What are the factors influencing adults visiting a rural Safe Haven or other mental health services when in crisis?

Martin Davis - Research Report

Study Investigators

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ACKNOWLEDGEMENT TO COUNTRY

I wish to acknowledge the traditional custodians of the lands across our region. I acknowledge that I live and work on Wiradjuri land and that this always was and always will be Aboriginal land. I pay my respects to Elders past, present and emerging and to all Aboriginal people and non-Aboriginal people reading this report.

Figure 1: Safe Haven Aboriginal Artwork by Sandon Gibbs-O'Neill: "Walumarra Dungal (Wiradjuri): protect, to be a guardian, support"

RECOGNITION OF LIVED EXPERIENCE

I recognise people with a lived or living experience of mental health, drug and/or alcohol concerns, to include those persons who have experienced a suicidal crisis. I recognise their journey to recovery and the experiences of people who have been carers, families, or supporters.

ABSTRACT

Objective: This study aimed to explore the factors, including past experiences that influence the decision-making process of adults visiting a rural Safe Haven or other mental health, drug and alcohol (MHDA) services when in a crisis.

Methods: This qualitative study used a descriptive phenomenological approach to explore the experience of individuals accessing a rural health service in New South Wales in 2024.Semi-structured interviews were conducted with seven purposefully selected participants aged 18 and above with experiences of attending a rural Safe Haven, an alternative to presenting to an Emergency Department as part of the NSW Health Towards Zero Suicides Initiative.

Results: The mean age of participants was 54 years (range 27-68yrs). Four participants identified as male. Six persons had previously presented to an Emergency Department for mental health concerns and had been cared for by the community mental health team. Four persons had experience of being an in-patient on a mental health unit. Thematic analysis of the participant's experiences identified four key themes shaping access and decision making: i) **Kindness and Support**, ii) **Options and Choice,** iii) **Rejection** and iv) **Deciding and Access.**

Conclusion: Findings highlighted the importance of simple human-centred interpersonal factors and service culture in shaping individual's help-seeking behaviour during a crisis. Conversely the absence of these factors may deter a person from accessing a service when in future crisis. Understanding these barriers and enablers has resulted in key recommendations including the need for staff being provided support, supervision and training around crisis intervention and that peer staff should be considered to be a part of these trauma informed multi-disciplinary teams. Persons who have presented in crisis should be offered independent follow up support and the opportunity to provide de-identified feedback on the care they received.

Key Words: Safe Haven, emergency, crisis, mental health, rural, trauma

CONTEXT

In 2023 I was fortuitous to be accepted into the Health Education and Training Institute's Rural Research Capacity Building Program.

My background is that of a Mental Health Nurse having spent most of my career as a Clinical Nurse Consultant working within Mental Health Consultation Liaison to Emergency Departments (EDs), General Hospital Wards and Mental Health Emergency Centres. I have also worked in Telehealth, covering over 50 EDs in my career. I have been an accredited person under the NSW mental health act since 2003.

I have the utmost respect for staff working in EDs and Community Services and acknowledge the majority of staff I have worked alongside having positive regard towards persons presenting to ED and community health in a Mental Health or Drug and Alcohol crisis.

For the past 5 years I have been a District Coordinator for Western NSW LHD in the Towards Zero Suicides Initiatives space, which includes coordination of our Safe Haven Alternatives to the ED in Parkes and Dubbo.

My passion lies with crisis intervention, suicide prevention, trauma informed and recovery orientated care, in seeking to improve the care pathway for persons presenting to the ED and Community Services, to include the Safe Havens when in a mental health crisis. It is for these reasons I chose the subject matter and my qualitative study. Whilst much has been written around patient experiences in visiting Metropolitan EDs and mental health facilities I found only limited study relating to Rural sites and no research including a Rural Safe Haven as a comparison, which may influence a person's decision on where and when to present.

The Western NSW Local Health District (LHD) covers 250,000km^2 making it geographically the largest of the 15 LHDs in NSW.

It is home to more than 276,000 people, of which there are more than 30,700 Aboriginal and/or Torres Strait Islander peoples, which represents over 11% of our population, significantly higher than the total NSW Aboriginal population rate of 3.6%, with rural rates of suicide higher than those in metropolitan areas for both Aboriginal and non-Aboriginal people(1).

