHW and so these figures do not add to the total.

People arriving by police or ambulance account for approximately 47 per cent of MH related presentations.[25] Additional data on their needs and their rates of hospital admission will be important to determining whether their needs would be better served by accessing an alternative to ED. People bought in by police tend to be younger and experience substance use issues in addition to being in distress.[26] They are more likely to be described as aggressive and also more likely to have physical injuries. There is limited data regarding the care they receive in ED. This group of people are rarely supported in alternative to ED services.

People aged under 18 are growing in number and account for over 12 per cent of people arriving at ED. More assessment of their particular needs is required to determine what percentage require medical and psychiatric support and what proportion may benefit from psychosocial support and how this can best be provided.

Approximately 12 per cent of people presenting to ED with a MH related issue are Aboriginal people. It is known that Aboriginal people experience higher rates of psychological distress but at the same time experience barriers in accessing culturally safe mental health services.[27] [28] A recent study indicated that young Aboriginal people in out of home care were amongst the growing numbers of young people presenting to ED.[29] Depending on an analysis of their co-occurring physical health needs, they could be a specific cohort of people supported by an appropriately designed alternative to ED.

In Western Australia, over 60,000 people provide ongoing support to someone close to them who needs support due to their mental health challenges.[30] In a period of crisis, it is common that both the individual and the person close to them require support.

At the **state wide planning level**, the Western Australian Primary Health Alliance (WAPHA) needs assessments and service atlases provide detailed, place based analysis and service mapping which can be used to determine locations in the Perth metropolitan area.[31] That information and analysis will not be replicated here but should be considered in determining priority location and system wide needs.

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[25] AIHW. (2019). Mental health services in Emergency Departments. Australia.

[26] Crilly, J., Johnston, A., Wallis, M., Polong-Brown, J., Heffernan, E., Fitzgerald, G., Young, J. & Kinner, S. (2019). Review article: Clinical characteristics and outcomes of patient presentations to the emergency department via police: A scoping review. *Emergency Medicine Australasia*, 31, 506-515.

[27] Department of Prime Minister and Cabinet. (2014). Aboriginal and Torres Strait Islander Health Performance Report. Commonwealth of Australia.

[28] McGough, S., Wynaden, D. & Wright, M. (2018). Experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study. *International Journal of Mental Health Nursing*. 27, pp. 204-213 doi: 10.1111/inm.12310

[29] Williamson, A., Skinner, A., Falster, K., Clapham, K., Eades, S. & Banks, E. (2018). Mental health-related emergency department presentations and hospital admissions in a cohort of urban Aboriginal children and adolescents in New South Wales, Australia: Findings from SEARCH. *BMJ OPEN*

[30] Carers WA. (n.d.). Caring in Focus: Caring for a family member or friend with mental health issues.

[31] WAPHA Needs Assessments Reports 2019-2022 and WAPHA Mental Health Atlases – available from https://www.wapha.org.au/service-providers/health-planning/

Data on ED presentations do not indicate what people were seeking when they attended ED. When people were asked as part of this engagement process what they needed most from ED, the majority indicated a need to be kept safe, and secondly, to have someone to talk to. People also explained that having the option of medical support was important because they weren't always sure why they were feeling so distressed. Some mentioned that an assessment of their medication resulted in improvements in how they were feeling.

Table 2.2 When you visited the Emergency Department, what was it you needed most?	
Someone to talk to	47%
Wound treatment	18%
I wanted to be kept safe	65%
I wanted hospital admission	32%
Medication assessment	26%
Treatment for overdose	35%

A number of the people who provided feedback to this project needed medical assistance in association with their visit to ED. While they would not have been able to utilise an alternative non-clinical service in the first instance, they may have been able to be referred to a hospital based safe haven once their physical health needs were met in ED. However, a significant percentage would have been eligible for an alternative ED service if it was available when and where required.

Table 2.3 When you visited the Emergency Department, what was your experience related to?	
Anxiety	51%
Alcohol and/or other drug related issue	34%
Experienced psychosis	25%
Feeling suicidal	75%
Needed medical attention for self harm	32%
Needed medical attention for an injury due to violence (including assault)	16%

In order to meet these needs, an alternative to ED must at least ensure that people feel safe and are safe. It must provide people with someone to talk to. *'I wanted to be treated with respect and not be subject to judgemental bias'.*[32]

At the **service level**, the potential number of users can be estimated when decisions are made about the services to be offered, the opening hours, the location of the service, the funding stream and the policy drivers, and any eligibility/exclusion criteria. For example, the following eligibility criteria have been applied to various safe havens and alternatives to ED.

- children (aged 10-17 years)
- children and young people (eg aged 16-24 years)
- people who live in a defined geographic catchment area
- people who are homeless or at risk of homelessness
- people with a particular diagnosis or 'condition' eg eating disorders, addictions
- must not be considered a risk to themselves or others – this usually refers to aggressive behaviour or being visibly substance affected
- people whose mental health 'condition' is described as 'severe and persistent'
- people who have been recently discharged from hospital following a suicide attempt
- people triaged at level 3 and below
- people who frequently present to ED
- people who are intoxicated in a public place

The location of the service and the number of referral pathways will also impact on the potential number of service users. At one extreme, if based within a hospital or on a hospital campus, with a single referral pathway from ED, the potential number of service users can be calculated from ED presentation data. The trial at Redlands Hospital, where the service is open for four hour shifts during weekday afternoons, has resulted in two people being referred from ED per shift.

At the other extreme, if the service is community based, with few restrictions on eligibility and people are able to walk in without an appointment or prior phone call, the potential number of users will be less straightforward to estimate and the service delivery model will need to have capacity to safely accommodate that. This is discussed in more detail in Section 4.

What do people need from an alternative to ED?

We asked people how they would design an alternative to ED, based on their needs and experience as consumers or as family members, carers and friends or as service providers. We asked people about their decision to access support, how they would travel to and from the service, how they would wish to be welcomed, and what they would need on arrival and during their time in the service.

[32] Consumer response to survey.

Firstly, we wanted to understand what would help people make a decision between going to an ED or to an alternative service. What consumers wanted to know was exactly what the service offered, how to get there and to know there was a peer worker available. Being able to phone ahead was also important.

Table 2.4 As an individual seeking support, what would help you choose between going to ED or an alternative service?	
Knowing exactly what the service offers and how to get there	77%
Knowing there was a peer worker (a staff member with personal experience of mental health and/or alcohol and/or other drug issues) to talk to	77%
To be able to phone ahead to make sure someone is there who can help	65%
On arrival, to be able to ask questions about my choices	63%
Knowing there was medical support available if required	63%

For people close to someone who is experiencing mental health issues, there were similar concerns about knowing exactly what the service offered. Being able to phone ahead was important. Family members and others in a caring role were also concerned to know that the service would be understanding of their role.

Table 2.5 As a family member or friend, what would help you choose between going to ED or an alternative service?	
To be able to phone ahead to make sure someone is there who can help the person you support	78%
Knowing exactly what the service offers to the person you support	81%
Knowing there was medical support available if required by the person you support	66%
Knowing there was a peer worker (a staff member with personal experience of supporting someone with mental health and/or alcohol and/or other drug issues) there who you could talk to	67%
Knowing that the service is aware of the role of family members/carers/friends and is able to support you in that role	91%

When family members and friends described experiences in ED, it was clear from their responses that being beside someone but not being able to assist them added further distress to the situation. Many consumers also mentioned the importance of family and friends receiving support if they were with them, but that privacy for both was important as the distress each was experiencing could impact on the other.

People may act on the advice of a service provider in deciding whether or not to attend ED. For example, people may speak to their GP or a crisis line when they are distressed. It was important that we asked service providers what information they would need to refer someone to an alternative to ED.

Table 2.6 As a service provider, what information would you require to recommend an alternative to ED service?	
Accurate description of services offered	91%
The pathway to accessing ED if necessary	75%
Eligibility requirements and restrictions	72%
The medical support available	70%
The clinical governance arrangements in place	54%

While the Sustainable Health Review and the MHC have stated the service will be available out of hours, there was overwhelming consistency amongst all responders to the survey that the service be available 24/7. National level data indicates that peak times in EDs are from mid-morning to mid-afternoon and that Monday is busier than Friday or weekends.[33] Further breakdown of this data is required to identify the times of presentation of people seeking psychosocial support to ensure the alternative service coincides with that need. However, the service will also be needed by people who do not present to ED. Many afterhours safe haven services include Monday amongst the evenings they are open.

People discussed their options for travelling to the service. Many people said that they could drive themselves, or someone close to them could assist. However, a significant number of people also stated that there would be times that their level of distress could prevent them from driving, or from using public transport.

'If I am in need of care I doubt I would be able to drive or take public transport or feel comfortable breaking down in front of a stranger driving a taxi/uber.'[34]

[33] AIHW. (2019). Emergency Department Care 2017-18. Australian hospital statistics, Table 4.3

[34] Consumer feedback.

Table 2. 7 What options do you have for getting to the service?		
Transport options	Individuals who might use the service	Family members/ carers/friends
Drive myself	68%	75%
Someone close to me can drive me	51%	34%
Taxi/Uber	35%	22%
Public transport	42%	31%
None	9%	3%

Transport was a recurring subject in the focus groups. *'Need a mental health taxi service run by peer workers'.*[35] It is one of the reasons some crisis services reimburse people for the cost of a taxi or public transport on their first visit to the service.

Approximately 47 per cent of people who present to ED for a mental health related issue arrive by police or ambulance. Currently they could not be taken to an alternative location by those means. If the safe haven was at the hospital then they may be able to access it post-triage.

The following should be considered in designing the location of the service. Additional comments emphasised the importance of the parking being free. This needs to be considered if the service is based on a hospital campus where parking is frequently not free.

Table 2.8 What is important to the location of the service?			
	Individuals who might use the service	Family members/ carers/friends	Service providers
Parking available	74%	78%	46%
Near public transport	72%	53%	81%
Easy to find at night	66%	67%	59%
Near a hospital with an Emergency Department	48%	63%	67%
A safe location at night	88%	91%	81%
Near other services	31%	22%	28%

[35] Consumer feedback

We also asked people to consider the physical design of the space. Their responses aligned with the existing research. Evidence of a positive impact on healing and behaviour have been attributed to specific aspects of spatial design including: [36]

- A homelike environment
- Access to views and nature including plants
- An individual's control over light and noise
- Privacy
- Positive distractions including opportunities for social engagement
- Additionally, the person's first point of contact within the space (reception or triage) is also crucial.

In the table below, people strongly indicated a need for privacy, for physical comfort, a connection to the outdoors and a non-clinical appearance.

Table 2.9 What is important about the physical design of the space?

	Individuals who might use the service	Family members/ carers/friends	Service providers
Private spaces where conversations can't be overheard	91%	91%	93%
Gentle lighting	78%	84%	83%
A family space	36%	66%	58%
A space to be active – yoga or gym	31%	-	29%
Non-clinical appearance	74%	84%	84%
Comfortable seating/furniture	78%	81%	86%
Connection to outdoors/ outdoor spaces	71%	72%	81%
Social spaces	36%	50%	52%

We asked people what services should be available from an alternative to ED service. While there were some variations in responses between consumers, family members / carers / friends and service providers, there was clear support for the employment of peer workers. In the table below, the top six responses of each group of respondents is highlighted in red. A low score does not necessarily mean a lack of support. It is more a reflection of the diversity of needs. For example, while child care appears to be a low scoring requirement for parents of dependent children, the availability of childcare may be essential to their ability to access the service.

[36] DuBose, J., MacAllister, L., Hadi, K. & Sakallaris, B. (2018). Exploring the concept of healing spaces. *HERD*, 11 (1), 43-56.

Table 2.10 What services should be available?			
Service	Individuals who might use the service	Family members/ carers/friends	Service providers
Peer support (consumer and carer)	84%	84%	81%
Overnight stays	71%	69%	67%
Referral to mental health services	74%	66%	86%
Access to medical assessment and support	69%	75%	68%
Information and links to community services	60%	69%	86%
After hours phone support	62%	75%	57%
Food and drinks	71%	63%	71%
De-escalation	69%	81%	70%
Counselling	66%	69%	62%
Safety planning	62%	69%	78%
Links to ED	59%	53%	77%
Problem solving	64%	66%	77%
Aboriginal Liaison Service	47%	38%	59%
Support for people close to the person (family members, carers, friends)	41%	75%	72%
A social space to talk with other people or just to sit	64%	63%	59%
Mental Health Care Plan (developed with a GP)	60%	58%	49%
Home visits	45%	53%	32%
Child care	33%	31%	38%
Transport	38%	44%	39%
Week long stays	36%	34%	28%
Longer residential stays	24%	25%	17%

Additional services suggested by consumers, carers and service providers included follow up and support while at home. This was also mentioned in the focus groups and interviews.

> *"I personally believe that patients would benefit immensely from services accessible from home. For example, I think that peer support workers / councillors / psychologists should be allowed to treat the patient within the confinement of their own home (given this was what the patient wanted)."*

Based on the early interviews and the literature review, a list of descriptions of different safe haven models was developed from which people were asked to choose one that best matched their preferred service. People were also invited to share their own description.

Table 2.11 Which best describes your preferred alternative to ED? Or please write your description.

	Individuals who might use the service	Family members/ carers/friends	Service providers
A café – a friendly social space offering drinks and snacks, with board games	7%	13%	12%
A hotel – a welcoming entry, private rooms to sleep in, a gym and other activities	9%	3%	-
A house – a bedroom to sleep in, a kitchen and loungeroom	5%	7%	3%
A retreat or sanctuary – a peaceful space to rest and talk quietly and take a break	30%	10%	12%
A hub – a supportive space to plan and problem solve and regain hope	16%*	33%	42%
A welcome visitor – a friendly voice on the phone or at my door who brings what's needed	5%	10%	6%
Your description (see discussion)	27%	23%	25%
*The most commonly mentioned model in your descriptions was **a hub** as part of a combination of the above suggestions.			

In summary, people have described a service that is able to offer both a space that allows them to feel safe, to de-escalate, and when they feel up to it, to talk privately with someone who will not be judgemental. For most people, that was a peer worker. For family members and friends in a caring role, knowing that the service would understand their role was vitally important, along with needing to know the wait time. For service providers, knowing the service was able to support the person to plan for the future was a key requirement, along with having sound processes in place to transfer the person to medical support if required.

Section 3. Existing models of alternatives to Emergency Departments and safe havens

This section reviews alternatives to emergency departments and safe havens where the service delivery model included a peer support component.[37] Clinical crisis support services are generally not included unless there is a peer support element. The review has utilised a wide variety of sources including academic and grey literature, media reports, government, peak body and service provider websites. Where available, the review has provided descriptions of the service delivery model, referral pathways, the actual or expected outcomes, consumer feedback and resources to assist with replication.

Particular services were included to support a discussion of contrasting service delivery models. Consideration was also given to services that are essential to supporting the functioning of the safe havens and services that people have identified as safe spaces useful for preventing crisis. The review therefore includes services that are not crisis services but include features that people in crisis have identified as useful. The service may also have acted as a 'soft entry' point to more intensive and formal mental health services. Given that stigma remains a barrier to early service use, soft entry points may be an important strategy in engaging people with the support they wish to access before reaching a crisis point.

Crisis stabilisation centre in California

As is noted in this review, the provision of urgent psychosocial care has varied across jurisdictions as new services emerge out of differing systems of social, health and mental health care and are driven by various policy and funding streams. For these reasons it shouldn't be assumed that a particular service delivery model can be transplanted into a different system and be expected to achieve the same outcomes.

Table 3.1 is an attempt to summarise the different service types.

Table 3.1. Psychosocial crisis support service delivery models: safe spaces and ED diversion services, where there is a peer component

Location	Service delivery model	Examples
In-hospital or on the hospital campus	An alternative ED waiting room that functions as a café in a communal space. Engagement with peer workers is available but optional. Referrals from ED and walk ins. Approx 1:4 staff client ratio. Open out of hours 18 hours per week	Safe Haven Café, St Vincent's Hospital Melbourne
	Peer supported transition programs. ED to home.	Choices and Peer2Peer, Perth
	Alternative waiting rooms providing with one to one peer support.	Living EDge, Brisbane The Living Room, Springfield, USA
Community based	Walk in respite centres (clinician triage followed by one on one peer support)	The Living Room, Chicago, USA
	Crisis stabilisation centres. Multidisciplinary clinical and peer team providing psychiatric, medical and psychosocial support. Walk ins and referrals -24/7	Exodus Centre, LA, USA Crisis Stabilisation Centre, San Bernadino, USA
	Crisis houses offering one to one peer support in a residential setting with varying lengths of stay (hours to days)	The Sanctuary, Bristol, UK
	Drop in space offering peer support and access to clinical assessment	Safe Haven Cafes, UK
	Crisis cafes offering small group or one to one peer delivered psychosocial support in a social setting	The Well-Bean Cafes, Leeds, UK
In-home	Outreach from community or hospital based peer support	Some peer transition programs Some crisis cafes
Mobile services	Street health teams, accompanied by food vans, housing support staff, laundry services	RPH Homelessness Street Health
Virtual	Warm lines, online and text chat services	Distress Centres, Canada, Carer Warm Line, Queensland

A number of services will now be reviewed. As the MHC requested a detailed discussion of the Safe Haven Café at St Vincent's Hospital in Melbourne, this will be examined first and in most detail.