The LHD has 3 major rural referral hospitals in Orange, Dubbo and Bathurst. Orange and Dubbo have acute and sub-acute mental health units. There are 38 general inpatient facilities and EDs, including 25 multipurpose services. There are 50 community health centres with a wide range of multidisciplinary primary and community health services (all data as per Western NSW LHD intranet site).

The town in which this study took place had a population of 9,832 at the 2021 census and is part of the traditional lands of the Wiradjuri people.

We are the largest rural mental health service in Australia, with care provided by hospitals and their EDs, In-patient services, Community Health and Community Mental Health Teams, as well as the 2 Safe Havens in our District. Telehealth is available at all hospital sites and a Mental Health Emergency Care (MHEC) Service which provides 24/7 phone advice and assesses via video-link persons presenting to the ED where there is no available MHDA staff member to provide a face-to-face assessment. This service extends out of hours to nearly 50 EDs as it then also branches out to the Far West LHD.

INTRODUCTION

Evidence suggests that there are many potential barriers and opportunities to improve ED crisis mental health care and that these might influence a person's decision on when and where to access care.

Persons who have previously presented in crisis and were then detained under the Mental Health Act and involuntarily admitted to a locked hospital ward have reported feeling coerced, disempowered, and unsupported, leading to a damaging impact on their psychological well-being(2).

Stigma is also seen as a negative factor in help-seeking(3), as persons who frequently access EDs for mental health-related reasons may feel they are disrespected and shown prejudice with the experience of a perceived lack of cultural competence and mental health literacy from health professionals providing care (4). Mental health legal documents completed by non-mental health staff in the rural setting have been adjudged to be of lower quality to that of documentation completed by mental health staff, which might also suggest a lack of engagement from non-mental health staff in the initial review(5).

Service users have reported fears around how health professionals may respond in their judgement of a person disclosing they have self-harmed(6) and persons who frequently present to EDs have described a sense that staff may also show a negative opinion around their having re-presented to the hospital(7), whereas more positive experiences are attributed to the availability of mental health liaison services in the ED(8).

Conversely, recovery-oriented service delivery has been widely adopted within mental health policy and remains central to reform efforts and improved outcomes for people accessing services(9). However, ED staff have reported being under prepared or insufficiently resourced to respond effectively for individuals presenting in a mental health crisis, with challenges also noted in accessing specialist mental health clinicians(10).

Staff members working across mental health services and the ED summarised the need for improvements to the physical environment of the ED environment, increasing mental health training and staffing levels to better support persons in crisis(11).

Aboriginal service users have identified other barriers including financial constraints; difficulties with transport; medical bureaucracy, the physical environment of the health care setting, interactions with medical reception staff; and waiting room environments(12). Suicide monitoring in NSW shows 70% of Aboriginal people who have ended their lives by suicide have had contact with health services in the last 12 months leading up to their deaths, compared with up to 64% of non-Aboriginal persons who suicide.

Older adults (aged 65+) also have a particular need for health services to engage when presenting in crisis as this age range has the highest rates of suicide per capita in Australia and this group is seen to have distinct patterns of help seeking and service use e.g. presenting with generalised pain when in a mental health crisis, accompanied by differences in risk factors e.g. a suicide attempt more likely ending in loss of life. Ageism may also influence assessment, decision-making and actions to address self-harm and suicide for older people(13).

Service users identifying within the LTGBQI+ group also have higher rates of suicide and have identified three interconnecting factors: negotiating sexuality, gender, mental health and age norms; being unable to talk about emotions; and coping and self-reliance14).