Safe Haven Café St Vincent's Hospital Melbourne[38]

The Safe Haven Café commenced operations in April/May 2018. It is located within St Vincent's Hospital across a quadrangle from the Emergency Department in a space that is an Art Gallery when the Café is not in operation. The Café received pilot funding from Better Health Victoria and some additional funding from within the organisation to conduct a 12 month trial. While the Café was named after the existing Safe Haven Cafes in England, the models are dissimilar, as explained below and in the following sections.

Accessing the service

A peer worker based in ED identifies people in the waiting area who may be experiencing distress and, in consultation with clinical staff, invites the person to come to the Cafe. There is an external locked door of the Café. This also allows for entry by members of the public. Although the figures were still be finalised, it was estimated that 1,100 visits were made over the first year of its operation (April/May 2018-April 2019).

Safe Haven Café, St Vincent's Hospital, Melbourne

Operating model and philosophy[39]

The Café is described as a non-clinical space that provides snacks and drinks in a welcoming atmosphere. All customers are served at their table. There is no self-service. This is to facilitate respectful interactions between customers and staff and provide a dignified café experience. The staff are peer workers with their own experience of mental health challenges and identify as such to café guests.

[38] Based on a conversation with Fran Timmins, Director of Nursing Mental Health Executive Services, St Vincent's Hospital, Melbourne June 2019.
[39] Based on a conversation with Fran Timmins, Director of Nursing Mental Health Executive Services, St Vincent's Hospital, Melbourne June 2019.

Minimal pamphlets or posters are displayed although information is provided when requested by a guest. There are no private rooms but there is a quiet corner where people choose to go if they want a more private conversation with staff or other guests.

Opening hours were chosen to coincide with busy times in ED and the Café initially opened Friday evenings, and half days Saturday and Sunday. This is under review. There are always two staff as a minimum. Maximum guest capacity at any one time is estimated at 20 people. Additional part-time and casual staff are rostered on during expected busier times. It is considered important that no one be kept waiting at the door for too long, and that everyone is greeted in an unhurried and friendly manner.

There are no formal activities, although board games are available if desired, and no individual records of customers are kept. Outside of the Cafe there is no ongoing engagement with customers. Advice about other services is provided to customers at their request. This is usually provided by the peer workers who have good knowledge about supports for people who experience homelessness. Anecdotally it appears that most customers who would want to know about mental health services are already accessing them.

The clinician currently employed to work in the Café is a social worker, but this is not required by the model. The service evaluation considered it viable that no clinician needed to be employed in the Café and suggested that the Café could be operated by peer staff alone with some additional training and with a clinician available via phone. This would reduce operating costs.[40]

Links with other services

For the first two months there were few customers referred from ED. Since then, champions have been effective in bringing about increased acceptance of the value of the Café. These champions include the Peer Worker in ED and individual clinicians, some of whom now volunteer in the Café. While the referral of a person from ED to the Café may be noted on an individual's notes in ED, it is not considered a formal referral as the Café is not a mental health service. This has impacted on the ability to collect outcomes data and may be reviewed.

Guests of the Café do not provide their name to Café staff unless they choose to. No case management of any kind is undertaken at the Café. Guests may, and do, ask for information about services, particularly services that support people who are homeless. This is an informal process with no records made or follow up expected.

[40] PWC. (2018). Economic Impact of the Safe Haven Café Melbourne.

Advertising and promotion is currently being reviewed and is expected to focus on public spaces, such as Malls, where people who are potentially clients of the café may spend time in order to access free Wi-Fi.

The evaluation considered there would be advantages in the Café being co-located with other community-based service providers as this could enhance referrals of customers to other services.

Outcomes from evaluation

An external evaluation was conducted in October 2018 [41] to consider the first five months of operation with a 12 month evaluation currently underway. The initial evaluation focussed on a cost benefit analysis along with some measures of quality from a customer perspective.

Based on analysis of ED data correlated to the opening times of the Café, it was estimated that the Cafe was diverting 10 visits per month from ED. In contrast, data from the Café guests suggested a reduction of about 30 ED presentations per month. It is not easy to attribute causality in this situation. No individual records are kept hence a methodology for attributing outcomes was agreed upon which placed most emphasis on the guest's responses to the survey completed on arrival. Using the higher rate of ED diversion, it was estimated that the Café would achieve an annual saving to the hospital of $225,400, by virtue of reduced ED presentations. Given annual operating costs were estimated at $191,540, a slight surplus of $33,860 would remain.

Other benefits from the service included an improved experience for hospital users who were able to wait in a safe and supported environment, away from ED. For café guests generally, whether walk in or from ED, the value accrued from being in a safe and respectful environment in which to have conversations that encouraged their further exploration of options to address difficult situations. People valued the knowledge of the staff and the deep listening and respect offered to them.

The evaluation made mention of that fact that no refugees from a nearby residential block visited the Café but did not discuss reasons for this beyond suggesting that relocating the Cafe to a residential location away from the hospital might have allowed for greater access by local community members and, if integrated with other services, may have increased staff knowledge of those services.

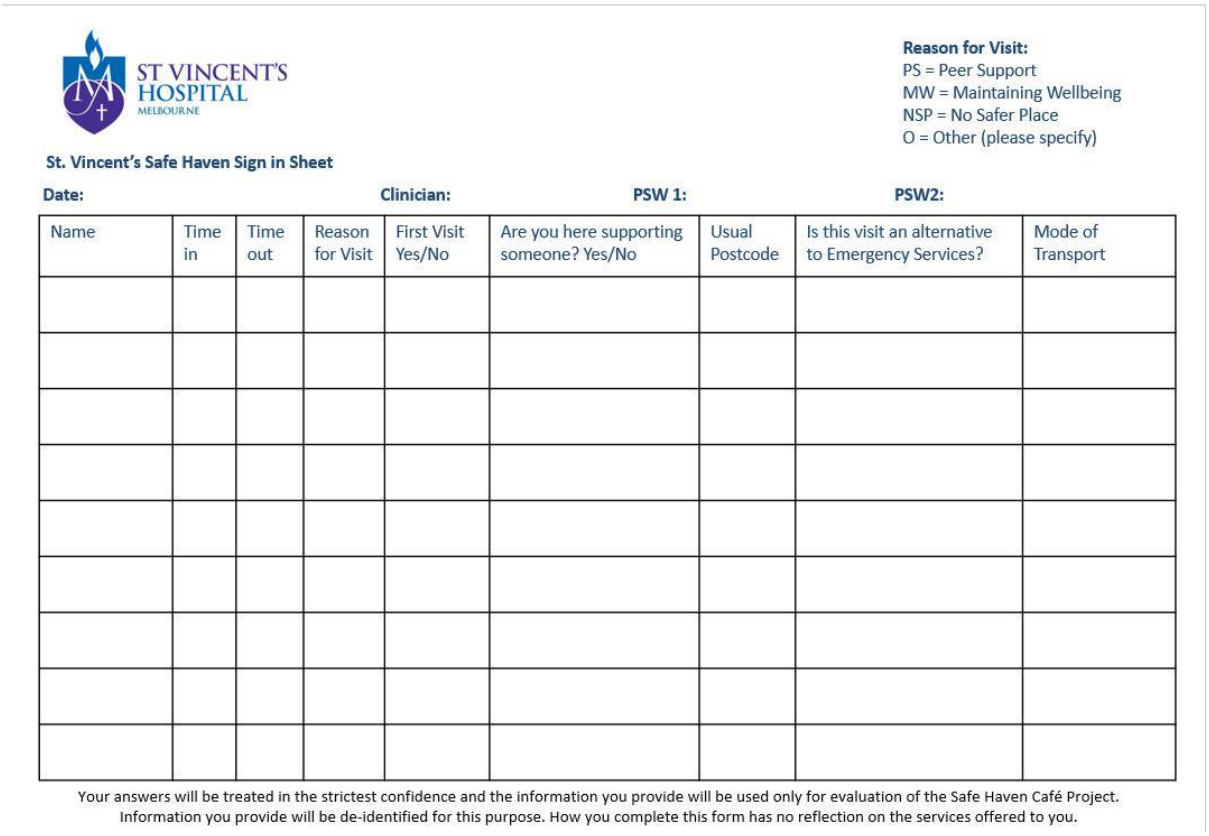
At an update in September 2019, Fran Timmins described additional activities for the Café which included linking in with external agencies who could provide longer term support to Café clients. [42] If Café staff are involved in providing longer term support, the limited opening hours can hinder a timely response. It is hoped that through linking people in with volunteers from local support agencies, greater continuity of support can be achieved for individuals.

[41] PWC. (2018). Economic Impact of the Safe Haven Café Melbourne.
[42] Community of Practice National Phone Hookup 13 September 2019

Consumer feedback and outcomes

Customers are asked to provide basic information on their first attendance, and then to provide non-identifying information each time they attend.

Table 1: The sign in form used to collate data for the evaluation of St Vincent's Safe Haven Café



ST VINCENT'S HOSPITAL MELBOURNE

Reason for Visit:
PS = Peer Support
MW = Maintaining Wellbeing
NSP = No Safer Place
O = Other (please specify)

St. Vincent's Safe Haven Sign in Sheet

Date: **Clinician:** **PSW 1:** **PSW2:**

Name	Time in	Time out	Reason for Visit	First Visit Yes/No	Are you here supporting someone? Yes/No	Usual Postcode	Is this visit an alternative to Emergency Services?	Mode of Transport

Your answers will be treated in the strictest confidence and the information you provide will be used only for evaluation of the Safe Haven Café Project. Information you provide will be de-identified for this purpose. How you complete this form has no reflection on the services offered to you.

Customer feedback indicated that people felt respected and valued and had made social connections with other customers, some of which were maintained outside of the Café. Case studies highlighted instances where the opportunity to engage with a peer worker at the Café provided a turning point for an individual, giving them the courage to consider new options.

Of approximately 1,100 visits over the 12 months, two people have been assisted to go to ED, and one person was asked to leave due to appearing to be substance affected. A few safety plans have been completed on request.

People not able to access the service

The service is not available to children and young people aged under 18. People whose behaviour suggests they are under the influence of psychoactive substances are respectfully asked to leave. People who are homeless and wanting to use the Café as a space for a nap have been reminded that this is not the purpose of the Cafe. It was reported in the evaluation that this resulted in a temporary drop in numbers.

Advice for replicating the service

The service was co-designed with consumers, carers and staff using a human centred design approach which was considered vital by those involved. Some physical design shortfalls that have become apparent to the operators are the shortage of power points and phone charging points and inadequate Wi-Fi. These facilities are highly valued by Café users.

The evaluation reported that it was not considered necessary that the service be co-located within a hospital but did not address the question of how this relocation would impact the referral pathway from ED if people had to travel some distance from ED to a new location. Currently, being located near the ED, staff in ED ensure that people who need medical attention do not come to the Café. In the absence of being located away from ED, there may be an increased likelihood of people entering the café who need medical attention and/or are substance affected. There may be additional visitors whose intention was never to attend ED but who appreciate being able to use the Café as a shelter from the elements and to have a meal. Policies and practices to manage this possible outcome were not discussed in the evaluation. There was discussion about the importance of ensuring peer staff were able to access appropriate training and support in their role should a clinician no longer be employed in the Café.

Establishment costs were $124,000 including consultancy costs and purchase of furniture and other equipment, fit out and evaluation. These are one off costs that could be significantly reduced if the Café was established by an ongoing organisation that utilised after hours capacity of an existing premises. Monthly operating costs were estimated at approximately $16,000 which equates to just under $200 per visit. This figure would potentially reduce as efficiencies are gained and guest numbers reach capacity. It's important to remember that in the St Vincent's Safe Haven Café, all of the client work occurs during café opening times and that staff are not required to keep client records. In contrast, a service that was actively referring clients to services would incur staffing costs in addition to opening times as those referrals would need to occur during business hours and there would be additional costs from maintaining client records.

As of September 2019, the service has been advised of continuing funding through St Vincent's mental health funding stream. Some minor changes to the service delivery model may emerge from the current internal evaluation that is underway, but as the service is considered to be meeting its objectives, major changes are not expected. [43] One initiative that is being considered, as mentioned earlier, is in reach by local service providers.

Emerging Australian projects with some similarity to the Safe Haven Cafés

The Government of NSW has announced a package of suicide prevention initiatives which includes $25.1 million for 20 services that will function as afterhours alternatives to EDs, 'derived from the United Kingdom's Safe Haven Café model'.[44] The exact model is currently being developed and is expected to commence later in 2019.[45] This initiative will deliver twenty services across 15 local health districts in two phases. Ten will be established from 2019/20 and a further ten from 2020/21. The services will provide an alternative to emergency department presentations for people experiencing a suicidal crisis, especially outside of hours. While a state wide co-design workshop will be held to develop a model that will then be implemented to accommodate local needs, it is expected that peer workers will be employed in the services and that people will be able to access information and support that will address the cause of the distress.

The Government of Queensland has announced a $10.8 million investment over the next four years to establish Safe Haven Cafes operated by non-government organisations and expected to employ clinicians and peer staff. [46] Suicide prevention is a policy driver for this initiative and early media commentary has clearly linked the establishment of the cafes to mental health needs. 'Cafes for eight Queensland towns crippled by mental health crises'. [47] The Queensland initiative is part of a wider program of system changes in mental health services.

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[43] Email exchanges with Fran Timmins Fran Timmins, Director of Nursing Mental Health Executive Services, St Vincent's Hospital, Melbourne, 4th and 5th September 2019

44 https://www.health.nsw.gov.au/mentalhealth/resources/Pages/towards-zero.aspx

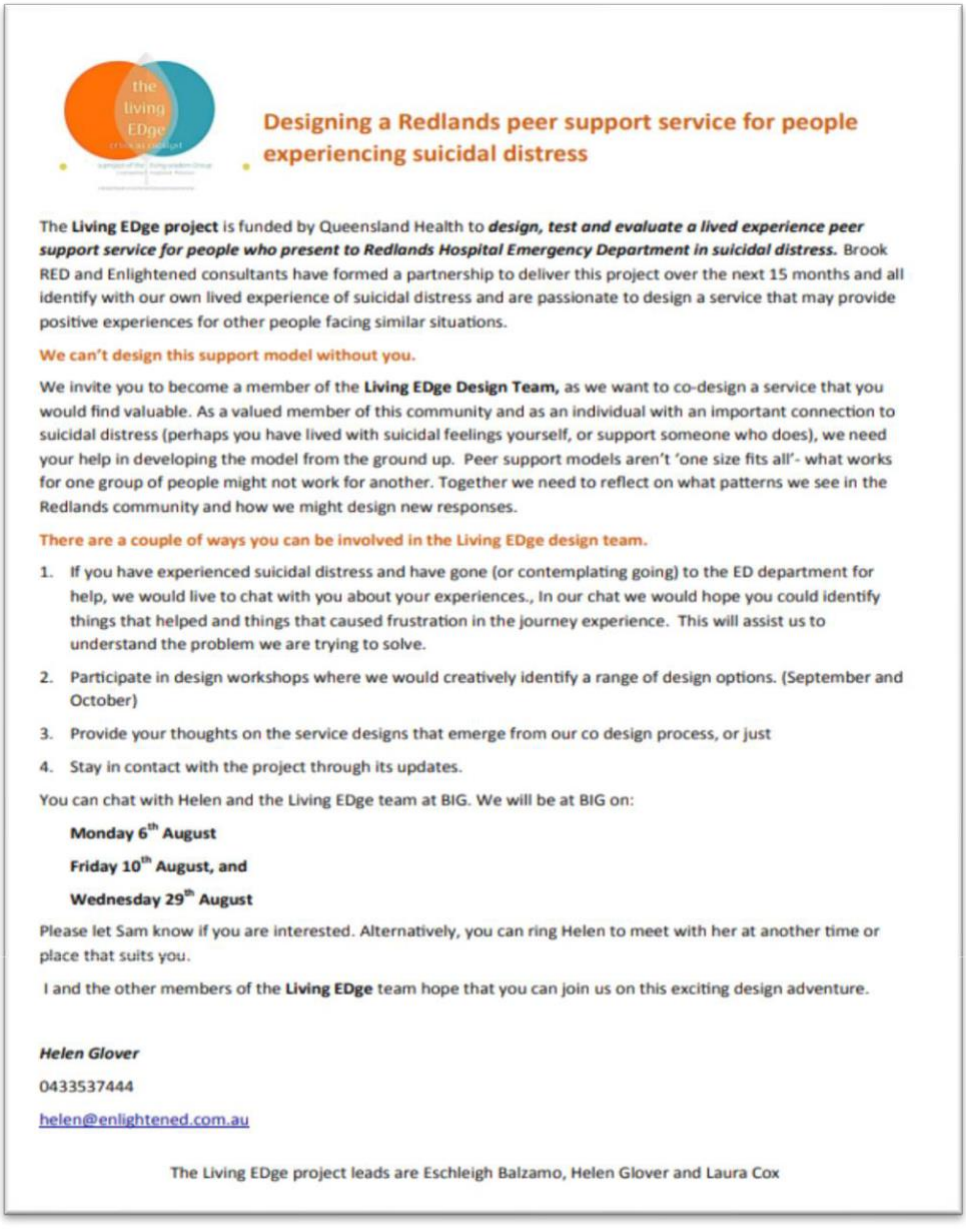
45 See the statement by Roses in the Ocean http://rosesintheocean.com.au/

46 . http://statements.qld.gov.au/Statement/2019/6/6/62-million-to-fight-suicide

47 https://www.brisbanetimes.com.au/national/queensland/cafes-for-eight-queensland-towns-crippled-by-mental-health-crises-20190606-p51v3u.html

Living EDge Redland Hospital, Brisbane [48]

Living EDge is located on the grounds of Redlands Hospital in a two bedroom unit that previously served as accommodation for visiting staff. It is 'a peer hosted space that serves as an alternative waiting room to ED – a space where people can self-manage and avoid needing to go to ED altogether'. An additional component of the service is the option to utilise ongoing community-based support with a peer worker, group work and the option of accessing residential respite. A trial of the service is currently underway (April to December 2019). Team members managing the project have shared their early learnings.