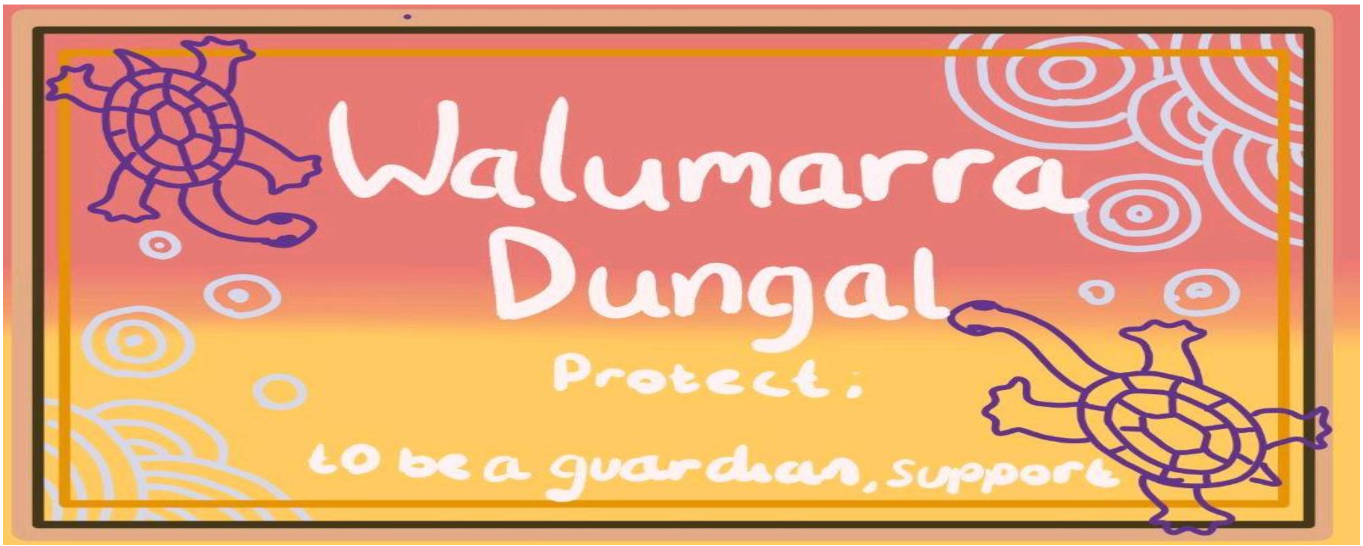
Service users who have experienced being physically restrained when behaviourally distressed have sensed a lack of staff compassion and therapeutic engagement (15). Furthermore, service users have reported ineffective communication by staff leading to service user aggression and the potential for being locked in a seclusion room (16). Alternatively, the prioritizing of autonomy, empowerment and respect for the person receiving services, has been seen as a helpful framework in which to view tools and techniques to enhance treatment engagement (17).

Where service users have had prior poor experiences when presenting in crisis this may delay their seeking of future assistance and in the case of major mental illnesses such as bipolar disorder and psychosis, can lead to worse outcomes in care (18). Care for mental illness is complex, particularly in the emergency setting. Strategies to provide care must align ED system goals with service user goals and staff experience (19) and frequent ED users' needs, may be compromised by program and personal characteristics as well as lack of broader system integration. (20).

There are also rural and remote specific implications related to a person's decision making process for presenting in a crisis, as they may have previously required acute mental health in-patient care involving their being transferred from their local ED or community centre by police or ambulance services, which in the Local Health District where this study took place may involve a 500 km journey from the person's home town, taking those persons away from their usual support networks. The travel distance from the town involved in this study to the nearest in-patient mental health unit is over 100km and transportation out of hours is highly unlikely given reduced paramedic and police services, along with wildlife on the road considerations.

The Safe Haven

Fig 2: the Safe Haven welcome sign



Safe Havens in NSW, Australia are café-style facilities as an alternative to the ED as part of the NSW Health Towards Zero Suicides Initiatives. They are adapted from an original model that is available through the National Health Service in Surrey, England, UK, where there are five Safe Havens listed. NSW currently has over 20 Safe Havens across the State. The original model was followed by NSW Health in providing an alternative to persons needing to visit the ED, with the recognition some persons decide not to do so when in a crisis. According to NSW health records around 50% of persons who end their lives by suicide have not seen a health professional in the last three months of their lives.

Persons can present to be supported when in psychological distress, to include when the person may be suicidal. No appointment or Medicare card is required and persons do not need to be in crisis e.g. a person who is not in psychological distress can also visit if they wish to talk to someone about what they might do if experiencing a future mental health crisis.

The rural Safe Haven involved in this study is 1 of 2 such facilities in our LHD and operates in business hours Monday to Friday and opened in November 2021. It is staffed by peer workers with their own lived and living experience of navigating care when in crisis. A rural counsellor who is a Social Worker also works at the facility. Staff are provided extensive training e.g. in safety planning, using sensory modulation equipment, engaging with a person who may be suicidal, basic Dialectic Behavioural Therapy skills and purposeful storytelling of their own journey towards recovery.