Designing a Redlands peer support service for people experiencing suicidal distress

The **Living EDge project** is funded by Queensland Health to ***design, test and evaluate a lived experience peer support service for people who present to Redlands Hospital Emergency Department in suicidal distress.*** Brook RED and Enlightened consultants have formed a partnership to deliver this project over the next 15 months and all identify with our own lived experience of suicidal distress and are passionate to design a service that may provide positive experiences for other people facing similar situations.

We can't design this support model without you.

We invite you to become a member of the **Living EDge Design Team,** as we want to co-design a service that you would find valuable. As a valued member of this community and as an individual with an important connection to suicidal distress (perhaps you have lived with suicidal feelings yourself, or support someone who does), we need your help in developing the model from the ground up. Peer support models aren't 'one size fits all'- what works for one group of people might not work for another. Together we need to reflect on what patterns we see in the Redlands community and how we might design new responses.

There are a couple of ways you can be involved in the Living EDge design team.

1. If you have experienced suicidal distress and have gone (or contemplating going) to the ED department for help, we would live to chat with you about your experiences., In our chat we would hope you could identify things that helped and things that caused frustration in the journey experience. This will assist us to understand the problem we are trying to solve.
2. Participate in design workshops where we would creatively identify a range of design options. (September and October)
3. Provide your thoughts on the service designs that emerge from our co design process, or just
4. Stay in contact with the project through its updates.

You can chat with Helen and the Living EDge team at BIG. We will be at BIG on:

Monday 6th August

Friday 10th August, and

Wednesday 29th August

Please let Sam know if you are interested. Alternatively, you can ring Helen to meet with her at another time or place that suits you.

I and the other members of the **Living EDge** team hope that you can join us on this exciting design adventure.

Helen Glover

0433537444

helen@enlightened.com.au

The Living EDge project leads are Eschleigh Balzamo, Helen Glover and Laura Cox

48 https://www.qmhc.qld.gov.au/media-events/news/ed-alternative-trial-underway?fbclid=IwAR2aP6A0ZWHSp9EX-qF-PCIK-k4FKESD9cw5rqqBvrhI8NYnhajOgbx6LC4

Accessing the service

On start-up, while the service was being established, it was decided to restrict the referral pathways to focus on people presenting at ED in emotional distress. Participants are people presenting to ED who have been triaged in the lower 3 categories. That is, they do not require urgent medical assistance but do need urgent psychosocial support and may be suicidal. Now that the service has been operating for some months, additional pathways have been established with adult and youth community mental health services.

Operating model and philosophy

The service is located on the hospital campus within walking distance of ED. People triaged at levels 3-5 who don't require urgent medical attention are offered the opportunity to move through to the cottage. This conversation is between clinicians in ED and the individual. For this reason, it is critical to the success of the service that the clinicians have confidence in making the referral. This is achieved through the building of relationships between clinicians and the peer workers operating the service. Before each shift, the peer workers visit ED to speak with staff about the program and to share feedback. This is necessary as there are often new staff in ED who are unfamiliar with the program.

The service is currently operating Mon-Wed 5-8. The service is at capacity with two people in the cottage at the same time as staff work one on one with individuals. The number of staff and individuals is also constrained by the size of the space and the budget.

Links with other services

Good working relationships between ED staff and Living EDge staff are essential. Given the high turnover of staff in ED, the peer workers allocate time at the beginning and close of each shift to meet with ED clinicians and ensure all are aware of the program and the referral pathway. Security staff at the hospital may also be involved in walking a person to or from the cottage. With the addition of new referral pathways from community mental health services, relationships with those services will need to be maintained.

Living EDge is integrated with BROOK Red, a peer delivered non-clinical service that provides a warm line, community based peer workers and peer delivered residential respite.[49] They, along with potential service users, community members and staff, were involved in a co-design project to develop the service delivery model.

49 https://www.brookred.org.au/

Peer2Peer ED to Home and Hospital to Home and Choices – Perth [50] [51]

Two ED transition and post discharge support programs are currently (2019) being trialled in Perth. Peer2Peer ED to Home supports people who have presented at ED for a mental health issue but who have not been admitted to hospital. Hospital to Home connects with people while they are using inpatient services and assists with their transition home. Peer2Peer operates at Midland Public Hospital. Choices operates at Royal Perth Hospital and Rockingham General Hospital and the Perth Watch House. With some variations in the service delivery model, each program involves the person being put in contact with a peer worker and provided with in-person and phone support for a period of up to eight to twelve weeks. The goal is to reduce the person's need for further ED presentations by assisting the person to link in with community-based services, problem solving, and building other supports.

Accessing the service

Potential participants are identified by clinical staff in ED or the inpatient ward and, with the person's agreement, are introduced to the hospital-based peer worker. Choices is operational in the hospital EDs seven days per week. Peer2Peer staff make contact with the person within 24 hours of receiving the referral from ED clinical staff.

Operating model and philosophy, services provided

Both programs include peer worker engagement with the individual either while they are still in ED, or shortly after returning home. ED to Home commenced in February 2019 and is entirely peer staffed, providing face to face contact, transport, information and other support as required by the person for a period of up to eight weeks. The Choices service pathway differs in that initial contact is generally between the individual and the peer worker in the hospital, who then puts the person in touch with a case worker who supports the person for a period of up to 12 weeks. Each service emphasises a commitment to a recovery-oriented approach which builds on the strengths of the individual, responds to the social determinants of health, and encourages hope.

Links with other services

Clinicians in ED, after determining that a person will not be admitted, offer the person a referral to the ED to Home service. Links with ED staff are therefore critical to the program. A goal of both programs is to work with the individual to establish links to any community-based supports they identify as important to their recovery. This may include primary health care, financial counselling, education and employment options and housing needs.

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50 MIFWA website https://www.mifwa.org.au/our-services/peer2peer-hospital-to-home/

[51] Wood, L., Vallesi, S. & Chapple, N. (2018). *Choices Evaluation Report, October 2018*. School of Population and Global Health, UWA.

Eligibility

The service is for adults. Participants must have presented at the relevant hospital and must have a mental health issue. A clinical assessment is made as to whether the person's behaviours would suit the service model.

Outcomes and evaluation

ED to Home is currently being evaluated. Choices commenced at two sites in late 2017 and the third from April 2018. The majority of people participating in Choices experienced AOD issues in addition to mental health challenges. The published evaluation highlighted the success of the program in connecting participants to a wide range of health and social care services. Other outcomes included a positive impact on ED staff as they had additional resources to support patients. Testimonials from individual participants indicated a reduced need to attend ED.[52]

The Living Room – several US locations [53] [54]

In the USA, The Living Room is a widely recognised model of crisis respite service that is described as an alternative to ED. However, the service delivery model varies between locations being particularly differentiated by whether it is co-located with a hospital or community based. Some function as exclusively peer operated day centres within hospital campuses (for example, Phoenix) while others are community based walk in services, open 24/7 combine clinical services with peer counselling.[55] Some include support for people who experience addiction.

Operating model and philosophy, services provided

The core of the model is the provision of a relaxing communal space ie The Living Room, where people can de-escalate, and the opportunity to engage with peer support workers. From there, the model changes depending on the provider's co-located services, funding streams and location in relation to acute medical services. The Springfield location is on the

[52] Wood, L., Vallesi, S. & Chapple, N. (2018). *Choices Evaluation Report, October 2018*. School of Population and Global Health, UWA.

[53] Heyland, M., Emery, C., & Shattell, M. (2013). The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments. *Global Journal of Community Psychology Practice, 4*(3), 1-8.

[54] Shatell, M., Harris, B., Beavers, J., Tomlinson, S., Prasek, L., Geeverghese, S., Emery, C. & Heyland, M. (2014) A Recovery-Oriented Alternative to Hospital Emergency Departments for Persons in Emotional Distress: "The Living Room", *Issues in Mental Health Nursing*, 35:1, 4-12, DOI: 10.3109/01612840.2013.835012

[55] Craze, L., McGeorge, P., Holmes, D., Bernardi, S., Taylor, P., Morris-Yates, A. & McDonald, E. (2014). Recognising and Responding to Deterioration in Mental State: A Scoping Review. Sydney: ACSQHC.

campus of a medical service with a referral pathway from ED. The Chicago service is based in an existing community mental health service, accepts walk ins and can support up to six people at one time and is open Mon-Fri 3-8pm. The Boulder service is open 24/7 and has a Living Room co-located with short term residential behavioural and addiction services.[56] Some have capacity to make arrangements made for overnight stays if required.

The Crisis Living Room in Colorado operates 24/7 and employs peer workers and a clinician.

On arrival, the clinician assesses the person's physical health and levels of distress and determines if the service is able to assist. The service utilised the Subjective Units of Distress Scale (SUDS) which people complete prior and post their visit.[57] If the person is visibly affected or discloses recent substance use they may be considered unsuitable for the service and provided with appropriate information for other services. If they are able to engage effectively with a peer worker and are not considered a risk to anyone else in the space, they then move into either a shared communal space, or a quiet room with a peer recovery counsellor. During this time, they may engage in de-escalation exercises, discuss coping strategies and prepare a plan to address the issues relevant to the crisis.

'The concept is to connect those in crisis with those who have been down a similar path and have an intimate understanding of what the struggle is like.'[58]

Links with other services

If a guest is assessed as posing a risk to themselves or staff, paperwork may be completed to initiate an admission to a psychiatric inpatient service, and an ambulance service or the police may be called. As some Living Rooms are co-located with other services, there are established pathways to different levels of support.

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[56] https://www.health.solutions/services/emergency-crisis-services/crisis-living-
[57] room/ Subjective Units of Distress Scale is a self assessment tool.
[58] https://bhninc.org/mental-health/emergency-services-mh/the-living-room-mh/

Outcomes and evaluation

In the first year of operation of the Chicago based Living Room, 228 visits were recorded by 87 people. The majority of people visiting The Living Room stated the visit was an alternative to attending ED. Almost 85 per cent of people left the service to return to the community and did not require a hospital admission or an ED presentation. Guests recorded significant reductions in their levels of distress. Based on the average cost of an ED presentation, and taking into account their operating costs, it was calculated that the Chicago service saved the state $550,000 in that first year.

Other Living Rooms measure amongst their outcomes whether the person needed to be referred to ED or was able to leave the service and return home, and the extent to which their SUDS score had shifted during their time in the service.

Accessing the service

Access options vary between locations. In some sites, people can walk in and self-refer. Mental health services can also refer people to the service. Those based on hospital campuses may require that the person first be triaged in ED.

Children and young people aged under 18 cannot use the service. People currently affected by substances may be restricted from using the service. People who are unable to hold themselves in the space and who are considered to be a threat to themselves or to staff may be prevented from using the service.

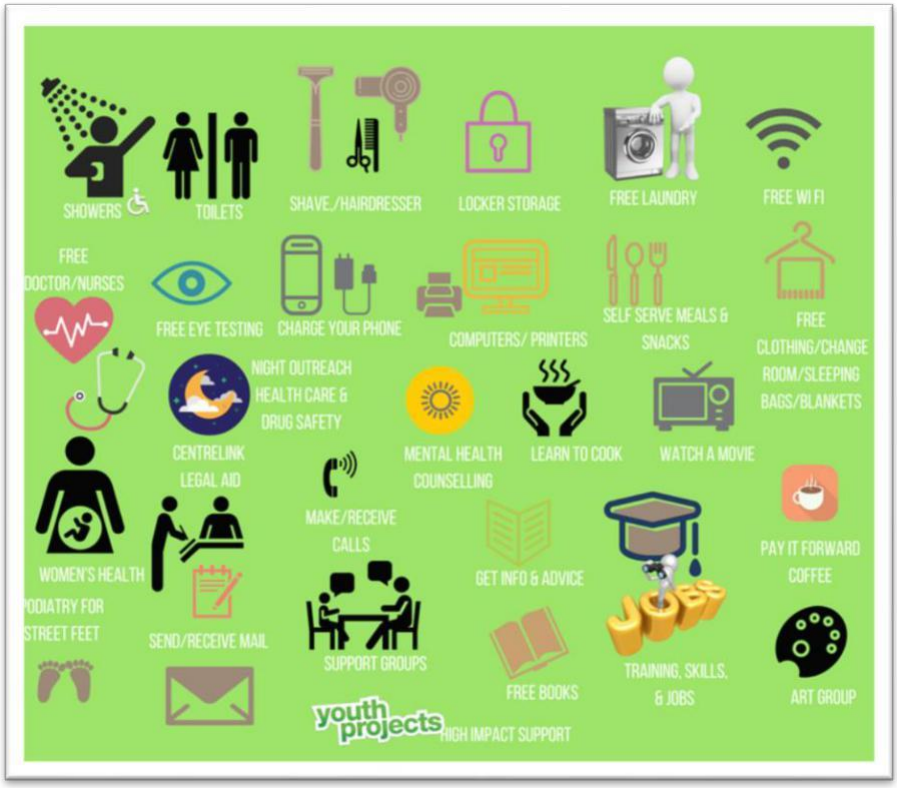
The Living Room in Springfield (MA). This space is separate from but nearby clinical services, is open during business hours, allows walk ins and overnight stays if required.

The Living Room/Youth Project – Melbourne[59]

Located in Melbourne CBD, the Living Room/Youth Projects is a primary health and social care service supporting people who are homeless or at risk of becoming homeless. It is operated by an independent charity established in 1984. It appears to have multiple funding streams and corporate donors. The GP service is co-located with a non-government organisation which, in collaboration with other organisations and consumers of the service, offer a wide variety of services, many of which are youth focused. It is also co-located with a social enterprise café. It is not a crisis service.

Accessing the service

The service is walk in although appointments are required for particular medical services and some services are offered at different times. The medical centre is open during regular hours Monday to Friday. There is a night outreach nursing service. Medical services are bulkbilled for Medicare card holders.



Operating model and philosophy

Designed around the social determinants of health, the services offered address people's needs for shelter, food and income. Multiple services are available from this location including employment, education and housing programs, advocacy, along with practical skills such as cooking classes designed to help people be as healthy as possible while sleeping rough and being on an extremely limited income. People can access drug and alcohol support delivered with a harm minimisation focus. Outreach is via the Foot Patrol, where teams of two staff walk the streets to talk with people who want advice or support to

59 Service website http://youthprojects.org.au/programs/living-room/

minimise the harm from drug use. People can be linked back into medical and other services.

Consumer feedback

The website includes a number of testimonials citing life changing experiences due to interaction with the services offered. A consistent theme from the testimonials is that being in a non-judgemental environment encouraged disclosure of the issues experienced by the individual which then allowed them to connect with support.

People not able to access the service

It is unclear from the information available if anyone is ineligible for the services offered although the focus and the practice means the service is most accessible to people experiencing homelessness or who are otherwise street present. People currently intoxicated are not prevented from accessing medical support.

Crisis Stabilisation Centres USA

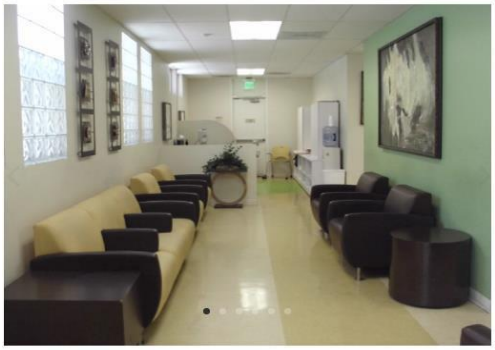
A number of community-based walk in mental health crisis services have been established in various US locations. These are clinical services supporting people experiencing 'a behavioural health crisis'. [60] Examples include the Urgent Care Centre[61] in Los Angeles and the Crisis Stabilization Service in San Bernardino.

Accessing the service

The services reviewed are open 24 hours per day 365 days per year. They are walk in services that also accepts referrals from police and other clinicians. It appears that services are provided at no charge to individuals. Intoxicated people are supported.

Operating model and philosophy

These centres aim to differentiate themselves from ED through their physical design which aims for a more 'homely' appearance, along with a holistic approach that can assist with linking people to community care services. If a person is not 'stabilized' within this time frame they may be admitted to hospital. Some of the services employ peer workers to provide peer counselling and peer support.



Eastside Stabilisation Centre, LA

[60] Saxon, V., Mukherjee, D. & Thomas, D. (2018). Behavioral health crisis stabilization Centers: a new normal. *Journal of Mental Health and Clinical Psychology*, 2(3), 23-26.

61 Urgent Care Centre – Eastside Los Angeles https://www.exodusrecovery.com/l-a-eastside-ucc/

Links with other services

Staff include social workers and per workers who will provide social assessments to connect people with community supports. Access to a hospital is important to facilitate the transfer of people unable to be stabilised within the service. The LA centre, for example, is across the road from a hospital with a mental health inpatient service.

Evaluation and outcomes

A return on investment analysis was conducted in 2012, taking onto account reductions in ED presentations, hospitalisations and outpatient use. It estimated that each dollar invested in a crisis stabilisation service returned $2.16 [62]

People not eligible to access

The services reviewed accepted people aged 12 and over.

Safe Haven Cafés - England[63 64 65]

Safe Haven Cafes or Safe Havens, exist throughout England in Surrey, also known as Safe Havens commenced in 2014. The published evaluations relate to the Surrey locations where seven Safe Haven centres have been in operation, including one specifically for children and young people aged 10-17 years. One site has since closed. The centres were established in existing community spaces and are operated by different social services agencies and charities in conjunction with the NHS. The stated goal of the services is to provide a safe space for people to attend when requiring mental health support. The provision of mental health crisis support aims to reduce people's need to attend ED. The opening hours vary but at the time of the evaluations, the Surrey services were open 6pm-11pm Mon-Fri and 12.30-11pm weekends and public holidays, with earlier closing times for the service for young people. The Haven in Bradford district is for people of all ages and is open daily 10-6pm.

Accessing the service

Some services encourage people to drop in, others request that people call ahead first. Most Safe Havens are for adults. The Haven in Bradford district is for people of all ages. There is a Safe Haven for children aged 10-17. Proximity to public transport is considered important.

There was no discussion in the Aldershot evaluation about the universal accessibility of the services or support specifically for non-English speaking people although disability access is mentioned at some of the individual service websites. There was no discussion about how to support people who were currently substance affected although it was noted amongst the evaluation recommendations that the ability to do this was important.

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[62] Substance Abuse and Mental Health Services Administration. (2014) Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, p.25.

[63] Wessex Academic Health Science Network. (2017). Independent Evaluation of the Aldershot Safe Haven Service.

[64] Healthwatch Surrey. (2017). Keeping the light on. Views and experiences of people living with mental ill-health in Surrey.

65 NHS website https://www.england.nhs.uk/mental-health/case-studies/mh-aldershot/

Family members/carers are welcome. At one service, it was estimated that approximately 30 per cent of people attend with a family member.

Operating model and philosophy, services provided

The stated delivery model is to provide a safe social space for people experiencing a mental health crisis such that they see the space as an alternative to attending Accident and Emergency.

The service is delivered by different partners in each location. Some provide organised activities such as art, photography or day trips, in some cases linking these activities with mindfulness strategies. Clinical mental health assessments are available. In Northeast Hampshire and Farnham districts, a psychiatric nurse undertakes an assessment of people on their arrival at the café and updates the 'patient's' record. [66]

Safe Haven in Guildford

Links and pathways to other services

Authorised clinical staff at the Safe Haven can refer people to Accident and Emergency, to clinical home support services and directly to inpatient services. Most consumers using the evaluated Safe Haven Cafes were already engaged with other social care and mental health services. Outreach workers are linked to some of the sites to support people unable to attend the Café. Other programs and activities are available at many of the Café sites, including a Recovery College at one location.

66 https://www.commonwealthfund.org/publications/international-innovation/2018/nov/north-east-hampshire-and-farnham-vanguard-safe-haven

Outcomes from evaluation of the Aldershot Safe Haven in Hampshire

Annual operating costs were estimated at £237,000. To recoup its costs, the service would need to prevent 15 psychiatric admissions annually. ED usage declined in the service catchment area. Admissions to acute inpatient psychiatric beds declined by 33% in the service catchment area. Mental health related police deployments reduced in the service catchment area. The evaluation methodology did not allow these outcomes to be directly attributable to the service as individuals using the service do not need to provide their NHS details.

Consumer feedback and outcomes

People were surveyed to gather data about their use of the service, the quality of the service and to gain ideas for service improvement. The majority of people attended for crisis prevention (56%), while 13% attended due to experiencing crisis. A further 23% attended for social reasons.

Table 3.2 Perceptions of quality – Safe Haven Aldershot	
People completing the survey said that they, always or often, felt treated with dignity and respect.	92%
People completing the survey who stated that they were likely, or extremely likely, to recommend the service to their family or friends.	96%
People completing the survey, when asked if they felt the environment of the Safe Haven was appropriate for their needs, who rated it as excellent or good.	95%

Consumer feedback indicated some people were uncomfortable with the communal social space when other customers were having conversations that they felt were unsafe. Keeping the space safe was important to people and for this reason, it was recommended that a staff member be available in communal areas to assist with potentially harmful conversations.

Advice for replicating the service [67]

"Teamwork is really important. Close partnership working between the three organisations has been central to the service.

Set clear boundaries. It is important for staff to explain to attendees the role of the service and to ensure that boundary setting is in place. Person centred care planning is important, with a focus on 'moving on' from the service.

The service needs to provide a safe space and offer autonomy to the service user upon arrival – it may be that sitting quietly or just talking with others is what is critical for that person at that time.

Provide a non-judgemental approach and have an attitude of wanting to help.

The ability to effectively signpost on to other services.

To be effective the service needs to be able to handle mental health emergencies either by accelerating treatment, triaging on to other services or, in rare cases, calling an ambulance. Ensure that the working environment is safe for both staff and users.

Effective promotion of the service needs to occur through the NHS and other stakeholders.

The service needs to hold certain values: offer sincerity and have staff with knowledge and acceptance of mental health.

Establish strong links with other NHS organisations and other local services."

[67] Wessex Academic Health Science Network. (2017). Independent Evaluation of the Aldershot Safe Haven Service

Crisis Cafes – England

Crisis cafes are NHS funded services with varying service delivery models, usually operated in partnership between local non-government organisations. They provide afterhours non-medical psychosocial support, often provided by peer workers. Most of the services are for adults. An exception is the Safe Zone in Leeds, a drop in crisis service for young people aged 11-17.[68] Another specialised service is Dial House @Touchstone which is specifically for people from culturally diverse groups, referred to in the UK as Black and Minority Ethnic (BME).[69]

Accessing the service

Depending on the location, people may either drop into the service, or they are required to phone ahead to check if it's a good time to attend. For example, the recently opened Well Bean Café in Huddersfield is open Saturday, Sunday and Monday from 6pm to midnight and people can phone ahead from 6pm. The Leeds Well Bean Café requires that people call ahead every time they wish to use the service. If people arrive without a call, their access to the café will be delayed while an assessment is made. In contrast, the Mind Cafes, open at multiple locations with various names, invite people to drop in with no need to phone ahead.[70]

The Well-Bean crisis café in Huddersfield, England opened in 2019 and offers one to one support in addition to snacks and drinks

68 https://www.themarketplaceleeds.org.uk/safezone/
69 https://www.lslcs.org.uk/services/dial-house-touchstone/
70 http://www.aimonline.org.uk/Crisis-Cafes/Help-and-Advice/

Access to the Safe Zone crisis support service is different. Teenagers aged 16-17 years are able to drop in but younger people are required to phone ahead to discuss their use of the service. They must provide a referral from a parent, Guardian or a service provider and they must also describe their means of travel to and from the service. The service has developed a privacy policy for young people and for parents/carers.

Operating model, services provided

The Safe Zone provides time limited (40 minutes) one to one support to young people as well as the use of a chill out space with activities and snacks. The adult cafes may also provide one to one support, some services limit this to one hour, as well as peer worker facilitated support groups.

To overcome potential concerns about stigma, some cafes particularly mention that their service is discrete in that it is not readily apparent to others that it is a mental health support service. To assist people to attend, some cafes provide a taxi voucher.

Links with other services

Many of the Cafes are operated by not for profit organisations that run multiple services. People attending the Café are encouraged to access these other services where appropriate. Some cafes share client data across other services.

PLEASE NOTE – ON YOUR FIRST VISIT TO THE WELL-BEAN CAFÉ – WE WILL PROVIDE A FREE TAXI (TO AND FROM) THE SERVICE, TO TAKE AWAY THE WORRY OF GETTING TO US FOR THE FIRST TIME

Crisis Houses – UK [71] [72]

Crisis Houses exist throughout the UK and provide short term emergency respite for people experiencing a crisis. The exact service delivery models vary as each is operated by local not for profit organisations, they are located in a variety of settings from residential houses to out buildings on health campuses and receive funding from different streams. Some provide a place to stay overnight or longer, while others are non-residential and offer a space for a number of hours, for example, over an evening.

A peer support group for people with hearing disability, Dial House.

What they generally have in common is the promotion of a non-medical safe space, or sanctuary, for people experiencing a situation where they feel unable to keep themselves safe. The policy drivers included reducing inpatient admissions, reducing suicidality and ensuring people have access to the least interventionist service possible.[73] Two examples are discussed here in more detail, Bristol Sanctuary and Dial House, as detailed descriptions and evaluations are publicly available.

Access

Some services encourage self-referral, usually by phone call earlier in the day when staff commence their shift, while others require a referral from a mental health clinician. From some websites, it appears that the service can be accessed on the same day although clearly it is possible that a small service may be booked out quickly. This is made clear in the promotion of the service. Phone lines open in advance of the opening hours so that people can call through to seek a booking. Knowing that people may be reluctant to use a new service, many of the locations provide a virtual tour of the service on their website, sometimes accompanied by an introduction to staff. [74] Several offer a taxi service to and from the service for the first time.

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71 https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/dealing-with-a-mental-health-crisis-or-emergency/

72 Perkins, R. (2015). Examples of innovative services that might form part of the acute care pathway. ImROC.

73 Obuaya, C., Stanton, E. & Baggaley, M. (2013). Is there a crisis about crisis houses? *Journal of the Royal Society of Medicine*; 106(8) 300–302 DOI: 10.1177/0141076813498585

Eligibility

Most of the services are for adults, with some services specifically for children and young people.[75] Some houses and their programs are designed for specific groups of people including, as examples, parents with dependent children, young people, people dealing with addiction or people feeling suicidal and women with dependent children. For example, Dial House, a service of the Leeds Survivor Led Crisis Service, provides space for families and runs a range of peer led social activities including a group for adults who are Deaf.[76]

Some websites emphasise that if a caller is not eligible for their particular service, they will put them in contact with a more appropriate crisis service. Some houses may not allow entry to people who arrive without a prior phone call, or who arrive as part of a group, or if the person is visibly substance affected. Return visits may also be subject to restrictions.

The Sanctuary is open Friday to Monday evenings from 6pm -12:30am. Staff will respond to messages/texts and emails from 4:30pm on the days the service is available. People are encouraged to call first to have a discussion about needs and availability. This is a method of planning and preparing for people and ensuring the service does not exceed its capacity to support people. People who arrived unannounced or under the influence may be turned away. The Sanctuary, as with a number of other services, funds the cost of a taxi or public transport for a person's first visit. There are residential eligibility requirements – people need to be residents of the residential catchment area.

Operating model and philosophy, services provided [77]

Most are free although some private services charge. Each house usually has from 4-10 beds. Peer workers and volunteers are employed within a variety of roles. People staying in the services are encouraged to participate in every day household activities where possible. Some sites emphasise the opportunity for peace and safety while others focus on active problem solving. Some locations have beds allocated for step up/step down. Others have day programs to which people can return once they are no longer staying in the House.

Links with other services

The extent to which links with other services are encouraged is dependent on the site and the purpose for which it provides respite. Some are very actively linked with local clinical services including via shared record keeping for each person to ensure some continuity of service for individuals and to assist with assessment of needs.

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74 See for example, Bristol Sanctuary. http://www.bristolmentalhealth.org/services/bristol-sanctuary/

75 For example, Safer Space for Children and Young People which is part of Bradford District Care.

76 https://www.lslcs.org.uk/an-introduction-to-groups-at-dial-house/

77 https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/crisis-houses/#.XSJsmegzaUm

Evaluation and outcomes

Crisis houses are an alternative to hospital admission and are therefore evaluated against their ability to prevent an ED presentation or hospital admission. On departure, a record is kept as to whether the person returned home or sought hospital care. Wales' first crisis house opened in 2006 with four beds and offering 7 day stays with intensive support. It had a staff of 7 mental health workers working in shifts to provide 24 hour support. A program for the guests' family members was also in place (since defunded). Over the first 18 months of operation. 200 individuals used the service and 88 per cent returned home, rather than to hospital, at the end of their stay. Over time, some Houses have experienced periods of high demand, others have operated below capacity and in response, have adapted their operating model to allow for longer stays.[78]

Costs to manage a crisis house will vary depending on other funding streams and services offered from the same location. In 2017 it was estimated that the cost per day was around £186 per day compared with an adult acute bed cost of £432.[79]

An evaluation of crisis houses identified inconsistency in practice, unresolved risk management issues and little evidence to claim the houses as a cost effective alternative to hospitalisation.[80] There was, however, evidence that people using the services had greater autonomy and voice and expressed a higher degree of satisfaction than with inpatient services. The conclusion was that even though there is uneven implementation of the service, crisis houses have a role in reducing hospitalisation and ED attendances.

Replicating this service

No single model of crisis house exists and most have been designed with regard to local needs, partnerships and opportunities that have arisen to take advantage of existing premises and the requirements of particular funding streams. A key feature of these small services with limited capacity is the requirement in some houses that people phone ahead, or in other cases, only people who have been referred are accepted. These strategies are integral to the ability of the service to manage demand and attempt to divert ineligible people to a more appropriate service. In some districts of England, a shared phone response system has been developed called First Response. Callers can call with concerns and be directly referred to the most appropriate service. One outcome of this is that people and services can be matched to suitability and availability which has resulted in fewer people travelling long distances to access services elsewhere. [81]

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[78] Mind UK. 2011. Listening to expertise: An independent inquiry into acute and crisis mental healthcare.

[79] D'Agostino, A. & Swaby, M. (2017). Crisis Houses and Crisis Café Report.

[80] Obuaya, C., Stanton, E. & Baggaley, M. (2013). Is there a crisis about crisis houses? *Journal of the Royal Society of Medicine*; 106(8) 300–302 DOI: 10.1177/0141076813498585

[81] NHS Case Studies. https://www.england.nhs.uk/mental-health/case-studies/bradford/

Recovery Café Network – multiple US locations, based in Seattle, USA [82]

Founded in 2004 in Seattle, this is an organised and supported network of peer operated, community-based cafes and meeting rooms that are currently operating across 15 US cities. The cafes provide long term support to people seeking to recover from addiction, particularly opioids.

Members of the Cafes commit to membership rules, such as attendance at meetings, and must actively contribute to running the Cafes. In the literature, this would be referred to as a 'club house' model.

Outcomes from evaluation

Evaluations of the clubhouse model identify positive outcomes for participants but are often limited in their findings as the model is applied in varied ways.[83] For example, in the service delivery model, eligibility of participants, the style of management and links to clinical services will vary. Over recent years, the Recovery Café Network has formalised its service delivery model which is now a licensed model available for purchase. Hence it appears more likely that each centre, despite being located across multiple sites, will operate more consistently.

Due to recent legislative changes in recognition of the evidence base for peer operated services, in some states of the US, Recovery Cafes and similar programs are Medicaid approved. It appears that this imposes an evaluation methodology which includes pre and post measures of a person's drug use, arrest record and use of medical and mental health services. This is only a recent initiative therefore evaluation data for the Recovery Cafes and similar programs is not yet available.

81 This information is largely sourced from the website of the Recovery Café Network. https://recoverycafenetwork.org/about/

82 Washington State Health Care Authority. 2018. Developing clubhouse programs. Report to the Legislature.

Consumer needs, feedback and outcomes

The cafes are for people experiencing addiction and co-occurring mental health concerns who are wanting longer term recovery support and willing to participate in a 'clubhouse' environment.

Links and pathways to other services

If a person arrives who is currently substance affected, they will be directed to another service. Referrals are received from health and mental health service providers and other government and social/community services. Data is shared with government funders including Medicaid.

Accessing the service

The service is advertised through Facebook, blogs, You Tubes and radio. Referrals are received from health and mental health service providers and other government and social/community services. People who have used a substance in the past 24 hours will be asked to leave as the Café premises are drug and alcohol free.

Advice for replicating the service

Existing and new locations are linked and supported to become established through a Social Licensing model. This costs $10,000 for the first two years after which time the new service is evaluated and becomes a Full Member and is granted a license. They will then be re-evaluated every three years.

It is estimated that a service will need approximately $300 000 in operational costs for the first few years, however, some centres have operated with around $150,000.[84] It is not clear from the source whether this is an annual figure, whether it includes a cost estimate of the services contributed by volunteers and whether it is in addition to donations of food and other goods.

[84] Uhl, D. 2018. Recovery Café Network. *Social Innovation Journal*, issue 52.

The Royal Perth Hospital Homeless Team[85]

The Royal Perth Hospital Homeless Team (RPHHT) commenced mid 2016 as a collaboration between RPH and Homeless Healthcare General Practice. It is a mobile service, focusing on Perth CBD and Fremantle, locations with high numbers of people sleeping rough. The goal is to improve outcomes for people who are homeless whose challenging situation means they are frequent presenters to ED. This program is not a crisis service but it has effectively reduced ED presentations.

Links to other services

The mobile clinicians are accompanied by case workers from non-government organisations linked to the 50 Homes 50 Lives collaboration. Brokerage funding is used to provide temporary accommodation.

Evaluation and outcomes

The majority of people engaging with the service experience significant mental health challenges in addition to physical health issues and alcohol and other drug use. The evaluation indicated that almost 30 per cent of clients using the service were Aboriginal, and almost 70 per cent were male. A recent evaluation of the RPHHT undertaken by UWA utilised patient records to compare the service use of 630 people a year prior and a year post accessing the RPHHT. They identified a 27 per cent reduction in the number of people admitted as patients, and a 28 per cent reduction in inpatient days.[86]

Sobering Up Shelters/Centres

Sobering Up Shelters are included in this review as they remain one of the few community based, non-clinical services to support people who are intoxicated. From 1999, sobering up shelters or centres have been established in most states and territories to provide a supervised space for intoxicated people to sleep overnight. This was a strategy to avoid criminalizing people for being intoxicated in public who were then at risk of harm while being held in police custody. In WA, nine services are currently operating.[87] Their opening hours vary with some open 5pm-7am Mon- Friday while others have slightly extended hours. People visiting the service are able to access a meal and a shower. Some may also provide other facilities like laundering or clean clothes, and the provision of information and referral to other social services.

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85 https://homelesshealthcare.org.au/clinics-timetables/street-health/

86 Gazey, A., Wood, L., Cumming, C., Chapple, N. & VAllesi, S. (2019). Royal Perth Hospital Homeless Team EVALUATION REPORT SUMMARY FEBRUARY 2019

87 Mental Health Commission https://www.mhc.wa.gov.au/getting-help/sobering-up-centres/

Outcomes and evaluation

There is evidence in support of sobering up shelters as an 'effective harm reduction strategy'.[88] Other benefits identified from the research include reducing arrests and incarceration and helping to link people to longer term services.[89] [90] [91] A 2018 evaluation of sobering up shelters in the Northern Territory identified that the ability of the service to achieve longer term and coordinated outcomes for individuals and families was limited in the absence of greater service integration and referral.[92] However, this was particularly challenging in regional locations where other services were unavailable or unsuitable. Another challenge identified was the ability of people to access the service when either police or a night patrol are unavailable.

Developing and effectively utilising a means of sharing relevant knowledge about clients was a vital risk management strategy critical to the wellbeing of service users given that many were impeded in their ability to communicate on arrival at the shelter. Staff at the shelters, police and health services must communicate effectively about the wellbeing of individuals in order to ensure that people with medical needs are identified in a timely fashion and taken to appropriate medical assistance rather than the shelter. [93]

Accessing the service

Sobering up shelters are an overnight walk-in service for people who are intoxicated. Mobile patrols are often involved in dropping people to the service given that intoxicated people may have no access to transport and may be impaired in their decision making impeding their ability to use other forms of transport. Police also bring people to the shelter.

When a person arrives, staff are trained to assess whether the person has more urgent medical or other needs and whether they are able to control their behaviour adequately to use the shelter without disrupting others' use of the space. [94]

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[88] Gray, D. & Wilkes. (2010). Reducing alcohol and other drug related harm. Resource Sheet no 3. AIHW/AIFS.

[89] Gray, D., Stearne, A., Wilson, M. & Doyle, M. (2010). Indigenous-specific alcohol and other drug interventions. ANCD Research Paper 20.

90 Wilkes, E., Gray, D., Casey, W., Stearne, A. & Dadd, L. (2014). Harmful substance use and mental health. In Dudgeon, P., Milroy, H. & Walker, R. (Ed.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd edition ed., pp. 125-146 (chapter 8). Canberra: Department of The Prime Minister and Cabinet.

91 Gray, D., Cartwright, K., Stearne, A., Saggers, S., Wilkes, E. & Wilson, M. (2018). Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people. *Australian Indigenous HealthBulletin*, *18*(1), 42

[92] PWC's Indigenous Consulting. (2018). Review of the Northern Territory Sobering Up Shelters. Department of Health (NT).

[93] Inquest into the death of Marrianne Fire Tikalaru Munkara [2016] NTLC 017.

[94] PWC's Indigenous Consulting. (2018). Review of the Northern Territory Sobering Up Shelters. Department of Health (NT).

Eligibility

Short term ‘Banned lists’ exist in some communities where people who have previously behaved aggressively towards staff or other people at the shelter are no longer allowed access. The list is shared with amongst services to prevent an inappropriate referral.

Other people unable to access the service include those with urgent medical needs and children and young people. If people have accessed the shelter multiple times, they may be referred to longer term AOD services where appropriate.

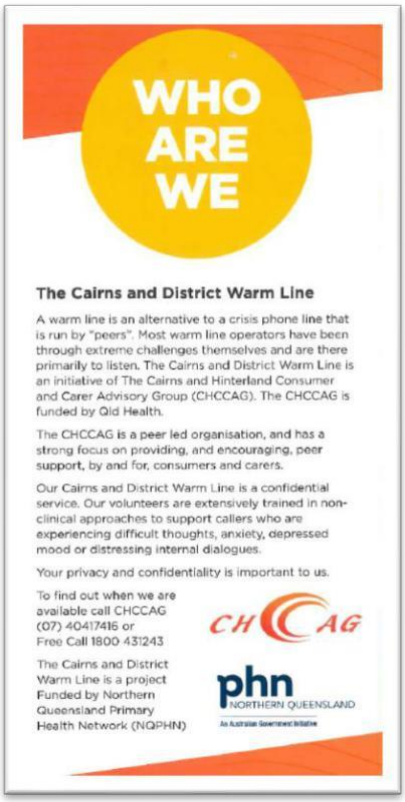
Links to other services

Mobile patrols are often used to transport people to shelters. In regional locations, these services are often operated by the same organisation. Some shelters refer onto more intensive services, such as in-home or residential detox and rehabilitation centres, counselling, domestic violence prevention, parenting support and other services.

Carnarvon Sobering Up Shelter

Warm lines – multiple locations internationally including Australia [95]

In contrast to mental health 'hotlines', warm lines are not a crisis service but can provide the support required to avoid or de-escalate a potential crisis. They are staffed by people with lived experience of mental health challenges and/or alcohol and other drug use or with experience of supporting someone close to them who experiences those challenges. Warm lines operate at various times but usually through the evening hours to meet the demand that arises as other services close for the day. While some are volunteer run services, others are run in addition to other contracted services offered by the provider.[96] In 2015 it was estimated that 100 warm line services were operating in 30 US states in addition to 12 national services.[97] Although many examples exist in Australia, an estimate of the total number was not found and a number of services exist that are not called 'warm lines'. An example in WA would be the MHC's Parent and Family Drug Support Line as part of which callers can speak to a trained volunteer with personal experience.[98]



Operating model and philosophy, services provided

Warm lines aim to provide a listening, non-judgemental ear with the goal of giving the caller the space to explain their situation and, depending on their needs, to talk through some possible actions to alleviate the distress. A recovery-oriented, non-directive approach is emphasised in most promotional material.

Evaluation and outcomes

Based on surveys of 480 callers to a US based state-wide warm line service almost 80 per cent of respondents stated the warm line had reduced their need for crisis services. [99] In addition, 73 per cent said their use of the warm line contributed to their personal recovery process.

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[95] http://www.illinoismentalhealthcollaborative.com/news/The_Warm_Line_Peer_and_Family_Support_by_Telephone.pdf

96 https://www.mhselfhelp.org/warmlines This is a directory of US peer delivered warm lines

[97] Prater, A. & Lane, T. (2015). Creating and operating warm lines. SAMHSA

98 Mental Health Commission WA Parent and Family Drug Support Line https://www.mhc.wa.gov.au/about-us/our-services/alcohol-and-drug-support-service/parent-and-family-drug-support-line/

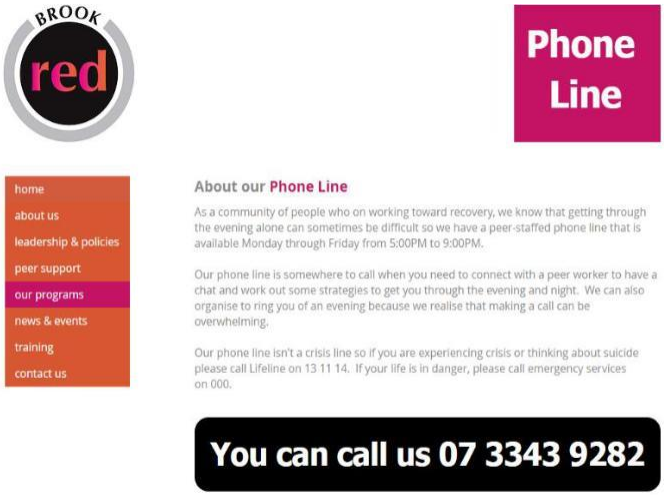
[99] Dalgin, R., Maline, S. & Driscoll, P. (2011). Sustaining recovery through the night: Impact of a peer-run warm line. *Psychiatric Rehabilitation Journal*, 35(1), 65-68.

Replicating the service

The particular warm line service for which an evaluation was available is based in the USA and employed trained peer specialists with 2-4 staff on shift. Approximately 2,300 calls were handled per month. Staff were required to be able to refer crisis calls to the crisis line where necessary. Protocols were developed to ensure this happened in a consistent manner. Guides to establishing peer operated warm lines are available. See for example, 'A Guide to Developing and Maintaining a Sustainable Warmline'.[100]

The cost of providing each warm call has been calculated at $10 in comparison to $100 per crisis line call (US costs).[101] Many staff are volunteers. This is also the case in some Australian services. Training of volunteers incurs costs. Training packages are available to be used in preparing carers to provide support and factors to be considered in establishing the service. [102]

If operators are contacted by callers from a wide geographic catchment area, it will be necessary to ensure access to an accurate, easy look up database of services in order to avoid providing inaccurate information that could lead to a loss of trust in the service.



99 National Empowerment Centre and the National Mental Health Consumers' Self-Help Clearinghouse. So you want to start a peer-run warmline? A Guide to Developing and Maintaining a Sustainable Warmline.

100 Prater, A. & Lane, T. (2015). Creating and operating warm lines. SAMHSA.

101 Carers WA https://www.carerswa.asn.au/publications/carer-peer-volunteer-program/ and the Australian Centre for Social Innovation https://www.tacsi.org.au/work/weavers-peer-to-peer-carer-support/

Step Up Step Down/Prevention and Recovery Care – short stay residential facilities – Australia

Located in various Australian states, these are short term, residential support and individualised care services for people following discharge from hospital, or those who are in the community experiencing a change in their mental health to avoid a possible hospitalisation. Services include a combination of psychosocial and clinical support programs and activities. In Western Australia, the services are called Step Up Step Down. In Victoria, they are referred to as PaRC. The services are operated by non-government organisations in partnership with state government mental health services. They are not crisis services.

Joondalup Step Up Step Down Facility - Perth

Accessing the service

Depending on the provider, a referral from a clinical mental health service may be required while some services allow self-referral.[103]

Operating model and philosophy, services provided

Usually a combination of sub-acute clinical services and psychosocial services are available, often peer delivered. It is not a crisis service and a stay must usually be planned and for a maximum of 28-30 days days with a limited number of extended services allowing up to six weeks. People who use the service are linked with a support worker who may be a peer worker. Group and individual activities are programmed. The goal is to prevent admission or readmission and to support the person to return home. Some services emphasise linking back in with family members/friends. This is a legislative requirement in some states. Some service websites specify the recovery approach is adopted, as part of which the person is actively involved in deciding on their needs and activities, others mention a collaborative care model.

103 For example, the Rockingham Step Up Step Down managed by Mind Australia allows self referrals. https://www.mindaustralia.org.au/services/mind-western-australia/rockingham-community-sub-acute-step-step-down-service-shoalwater

Links with other services

Referral pathways are established between inpatient and community mental health services. GPs can also refer. In reach services may be provided onsite to support links with community-based services.

Eligibility

Eligibility varies due to differences in state-based legislation and funding. The majority of the services were for adults, with some assessing 16-17 year olds on a case by case basis.[104] Some services further restrict the upper age to 64 years. Some youth specific locations exist for young people aged 16-24.

Outcomes and evaluation

An analysis of Victorian data for the period 2009-2014 concluded that people's mental health was improved during their stay at PaRC, although less so than for people accessing inpatient services, but was unable to identify reductions in hospital admissions.[105] An evaluation of the hospital use by 267 people who had accessed the Joondalup Step Up Step Down facility identified decreases in their rates of hospital admission compared with a matched cohort.[106] Of the people using the facility as a step up, only two per cent were admitted to hospital. Similarly, of those stepping down, 95 per cent were able to return home.[107]

The Resolve Program – NSW [108]

Operating since 2017, this program combines elements of Step Up, in home, community-based and transition services, both clinical and peer delivered, for people who have previously had significant periods of hospitalisation for a mental health issue. The program is funded through a Social Investment Bond. [109] It is not a crisis service.

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104 Mental Health Commission WA. (2017). Community Mental Health Step Up Step Down Program. Frequently Asked Questions. https://www.mhc.wa.gov.au/media/1968/community-mental-health-step-up-step-down-frequently-asked-questions-faqs-website-version-june-2017.pdf

105 Galloway, J., Scollo, G. & Thomson, N. (2016). *Mental Health Prevention and Recovery Care: A clinical and community partnership model of sub-acute mental health care*. Department of Health and Human Services.

106 Wolstencroft, k., Bellot, C., Bruce, D., Criddle, G., Dennis, A., Johnston, M., Hughes, C. & Zenetti, D. (2018). Co-Designing Service Quality at the JMHSS. Neami National.

107 Mental Health Commission WA. (2017). Community Mental Health Step Up Step Down Program. Frequently Asked Questions. https://www.mhc.wa.gov.au/media/1968/community-mental-health-step-up-step-down-frequently-asked-questions-faqs-website-version-june-2017.pdf

108 https://www.health.nsw.gov.au/sii/Factsheets/resolve-general-factsheet.pdf

109 https://www.osii.nsw.gov.au/news/2017/05/05/resolve-social-benefit-bond-australian-first-social-impact-investment-to-improve-mental-health-outcomes/

Accessing the service
Eligibility and access is limited to a clinical referral process through the local district health service. [110] GPs are unable to refer.

Operating model and philosophy, services provided

Peer workers provide a wide range of non-clinical supports including in-home visits, phone calls, care coordination and management. Residential support is available as required as a step-up service. People are able to participate for two years.

Links to other services

A goal of the program is to support people to make links to services they may need including drug and alcohol support services. The service is described as a deep collaboration between the health district and the provider, Flourish, a peer-led non-government service provider.

Eligibility

Adults aged 18-64 who have previously accessed hospital services for a significant period of time, and who live in the region are eligible for the service once assessed by the local health district clinical team. Additionally, people must not be affected by dementia.

Community Cafes – also known as Memory Cafes

Formed originally in 1997 in The Netherlands by Bere Miesen in response to the social isolation experienced by people with dementia and their families, the first Australian Community Café was established in 2002 in Victoria with support from Alzheimer's Australia and Home and Community Care (HACC) funding. The cafes are variously named in each Australian state. In Victoria they are referred to as Memory Lane Cafés and in WA, Memory Cafes. They continue currently with seven across metropolitan WA and three country locations.[111] The most recent was established in Toodyay in April 2019.[112] Local Government Authorities are commonly partners, along with Alzheimer's WA and the owner of the café premises. Café sessions are usually held monthly and may include entertainment and activities. The Café sessions take place in existing café businesses, social and sporting clubs. Others choose outdoor locations.

In the evaluated model, a counsellor attends along with individuals living with dementia and their family members. To be eligible, the person must be in the early stages of dementia and attend with a family member/friend.

110 https://www.health.nsw.gov.au/sii/Pages/resolve-clinicians-factsheet.aspx

111 https://www.alzheimerswa.org.au/about-dementia/supporting-person-living-dementia/memory-cafes/

112 https://www.msn.com/en-au/health/medical/memory-cafe-eases-the-burden-for-people-with-dementia/ar-BBVOnIa?li=AA2FZ8I&%25252525253Bocid=spartandhp

Building on existing research which has identified potential physical, psychological and cognitive benefits of socialising, the stated aim of the model is to:

- Promote social inclusion and prevent isolation
- Facilitate communication and sharing of experiences between families and carers, thereby fostering peer support
- Improve understanding of dementia and related issues
- Provide a forum for informal advice and consultation with counselling and support staff
- Promote and facilitate access to the broader service system within the community

Evaluation outcomes [113]

The evaluation indicated benefits to both the individual with dementia and their family member. For the family members, relationships formed at the Cafes became crucial at points of transition in the couple's lives, for example, if their partner died or moved into residential care. A significant reason for non-attendance was the travel distance. Additional cafes have now been established in an attempt to address this. It was noted that few people from non-English speaking backgrounds participated and no Aboriginal people were participating.

Accessing the service

Initially the pathway to service access required people to undertake a training course and assessment. On identifying this was a barrier to participation, other entry points were introduced.

In WA, the service is promoted through the peak body Alzheimer's WA and through the collaborating LGAs which also provide other community services for older people.

Replicating this service

Alzheimer's Australia provides a toolkit for people and organisations considering the establishment of a café.[114] If receiving government funding and partnering with a service provider, there is a potential for the setting to become more formalised, and the participants may be considered 'clients' of the service which could then require some additional record keeping and reporting of personal information. Practice Guidelines are available.[115]

[113] Evaluation of Alzheimers Vic Memory Lane Cafes 2011, p. 247.

[114] Alzheimers Australia. (2016) Community Café Toolkit. Your manual and tools for establishing a café for people living with dementia. https://www.dementia.org.au/files/NATIONAL/documents/Community-Cafe-Toolkit.pdf

[115] Government of Victoria. (2013). Café Style Support Services. Practical Guidelines for Home and Community Care Providers in Victoria.

Virtual safe spaces- crisis and non-crisis

Lifeline Crisis Support Chat[116] and eheadspace Group Chat[117]

Lifeline provides a live chat service 5 hours per evening. It is advertised as short term support for people feeling overwhelmed, having difficulty coping or staying safe. Headspace offers a range of online and email services counselling supports to young people aged 12-

25. Group Chat involves one hour long hosted sessions, facilitated by members of the headspace Youth National Reference Group of other guests. Almost 34,000 young people accessed the full range of eheadspace services during 2017/18. It is not clear how many accessed Group Chat in particular.

How is it accessed?

To access the Lifeline service, a person must register and complete a survey although it is option to remain anonymous or provide a name and email address. To participate, a Group Chat profile must be created and the person must log in with an email address. People can participate anonymously once they have logged in. Individuals can contribute to the conversation which will be hosted around a particular topic.

Host families scheme – NHS UK [118]

A short term stay with a family is a step-up step-down option available to adults within Hertfordshire, England. It is considered an alternative to a hospital admission, or an option to shorten a hospital stay. It is not a crisis service and the person participating must not be in need of urgent medical support.

How is it accessed?

Host families apply for registration through the service provider. The referral process for individuals is not described.

Operating model and philosophy, services provided

The model is based on the evidence that people feel better earlier when in a home-based setting than in an inpatient setting. According to the website and service brochure, hosting families are not required to have any clinical training. What is valued is their ability to be non-judgemental and positive. The guest can participate in everyday activities along with the host family.[119]

116 https://www.lifeline.org.au/get-help/online-services/crisis-chat
117 https://headspace.org.au/eheadspace/group-chat/
118 https://www.hpft.nhs.uk/services/acute-and-rehabilitation-services/alternative-services-to-an-inpatient-stay/host-families-scheme/
119 https://www.hpft.nhs.uk/media/1224/host-families-jan-2016-_dl-leaflet.pdf

Links to other services

The Crisis and Assessment Teams provide clinical support to families and individuals and are expected to be available 30 minutes of being requested. The person participating in the scheme may be accessing other mental health services during the day.

Evaluation

Anecdotal evidence provided by Hertfordshire Trust[120] from hosts and individuals speaks to the benefits of being in a family setting. Earlier evaluations of the cost effectiveness identified savings compared to inpatient services.[121] It is not clear whether the current scheme, which pays the hosts an amount to cover their costs, has been evaluated from a cost perspective.

Replicating this service

A review of the literature on this and similar schemes identifies the importance of the support provided to the host families and to the individuals. This could be provided by experienced peer workers who should be readily available to support the host family or the individual guest. Hosts receive training prior to accepting a guest and are funded for making their home available and for hosting a guest.

120 https://www.hpft.nhs.uk/services/acute-and-rehabilitation-services/alternative-services-to-an-inpatient-stay/host-families-scheme/

121 Cox, L. (2018). Support models for individuals in suicidal distress: A literature review of non-clinical interventions. The Living EDge Team.

Section 4 How well do safe haven models meet the needs of Western Australians?

This section explores the benefits and challenges of various safe haven models against the following:

- the purpose of a safe haven as described by the Sustainable Health Review;
- the required access and service delivery features required by people experiencing mental health issues and/or alcohol and other drug issues, as identified through the consultation process;
- the needs of particular groups of people who face additional barriers to accessing services;
- the need for the service to be a mentally healthy workplace for staff
- ability to prove outcomes
- sustainability of funding

The Sustainable Health Review described safe havens as 'a safe environment for respite and peer support' which would 'also help people learn more about their own needs and find options available for them locally to get further support'.[122] In general, feedback from people who engaged with this project is consistent with that description. People are seeking a safe space to de-escalate, to feel safe, to talk and to explore options if they are up to it.

However, there were particular groups of people for whom a café, or a communal space, was not an option. For example, a consumer who identifies as Autistic stated that *'if it was too social it could exacerbate my isolation. I find it difficult to mix when things are too loud and there's too much going on…Too much social energy can be distressing.'*[123] Another consumer who experiences hearing loss also saw a communal space as challenging. They were more likely to prefer a home visit or to use an SMS or online text chat service.

People who currently are experiencing distress but do not use mental health services may need an option that serves as a 'soft entry point', perhaps by being 'discrete' enough to overcome their concerns about using a mental health service, or through providing a service model that overcomes other concerns they may have that have prevented them from using clinical services. Particular groups of people experience additional barriers to accessing mental health and other supports. [124] It's important that the safe haven attempts to overcome these barriers. Suggestions are made below.

Finally, it is important that the service is a mentally healthy workplace for staff.

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[122] Sustainable Health Review. (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia, p. 65.

[123] Consumer interview

[124] Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Simpson, A., Webber, M. and Meader, N. (2016). Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. *Health Technology Assessment*, 20(3), doi: 10.3310/hta20030

The benefits and challenges of different service delivery models

Most of the services that have emerged are relatively small and therefore experience service delivery challenges. They are required to:

- respond rapidly – yet many only have budget for restricted hours
- have the capacity to respond to acute needs – with protocols in place for transferring a person whose needs will be better met in a medical service
- provide a service that is clearly understood by funders and other stakeholders – yet the language of peer support and recovery is still not consistently understood
- demonstrate fidelity to their service model such that expected outcomes are measurable and achieved which could impose assessments that are not consistent with peer work

The discussion below highlights how these challenges arise in particular service delivery models and responds with strategies provided in feedback from community members who engaged with the project and with examples utilised by some services.

In hospital or on the hospital campus

Benefits

- The service will potentially be available to the 47 per cent of people who arrive at ED via ambulance or police
- There are many existing pathways to ED
- People will be triaged for their medical needs
- ED will act as a gatekeeper to the service, ensuring appropriate referrals
- Hospital locations are well known
- Hospitals are open 24/7 so ED is available as a backup if the service has reached capacity or is closed
- Hospitals have security staff
- Hospitals fund mental health services in ED and can potentially benefit financially from implementing an ED alternative that reduces their costs

Concerns

- If people have already gone to ED, they are likely to have experienced the negative impacts of the environment and potentially a long wait
- People may have negative experiences of hospitals
- Cost of hospital parking
- Hospital security staff may not be trained in recovery orientation

Strategies to address concerns

- Create a specialist triage position in ED able to quickly redirect people to the ED alternative
- Create peer worker positions in ED who can work with clinicians to quickly divert people from ED and introduce them to the ED alternative.

Community based services

Benefits

- People do not need to attend a hospital
- The capacity of existing services may be utilised to save start-up costs
- May be able to implement desired features such as outdoor spaces and outdoor activities
- Knowledge of local community services
- Person can link into to ongoing activities based at the same location
- Can be peer managed and/or peer delivered
- Potential for greater control over the service delivery model, governance and the recruitment, training and supervision of staff

Concerns

- People in ED who have not been admitted will need to undertake another journey in order to access this alternative service
- Management of people arriving – will need to assess people on arrival
- Transport options – can't arrive by ambulance or police
- Capacity – a small service will require strategies to manage capacity
- IT, data sharing and client management systems may not be consistent with the new service
- New pathways to the service will need to be created
- People may need but not get medical attention for physical health needs
- In the absence of medial support, people who are intoxicated may be unable to access the service

Strategies to address concerns

- Co-commission and co-design the service with local primary and tertiary health service providers and emergency responders
- Explore the potential an existing telephone service to triage people over the phone before referring them to the safe haven
- Explore options for the Mental Health Co-Response Team to refer people who they have been called to but who do not need to go to hospital
- Co-design the service with community leaders who build referral pathways back to the service
- Implement a phone ahead access arrangement to help plan for arrivals
- Build monitoring and evaluation of the service into the program logic so the service is able to demonstrate benefits as a means of securing ongoing funding
- Peer delivered transport – mental health taxis/uber/minibus[125]
- Co-locate with an afterhours primary health service
- Have a communal space that encourages peer support amongst people using the service so that they benefit from being in the safe space while waiting to have a private conversation

[125]Investigate options for a mental health specific ambulance service. See for example the model in Sweden – Psychiatric Emergency Response Team – a mental health ambulance service.

- Time limit one on one access eg one hour
- Advertise the service well using straightforward language, develop an introductory video
- Be located near public transport
- Be located in proximity to an ED
- Develop a fast track arrangement with ED

Café style services (crisis cafes, safe haven cafes)

Benefits

- Discrete – doesn't have to look like a mental health service
- Provides the opportunity for mutual support amongst peers
- Meets basic needs for food and shelter
- An opportunity for people to experience hospitality
- Can support a more natural conversation
- Can be a soft entry to accessing longer term support
- Can potentially support more people at one time than a one on one service

Concerns

- Can further isolate people who aren't comfortable in social settings
- People may be uncomfortable if others in the space are intoxicated or are behaving in ways they don't understand
- Others' conversations may be triggering for some people[126]
- Limited opportunity for private conversations
- People may need to wait too long to see a peer worker
- People may not get the opportunity to address the underlying reasons for their distress if they are not comfortable talking in the space
- May attract people who need food and shelter but are not using the service as an alternative to ED
- Does not support people who don't speak the mainstream language, people with hearing problems
- May be difficult for staff to manage all scenarios
- May need to get people to emergency medical support

[126] A risk identified by users of the Safe Haven Café in Surrey was the possibility of distressing topics of conversation arising amongst café users in the absence of some form of facilitation by staff.

- People inside the café may allow others in who have not been introduced to the service
- It may get too noisy for some people
- People may arrive in groups eg extended families with children
- Need a safe food handling environment and staff able to prepare and serve food and hot drinks
- What happens in the car park and beyond?

> *'Universal Design, making the space accessible to all. Disability access is important for all disabilities not just thinking about wheelchair access but deaf/blind access and Sensory access, reduces noise, reduced lighting, reduces smells and a variety of spaces to suit everyone's sensory needs. Private spaces for those people who find it hard to connect socially.'*[127]

Strategies to address

- Facilitate the communal space to support positive conversations
- Locked door with signage to advise people why it is locked and that they will soon be welcomed in
- Develop and promote shared rules of behaviour
- Welcome and orientate people to the service
- Link people into other services so they do not need to rely on the crisis service
- Implement a phone ahead access arrangement to help plan for arrivals
- Bilingual staff, provide a space for the person to use Translating and Interpreting Services
- Have distracting activities available such as puzzles and games
- Ensure the Wi-Fi is adequate to support people's need to communicate and search for information
- Physical design consistent with good practice such as positioning of plants and furnishings to absorb noise and create some privacy
- Adequate staffing – have staff on call if necessary
- Co-locate the Café with an existing complementary service
- Provide spaces within the café for people to undertake their own self soothing strategies
- Provide a family space and child care
- Provide snacks that do not require cooking
- Encourage people with particular communication needs to use whatever strategies work for them e.g. bring someone along who speaks their language, bring a supportive family member or friend
- Provide the service within premises that have back up staff available
- Locate the service in a space that is safe at night – implement a buddy system for people going to their cars

Crisis stabilisation centres – multidisciplinary teams of medical and peer workers in community based 8-10 bed centres

Benefits

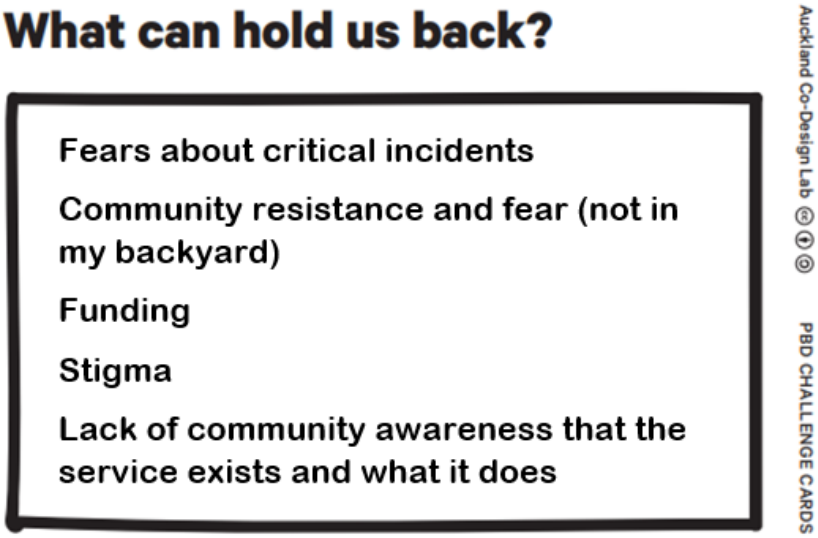
- Provide medical support to people if required

[127] Consumer feedback.

- A more homely environment than ED
- Able to support people who are intoxicated
- Focused on overcoming the current distress as well as initiating links to longer term supports
- Effective in reducing the need to attend ED
- Could be located to support a particular cohort who frequently attend ED eg people who are sleeping rough

Concerns

Questionable suitability for the local funding environment



Feedback from the Public Forum

Groups who experience additional barriers to service access

The following discussion incorporates what is known about the needs and preferences of particular groups of people and how these may or may not be met by various models discussed.

The needs of children and young people

The majority of crisis services identified in the literature are for adults. Consistent with many other areas of human services design, this poses the question of whether services for children and young people should be separated from adult services, and what aspects of service delivery will need to be designed differently to meet the needs of children and young people. Young people participating in a focus group for this project were mainly in favour of a service specifically for young people. In the UK, both a Crisis Café and a Safe Haven have been created specifically for young people over the age of ten. To support the access of young people to the service, a phone ahead system is in place which allows for arrangements to be made to ensure the young person can travel to and from the service safely. People over 15 may attend the service without this requirement.

Few services mention how they would support the needs of children whose parent has a mental health issue and is seeking crisis support. One exception mentioned in the Literature Review is Dial House, a crisis respite service which provides a family room to allow a parent to continue their parenting role for younger children while accessing support.

Research on the needs of younger people experiencing mental health problems suggests that hubbing services in one location, ensuring those services are integrated, and providing the practical support the person requires in a less clinical environment, is most likely to overcome the barriers to access experienced by many young people and to support their ongoing engagement.[128] There may be scope to explore existing services that are valued by young people to see if it's possible to extend their hours of operation to provide an afterhours service.

Young people participating in the focus group said they can feel exposed and vulnerable if attending a well-publicised and highly visible location, particularly if it is near adult night spots such as bars and clubs. This can occur whether the service is in a fixed location or a mobile service such as a van or bus. Mobile services can, however, come to where young people are located, overcoming issues around a lack of transport, and can relocate them to safe spaces if these exist. Mobile and fixed safe spaces can provide young people with an alternative to being in an unsafe home situation. A further suggestion from service providers is the use of multipurpose buildings that do not indicate the service is a mental health service. For example, pop up services held in community centres or youth centres.

Feedback from young people who do not always feel safe at home is that a safe space for them should be age restricted with some suggesting an upper age of 30. They also raised concerns around family members being involved and having access to the safe space. They wanted the right to access the space without a service provider seeking parental consent. Services will need to be confident that their consent arrangements do not present a barrier to young people's access to the service. Further examples of best practice in this area will be important additional research at the co-design stage.

E-headspaces provide support to young people in crisis via phone and online including group chats.[129] Group chats are organised in advance for fixed times, and registration is required. Outside of these times, individual chat and email services are available. It would be useful to further exmplore the possibilities offered by virtual cafes, facilitated by peers, in meeting the needs of people who cannot easily travel but require assistance during a mental health crisis. [130]

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[128] Hetrick, S., Bailey, A., Smith, K., Malla, A., Mathias, S., Singh, S., O'Reilly, A., Verna, S., Beniot, L., Fleming, T., Moro, M., Rickwood, D., Duffy, J, Eriksen, T., Illback, R., Fisher, C. & McGorry, P. (2017). Integrated (one-stop shop) youth health care: best available evidence and future directions. *MJA* 207 (10).

129 https://headspace.org.au/eheadspace/

[130] March, S., Day, J., Ritchie, G., Rowe, A., Gough, J., Hall, T., Chin, YJY, Donovan, C. & Ireland, m. (2018). Attitudes toward e-mental health services in a community sample of adults: online survey. *Journal of Medical Internet Research*., vol. 20, issue 2, e59.

The needs of Aboriginal people

Aboriginal people on average experience higher rates of psychological distress than non-Aboriginal people but also experience barriers to service access as many mainstream services struggle to provide culturally safe support.[131] Research is clear that adapting mainstream services will not work unless there is genuine and facilitated engagement with relevant communities.[132] The recent example of Anglicare's co-design of the Pilbara headspace illustrates a range of engagement strategies and design tools as well as providing a useful timeline as to the length of the engagement required.[133] There may be useful collaboration opportunities with the current WA Country Health Services (WACHS) project exploring pathways by which people can be linked to post discharge supports following a suicide attempt, knowing that people are especially vulnerable at that time and cognisant of the high rates of suicide amongst younger Aboriginal people. There may also be useful learnings from the WAPHA National Suicide Prevention Trials.

A current project underway in NSW seeks to build a better understanding of mental health related ED presentations by urban-based Aboriginal children and young people, a significant percentage of whom have an experience of out of home care.[134] In WA, similar research could be undertaken with the Aboriginal Health Council of WA and Aboriginal Community Controlled Health Services, which could then lead to a co-design project with local community members.

A focus group held with Aboriginal people emphasised the importance of a safe haven providing for practical material needs as the absence of these was often the cause of a person's distress. There was also a need for people to be supported holistically which could involve expressive activities as well as yarning. Family members must be made welcome if they accompany the person in distress. This would be challenging to some small services that implement a ban on allowing large groups to enter.

[130]McGough, S., Wynaden, D. & Wright, M. (2018). Experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study. *International Journal of Mental Health Nursing*. 27, pp. 204-213 doi: 10.1111/inm.12310

[131]Dudgeon, P., Walker, R., Scrine, C., Shepherd, C., Calma, T. & Ring, I. (2014). Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people. AIHW/AIFS.

[132]Anglicare WA and WAPHA. (2017). Environmental scan and insights report for the preparation of a headspace service model for the Pilbara region of WA.

[133]Williamson, A., Skinner, A., Falster, K., Clapham, K., Eades, S. & Banks, E. (2018). Mental health-related emergency department presentations and hospital admissions in a cohort of urban Aboriginal children and adolescents in New South Wales, Australia: findings from SEARCH *BMJ OPEN*

The needs of people from diverse cultural backgrounds

In the UK, recognising that people from cultural minorities were underrepresented amongst users of crisis houses and crisis cafes, a service has been developed specifically for people from CaLD backgrounds. It is staffed by people from CALD backgrounds.

Research into the psychosocial supports most likely to be acceptable to people who have arrived as refugees emphasises the importance of 'soft entry points' to mental health services. [135] A café style service could provide this function, but it would further need to support the cultural and language needs of participants, in addition to being trauma informed. [136] [137]

Consideration would need to be given to supporting the presence of whole families in the space and to the provision of child care. As pointed out in the focus groups, some people are in Australia without extended family members and do not have other networks of support available to provide care to dependent children.

Feedback from a focus group with people from diverse cultural backgrounds also highlighted the importance of the service being considered acceptable within the community. A program successfully trialled in WA created ambassadors who promoted mental health access within cultural groups.[138] Something like this could serve as a means of interrupting the pathway to ED and redirecting people to the alternative service and subsequently linking them to primary health services and other community based supports.

People who are not currently engaged with mental health services

A significant number of people who feel suicidal and who die by suicide have had no prior engagement with mental health services.[139] This raises the issue of how they can be alerted to the fact that this service is available to them, and be convinced that it will be of assistance to them. Reliance on referral pathways from other mental health or social services will potentially miss this cohort of people.

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[135] Slewa-Younan, S., Blignault, I., Renzaho, A. & Doherty, M. (2018). Community-based mental health and wellbeing support for refugees: An Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health.

[136] Gopalkrishnan, N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice. Front. *Public Health* 6:179. doi: 10.3389/fpubh.2018.00179

[137] Young, P. & Gordon M. (2016). Mental health screening in immigration detention: a fresh look at Australian government data. *Australasian Psychiatry*, 24(1):19–2.

[138] The program was PHN funded and evaluated in 2018 and recommended that the scheme be extended given identified outcomes being achieved, in particular, a greater willingness to consider engagement with mental health services. Cross Cultural Intellect. (2018). Community Ambassadors. Evaluation Report. WAPHA/PHN

[139] Ashfield, J., Macdonald, J. & Smith, A. (2017) A 'Situational Approach' To Suicide Prevention. https://doi.org/10.25155/2017/150417

In most countries, including Australia, the rate of suicide for men is significantly higher than for women.[140] However, men are generally less likely than women to access mental health services. St Vincent's Safe Haven Café has successfully engaged men based nearby the hospital who are homeless. There was also a positive response to the idea of a Café by men interviewed for this project who have experience of being homeless. It was viewed as a much less distressing setting than a clinician's office and the hospitality and shelter would be a practical benefit. However, it is unclear whether a Café will present itself as an option to, men who have an income and are not in need of shelter but do need urgent psychosocial support. Australian research has attempted to identify the actions most likely to prevent men from attempting suicide. Findings indicate that men are most likely to be engaged by activities that provide a positive distraction, along with practical supports that address the cause of their distress and provide strategies to manage periods of crisis.[141]

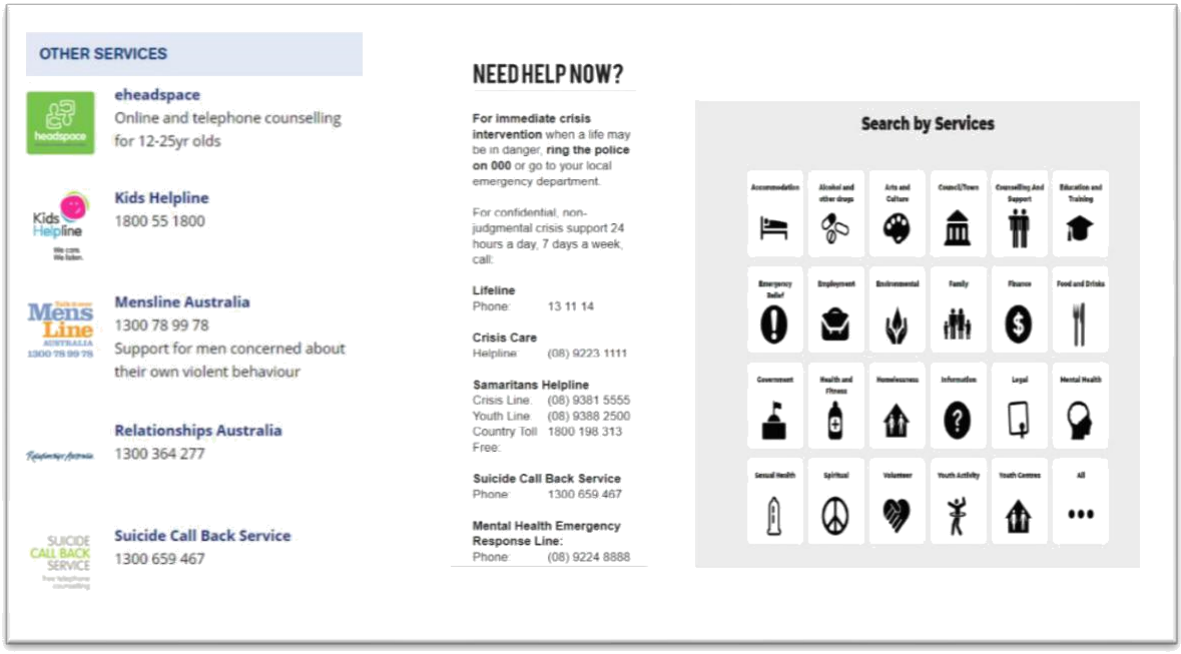
Suggestions from consumers, people close to them and service providers for supporting men to access an alternative to ED.

- Build an informal pathway to the service by raising its profile in Men's Sheds, sporting and fishing clubs, gyms, small business and trade organisations and community service groups like Rotary or Lions.
- Have a space in the safe haven for physical activity that helps people to de-escalate and be positively distracted.
- Include some outdoor space where people can dig in a vegie patch or feed the chooks.
- Be discrete in the naming of the service – so it's not apparent to other people that it's a mental health support service.

Below are current examples of mental health services websites. It will be important to create tags to this service that are meaningful to people. Many people do not use terms such as 'peer' or 'lived experience' or 'psychosocial'. It will be possible to develop proposition statements using the data from this project and incorporate this into the co-design activities.

[140] ABS. (2018). Causes of Death, Australia 2017. Catalogue No. 3303.0. ABS, Canberra.

[141] Player, M., Proudfoot, J., Fogarty, A., Whittle, E., Spurrier, M., Shand, F., Christensen, H., Hadzi-Pavlovic & Wilhem, K. (2015). What interrupts suicide attempts in men: A qualitative study. *PLOS ONE*. DOI:10.1371/journal.pone.0128180



Stigma presents a significant barrier to accessing mental health services. This particularly impacts on people experiencing AOD challenges in addition to mental health issues.[142] Café settings and other community-based services often attempt to overcome this stigma by employing peer workers with their own lived experience, and by creating a non-medical social space and by using names that signify safety and comfort such as The Living Room and Safe Haven or Solace Café, or which builds on a positive sense of community, such as the Recovery Cafes. Attention therefore needs to be given to the naming and promotion of the space. Names suggested during focus groups included:

- A Step Forward
- The Hub
- A Safe Hub
- Belong
- The Meeting Place
- My Space My Way
- Our House
- The Lounge Room

[142] McCann, T., Savic, M., Ferguson, N., Cheetham, A., Witt, K., Emond, K., Bosley, E., Smith, K., Roberts, L. & Lubman, D. (2018). Recognition of, and attitudes towards, people with depression and psychosis with/without alcohol and other drug problems: results from a national survey of Australian paramedics. *BMJ Open* 2018;8:e023860. doi:10.1136/ bmjopen-2018-023860

Ideas from consumers, people close to them and service providers for overcoming stigma and building trust in the service amongst particular community groups

- Involve community members and leaders in the design and establishment of the service. These people become promoters of the service to others in the community and can provide feedback about community needs and perceptions of the service.
- Train up cultural ambassadors to reach out to culturally diverse communities to promote the service and help break down stigma and convince people the service will not be judgemental and can be helpful.
- Communities that are active online, such as members of the Veteran community, could be invited to view the service in person. They could produce a short video about the service and include it within their social media spaces along with some discussions about how to use the service.

Creating a mentally health workplace for staff

Being a more recently established part of the workforce, peer work is still building a best practice set of work place supports. A recent (2018) survey of peer workers in WA identified that 75 per cent are satisfied with their role but a significant percentage (42%) were not satisfied with the levels of stigma and discrimination experienced in the workplace.[143] Professional external supervision has been identified as integral to supporting peer workers in the role and in supporting program fidelity.[144] Research on the role of peers in crisis support services emphasises the importance of an organisation wide implementation of a recovery approach, and if required, cultural change implementation to address any concerns between peers and non-peer staff.[145] In crisis settings, it's particularly important that all staff be appropriately experienced and skilled and this applies equally to peer workers.[146] Higher levels of skills and experience should attract appropriate levels of pay.

[143]WA Peer Supporters' Network. (2018). The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services. http://www.comhwa.org.au/wapsn

[144]MHC NSW. (2016). Employers Guide to Implementing a Peer Workforce

[145]Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). Peers as crisis service providers. SAMHSA.

[146]Conversation with Helen Glover, Living EDge Project.

Standards, quality measures, assessment tools and evaluation methodology

As highlighted in the review of services, the outcomes expected by the service may be determined by the funder. For example, in the US, some crisis services eligible for Medicaid have been required to collect clinical pre and post measures from people using the service in addition to data about drug use and police charges. This may pose challenges to a service that is attempting to address the power imbalance often experienced when a service requests personal data of the person using the service.[147]

St Vincent's Safe Haven Café has chosen to collect minimal data which is consistent with its operating philosophy of treating individuals as customers of a café. However, it also means the service is limited to that of a Café. The majority of respondents to the engagement process wanted a more active form of engagement including referrals to other services. This by necessity requires the keeping of client records of some kind. Apart from St Vincent's Safe Haven Café, most services reviewed required some kind of client management system as part of providing the service, as part of risk management and for reporting purposes.

In Western Australia, a service funded by the Mental Health Commission must comply with the National Standards for Mental Health Services and the Carers Recognition Act. Additionally, depending on which services are offered, the age and needs of clients, and the range of occupations employed within the service, a service may be required to comply with additional standards, regulations and record keeping, including minimum data sets requiring standardised assessment tools.

The outcomes expected of the service, individual assessment tools and the evaluation methodology necessary to measure the achievement of the outcomes should be considered in the commissioning process. If the service provides clinical services, that may impose the gathering of personal data from service users via the application of clinical assessment tools. Requirements such as this will impact on the service delivery model and need to be discussed at an early stage in developing the service delivery model.

Eligibility criteria and restrictions – the impact on the service delivery model

Funding streams from particular agencies will generally target a section of the population. In practice this means the agency delivering the program will impose eligibility criteria. This was evident in a number of the safe havens and alternatives to ED. As examples:

- must be experiencing a certain level of 'illness', have a formal diagnosis, or a particular level of disability
- must be a certain age, e.g. over 18, between 18-64, or under 18
- must live within a certain catchment area.

[147] Ostrow, L. (2012). Evaluating peer operated crisis care alternatives. https://power2u.org/wp-content/uploads/2017/01/Evaluating-Peer-Operated-Crisis-Care-Alternatives.pdf

Eligibility criteria can contribute to the patchwork effect of service, or a 'postcode lottery' where people attempting to engage support must shop around in order to find a service that they are eligible to use or miss out on a service due to their address.

Some current funding streams require a person to have a severe and persistent mental health issue, while others require a particular diagnosis. It is important to keep in mind that many people who contemplate suicide do not have a mental illness[148] and that around a third of people presenting to ED with a mental health concern do not have a diagnosis.[149] If eligibility criteria include a diagnosis, this will potentially exclude significant numbers of people experiencing distress and/or suicidal ideation who could benefit from psychosocial support.[150]

A social café setting is based on creating a welcoming and safe environment. If eligibility restrictions are applied, the service delivery model will need to consider the process by eligibility will be determined and how the exclusion of ineligible people will be managed in a café setting so as to achieve a safe space for both consumers and staff. An option adopted by some Crisis Cafes is to either require or at least to encourage people to phone ahead before attending and to clearly describe eligibility requirements on the service website and in video introductions to the service.

The ongoing sustainability of psychosocial crisis response services

Current moves towards recovery oriented, peer delivered services are driven in part by the advocacy of consumers and a desire to improve consumer outcomes. This is in the context of emerging evidence of the efficacy of recovery oriented and peer provided services involuntary services.[151]

Another significant driver is cost reduction and the pressure on services to demonstrate their ability to achieve reductions in ED presentations, hospital admissions and readmissions. One group of people likely to be eligible for community based services are those who frequently present at ED. [152] In a non-clinical peer operated service which does not collect clinical service history details from clients, it can be challenging to gather the data that allows for attribution of outcomes such a reductions in ED use to the delivery of the service. This comment was made in several service evaluations.

148 Inder, K., Handley, T., Johnston, A., Weaver, N., Coleman, C., Lewin, T., Slade, T. & Kelly, B. (2014). Determinants of suicidal ideation and suicide attempts: parallel cross-sectional analyses examining geographical location. *BMC Psychiatry* 14:204 https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-14-208

149 Johnston, A., Spencer, M., Wallis, M., Kinner, S., Broadbent, M., Young, J., Fitzgerald, G., Bosley, E., Keijzers, G., Scuffham, P., Zhang, P., Martin-Khan, M & Crilly, J. (2019). Review article: Interventions for people presenting to emergency departments with a mental health problem: a systematic scoping review. *Emergency Medicine Australasia*. doi: 10.1111/1742-6723.13335

150 Ashfield, J., Macdonald, J. & Smith, A. (2017) A 'Situational Approach' To Suicide Prevention. (2017) https://doi.org/10.25155/2017/150417

151 Lloyd-Evans, B. & Johnson, S. 2019. Community alternatives to admissions in psychiatry. *World Psychiatry*, 18:1, 31-32.

152 Moe, J., Kirkland, S. Rawe, E., Ospina, M., Vandemeer, B., Campbell, S. & Rowe, B. (2017). Effectiveness of interventions to decrease Emergency Department visits by adult frequent users: A systematic review. *Society for Academic Emergency Medicine*.

A recent Australian example illustrates the importance of consistency in policy and funding streams. In Brisbane, a long standing community development project, Safer Spaces Network, resulted in a 12 months trial of two safe spaces funded by Brisbane North Primary Health Network (PHN). However, there was no long term funding available for the initiative and both services closed mid 2019.[153] Therefore, despite evidence for their effectiveness, psychosocial crisis support services are frequently funded through trials and pilots which can make their funding tenuous and short lived.

Conditions for successful implementation

Effective relationship building with existing crisis services, emergency response, community mental health and other services is necessary to achieve effective pathways to and from the alternative service, to ensure appropriateness of referrals and to ensure safe and effective operations. Concomitant changes to those services are therefore likely. This suggests, as has occurred in other jurisdictions and consistent with the recommendations of the Sustainable Health Review, that both a co-commissioning and a co-design approach will be required to identify the complete range of resources required to successfully implement a new service in a sustainable manner.

- A co-commissioning approach will identify the change management implications for all services, providing an opportunity to address and facilitate any system changes required to support the introduction of alternatives to ED.[154]
- Identify all policy drivers for the initiative and determine whether these are complimentary or competing. Identify whether they prioritise different population groups and geographic regions, impose conflicting eligibility criteria, or have differing outcomes reporting periods, risk management, quality frameworks and measurement tools.
- Locally co-designed models are more likely to be accepted as evidence based by staff than a model developed and tested under different circumstances. The co-design process will itself assist to build relationships.
- Shared IT platforms can be costly and take time to develop and delay the project implementation. Decide at an early age how this aspect should be addressed and what level of investment is necessary so that information sharing requirements do not become a burden.
- An iterative approach to implementation allows for evidence to emerge from practice. An agreed process to support this can be developed at the co-design stage.
- When estimating costs, include provision for external supervision and for the design and implementation of outcomes monitoring and evaluation. Make generous allowances for relationship building activities which are likely to be labour intensive.

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[152] Phone meeting and emails with Angela Taylor, Brisbane North PHN.

153 See for example, the implementation of the Mental Health Crisis Care Concordat in the UK in 2014 which was used to develop First Response in Bradford NHS Trust District https://mentalhealthpartnerships.com/resource/crisis-care-concordat/ and https://www.england.nhs.uk/mental-health/case-studies/bradford/ .

- Expect and plan for unevenness in initial service take up. This will also impact on the period chosen for evaluation. Time must be invested in establishing the relationships that will be essential to creating new referral pathways.
- Conversely, while it remains the only service of its kind, it may be necessary to implement strategies to ensure this service is not called upon to meet all current unmet demand. For example, other trials have commenced with restricted referral pathways and eligibility criteria in order to prevent the service being overwhelmed. Please note, these eligibility restrictions are not features consistent with feedback received as part of the public engagement process and it will be important to develop a stakeholder communication process that ensure people are aware of the reasons for any restrictions imposed and to seek their input, as part of the next co-design stages, for minimising any restrictions imposed as part of the trial period.

Summary

Alternatives to ED and safe haven models exist that meet many of the needs and preferences expressed by people likely to use such a service. However, it is difficult to determine whether any of these services operated within the budget available to this project.

Evidence for the effectiveness of any crisis service can be challenging to gather. By definition, the person is in need of urgent support and their engagement with the service may be a one off, brief and focused on immediate needs. Short, validated self-assessment tools are available and a decision on which tools to utilise should be considered as part of the co-commissioning and co-design process. More opportunities to gather data on outcomes arise when a person maintains their engagement with a service or when a system wide unique identifier is utilised, such as a patient number in PSOLIS, a Medicare card or My Health Record. However, most peer workers and not for profit service providers do not have access to these systems.

Despite these challenges in data collection and quality, various safe haven/alternatives to ED have demonstrated the following mix of outcomes.

Measured at the system or population level

- diversion from ED
- reduced ED waiting time and reduced inpatient length of stay
- reduced hospital admissions
- reduced engagement with police
- reduced rates of incarceration

Measured at the individual level

- Reduced suicidality
- Re-established social connections/maintenance of social connections
- Increased confidence to pursue housing, education and employment options
- Greater confidence and skills to address financial concerns
- Increased self-advocacy skills
- Increased access to health services
- Improved ability to self-recognise levels of wellbeing and to implement self-management plans

However, the following groups of people were either actively excluded or at least overlooked by many safe haven/alternative to ED models.

- people currently substance affected
- people whose behaviour was perceived as aggressive or violent
- children and young people aged under 18, in particular, those aged under 14
- people currently under a mental health order
- people who don't speak the mainstream language
- people uncomfortable in social settings
- people with intellectual disability and mental health issues
- people with dementia and mental health issues

People likely to use an alternative to ED service have diverse needs. This means it is challenging to implement all the service design and delivery features required to deliver a safe space for everyone within one service. There is widespread agreement amongst young people and service providers and from the literature that children and young people need age specific services. In addition, adult services also need to be family friendly to support children and young people accompanying parents who use adult services.

A single service will be more able to meet diverse needs through referral arrangements that allow the service increased control over who enters the service at particular times; by having multiple spaces available within the service; by creating shared rules of behaviour; and through multiple modes of delivery that meet the needs of different groups of people including online and text chat, phone calls, home visits, warm lines, check ins, transport to and from the service, rapid pathways to ED, linking people with community based peer workers, rapid referral to residential respite, and ensuring the peer workforce is diversely experienced.

People experiencing co-occurring AOD and mental health issues expressed service preferences similar to those identified by other people who might use the service. The service will need to include peer workers who have relevant lived experience with co-occurring AOD and mental health needs and will require protocols to support heavily intoxicated people to access a more appropriate service including medical support if required.

People with diverse needs should be actively involved in co-designing the service.

There are likely to be opportunities to extend the capacity of spaces already considered as safe havens by particular groups of people so that these services can function as alternatives to ED.

Section 5 Recommendations – options for a service delivery model

The following recommendations, with options for a hospital-based service and for community-based services, are built on the knowledge and ideas shared by consumers, people close to them, service providers and community members, and from evidence gathered from existing services. The recommendations are based on the following conditions specified by the MHC:

- annual funding of approximately $700,000 per annum will be provided;
- the service must be delivered in a manner that ensures compliance with the National Standards for Mental Health Services;
- the service is for people with urgent psychosocial needs who do not require urgent medical assistance;
- the service will be located within the metropolitan area, within, or in close proximity to, an ED;
- the service should be operational in the first half of 2020.

Given these conditions it is unlikely that the design will meet all the service design features identified by the consultation process, and some measures required to assure quality and safety are inconsistent with the expressed desire for a 24/7 walk in service.

Assumptions regarding set up and operation

The majority of people responding to the consultation process stated that the service should be available 24 hours for seven days per week. This is unlikely to be achievable within the specified budget.

If a 24/7 service cannot be achieved, then an assessment of local needs can be used to determine the opening hours. Similar services, if not available 24/7, tend to focus on out of hours opening times, particularly evenings, including Monday evening, and also weekend afternoons. However, local ED presentation patterns may identify that day time services are warranted. This has emerged as a time that parents of dependent children may arrive at ED in distress.[155]

If the safe haven provides support to individuals in the form of linking them to services, there will be additional work to be undertaken during business hours, such as following up on service availability and updating client records. Time will also be spent on set up and close down.

To minimise capital set up costs, it is most likely that the service will need to utilise existing infrastructure, taking advantage of underutilised afterhours capacity. Many of the services reviewed had multipurpose premises to achieve a better spread of costs and to utilise the infrastructure over more hours of the day.

A service that already has referral pathways and a positive reputation will reduce advertising and administrative costs and is likely to attract people to the service in an earlier time frame.

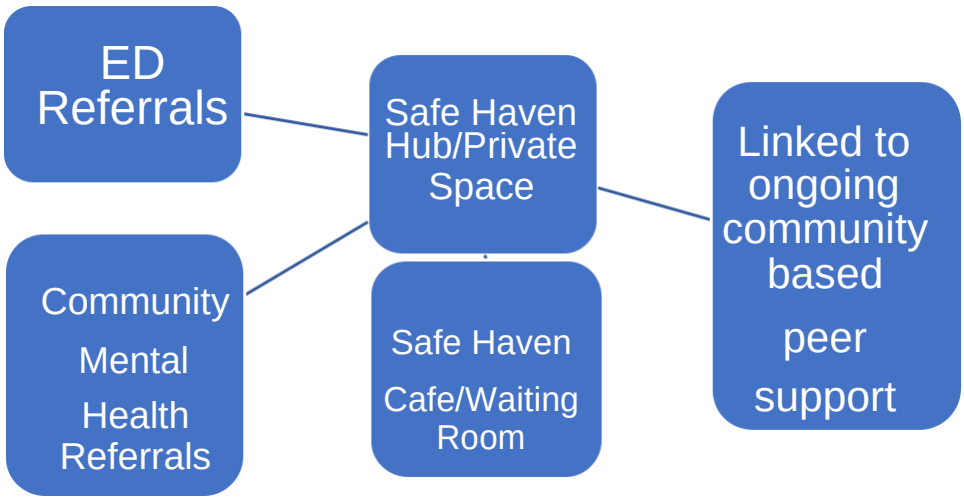
[155] Discussion with Kate Gill, researcher involved in Living EDge, Redlands Hospital, Brisbane.

Staff costs, given that the peer workers should be experienced senior staff, are calculated at a range between Level 4.1 to Level 5.1 ($67,300-$76,500). [156]

Options for a service to open in 2020

Option 1. A hospital-based Café/Hub

Based within a hospital or on the hospital campus – closest existing examples – Redland Hospital's Living EDge and St Vincent's Safe Haven Café combined. If available, this could be integrated with a separately funded community-based peer worker program to provide ongoing support, a peer operated warm line and a phone/web chat service.



Service description

A peer delivered service with referral pathways from ED, inpatient and Community Mental Health operating 18 hours weekly in three shifts, actual hours to be determined by local needs but it will include business hours. 3 staff at 18 hours each per week. Staff in ED identify distressed people in the ED waiting area who do not require medical attention but are in need of urgent psychosocial support. In consultation with clinicians, people are offered the opportunity to move into the Safe Haven Café/Waiting Room. One staff member would facilitate the communal space. One staff member will be in private conversations and one will manage phone calls. Everyone is welcome in the space including accompanied children. While in the communal space, people will be able to access online support services including text chat services if they wish. They could just sit with a drink and a snack or they may wish to engage in conversation with other people waiting.

[156] Fair Work. (2019). Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100]

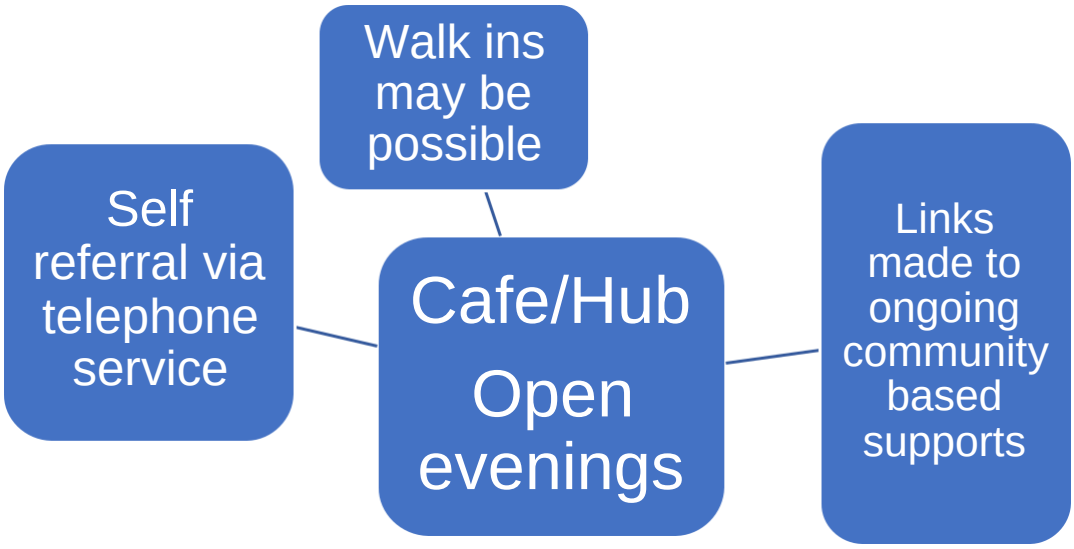
Feedback from the Safe Haven Cafe was that some people appreciated this peer support and connection. When a staff member is available, individuals will then be welcomed into a private conversation space to undertake problem solving and de-escalation and any other psychosocial support as desired by the individual. They will undertake a brief self-assessment. Their one on one time will be limited to approximately an hour although they will be able to return to the Safe Haven Café / Waiting Room while it remains open. Referrals from ED will be accepted at any time the Café is open. Referrals from Community Mental Health will be via phone and preferably same day. This will assist with managing service capacity, will reduce the waiting time for people wishing to access the one on one service and will assist to keep the space safe for different groups of people. People who are interested in doing so will receive a follow up communication the following day to check in on how they are and to discuss their options for continued contact through an ongoing community based peer support service. This model is dependent on integration with ED staff and would benefit from being integrated with a separately funded community based peer support service. The staff member in the waiting room will provide care to children if required when their parent enters the private space. There is no walk in service. Referrals are only accepted through ED and Community Mental Health.

FTE 1.5 (3 x 18 hours per week)

Estimated numbers of people able to be supported: From ED approx. 3 per day, from Community MH, approx. 3 per day. Times 3 days per week. Total weekly = 18 people. Annually = 936. Approximately $213 per visitor to the service

Option 2. A community based Café/Hub

A community-based Café service, open 15 hours weekly in the evenings, near public transport and nearby a hospital – closest existing service delivery model – Bradford NHS District Crisis Café.



Service description

Located in an existing multipurpose venue, combining an open social space with access to private rooms, offering light refreshments, self-serve or assisted, staffed by skilled and experienced mental health peer support workers and peer counsellors, available 15 hours weekly, mainly evenings. Walk ins may be possible but preference would be for a prior phone call to check availability and waiting times. People can stay until they are ready to leave with planning for their departure occurring within a half hour of closing. People can make return visits but the goal is for people to be linked in with non-crisis services and supports to prevent future crises. People currently substance affected will be supported to access medical assistance and invited to re-engage when they wish. Young people can be supported as staff will be aware of who is coming in as people will phone ahead before arriving.

If the Café is operating in premises with a reception area already staffed and able to do a brief assessment, then walk ins to the café may be possible. If the café is operating as a standalone service, then entry to the café will be by prior phone call. If a telephone service was able to support referrals, then this would be the preferred pathway to the service. A dedicated telephone service would undertake the triage and find out from the person if they needed assistance to get to the café, if they wanted to bring other people with them and any other considerations that would make the space safe for the person. While in the Café, individuals can sit quietly, talk to others or play board games etc.

When in the private space, they will work with a peer worker to achieve whatever they feel up to at the time with a focus on the provision of practical support. A follow up phone call will be made the following day to see if the person wishes to be linked with ongoing community based peer support, if available. Future interactions with the Café will remain through the telephone service. The peer worker and the individual may contact each other during business hours to follow up on any plans made or information to be shared.

As numbers in the café will be limited and people's needs will know in advance from the phone call, it will be possible to support a wide range of needs. Young people will be able to access the service if they wish. Arrangements for their travel will be made over the phone. Those under 15 will need to provide the name of a responsible adult. If there are concerns that this will lead to family conflict, a process to provide alternative assistance will be in place. Staff will have access to a phone for people who may wish to use the interpreter service. People will also be invited to bring along someone close to them who supports them, if they wish. Taxi vouchers will be available on the first visit if the person is otherwise unable to access the service.

FTE 1.5 (2 x 18 and 1 x 15 hours per week)

Estimated numbers of people able to be supported: From 6-8 people per evening. Times 3 days per week. Total weekly = 18-24 people. Annually = 936-1248 visitors to the Cafe

Approximately $160-213 per visitor to the service

Greater budget would allow for increased hours and staff and could support walk ins.

Option 3. A community-based Sanctuary

Closest existing service – The Sanctuary in Bristol. A residential type setting staffed by peer counsellors who assist with de-escalation, self-management and problem solving and other calming activities. Available in the late afternoons until early morning hours. Accessed by phone through a separately funded crisis line triage and referral service, preferably a telephone service.

Service description

The Sanctuary will be open three evenings per week, from approximately 6-midnight to support people who prefer a very quiet and calm space and who may wish to talk or just to sit. The space is communal with comfortable chairs and low lighting. There will be a family room available and a separate room for people who wish to talk. People can stay for the evening but may only be able to speak with the peer worker for an hour or so, depending on the number of staff and other visitors. People phone the telephone service to see if there is a space available and to discuss any needs they have of the space. There will be three staff in the space at any time. On arrival, people using the service for the first time will be introduced to the space. An introductory video will be available on the website explaining how to access the service, who works there and giving a tour of the space.

FTE 1.5 (2 x 18 and 1 x 15 hours per week)

Estimated numbers of people able to be supported: From 6-8 people per evening. Times 3 days per week. Total weekly = 18-24 people. Annually = 936-1248 visitors to the Cafe

Approximately $160-213 per visitor to the service