Fig 3: *Members of the Safe Haven Team* (photograph included with permission)

NSW Health guidelines original suggested that Safe Havens should be close to, or on hospital grounds. In Western NSW most hospitals are out of the central district of town and so our Safe Havens were positioned in discreet business addresses on or close to the high street in buildings where there are more than one business so that visitors may be seen as possibly going into other services, thus reducing the potential for stigma from others witnessing their entering the building.

Fig 4: the walks to the Safe Haven (photograph included with permission)*, the ED, its Waiting Room and a Rural ED Safe Assessment Room*

There are no age restrictions for visitors and at the time of writing this report there have been over 3000 visits to this Safe Haven. Only around five visitors have needed to be escalated to attend the ED; three for medical concerns and two due to their high level of psychological distress, affirming that the Safe Haven is a crisis service. This particular study focussed on adult visitors aged 18 and above.

The service runs a diversity program which reaches out to sub-groups including, younger people, middle aged people, older people, the LTGBQI+ community and family and carers. The team have had extensive consultation from Aboriginal elders and leaders in the delivery of cultural competency and creating a safe space for both Aboriginal and non-Aboriginal people.

Fig 5: Aboriginal art and artefacts at the Safe Haven

There are no listed prior research studies into the effectiveness of Safe Havens world-wide. The effectiveness of this Safe Haven is evaluated through visitors' verbal feedback, as well as the opportunity to completing a confidential survey, as well as a suggestions box and post-it note wall for feedback.

A separate study has been concurrently carried out for younger people and their considerations when accessing the Safe Haven by Victoria Lovecchio, District Coordinator Infant, Child, Youth and Family Mental Health Service, Western NSW LHD.

RESEARCH AIMS, OBJECTIVES AND QUESTIONS

The purpose of this study was to better understand the factors, including past experiences which might influence the decision-making process of adults visiting a rural Safe Haven or other mental health, drug and alcohol (MHDA) services when in a crisis.

Aims

ii) to evaluate the suitability of a rural Safe Haven for adults seeking mental healthcare when in a crisis
ii) To better understand decision-making about accessing rural Safe Havens, Emergency Departments and other healthcare settings for crisis mental health care

Objectives

iii) to identify the key components to evaluate the suitability of rural Safe Havens for adults seeking mental healthcare when in a crisis
iii) describing the experiences of adults seeking support at a time of psychological distress
iii) establishing the factors which influence the decision-making process around accessing a rural Safe Haven in comparison to Emergency Departments and community services for accessing crisis mental health care

Questions

1. Why are visitors to a rural Safe Haven declining or accepting other mental health care services when in mental health crisis?

2. What factors do people in mental health crisis perceive as barriers and enablers to seeking help at a Safe Haven or another type of mental health facility?

3. What underlying structural and organisational mechanisms influence where a person in mental health crisis may seek help?

4. What do persons in mental health crisis expect from Safe Haven and other mental health staff when receiving mental health care?

METHOD

This qualitative study employed an inductive descriptive phenomenological approach to explore the experiences of individuals who presented to a rural health service in New South Wales during a mental health crisis. Given the suicide prevention of the Safe Haven where recruitment occurred, participants' experiences may have included suicidality.

The research team consisted of Monica Guha a registered nurse who has previously worked at a Nurse Consultancy level and has worked in EDs, mental health acute care teams, community care and in-patient care.

Dr Scott Lamont also has a background of Consultation Liaison Mental Health nursing and is a Senior Research Fellow at the University of Central Lancashire (UCLan), UK. Scott acted as my supervisor and consulted on the data analysis and narrative report.

Dr Kerith Duncanson has been my Health Education Training Initiative (HETI) manager for the project and also contributed to the research development, formulation of the analysis and advice on the report write up.

Braun and Clarke's six step approach(21) was followed, to allow themes to emerge that were strongly associated with the data. Steps to garner these themes included:

1. familiarisation with the data
2. creating initial codes form the data
3. developing initial themes from these codes
4. revising and reviewing themes from step three
5. refining and re-evaluating themes
6. Incorporating the themes and potential sub-themes into a narrative report.

The descriptive design aimed to reflect on, and connect to, the reality of the participants and their often-complex experiences in receiving care in a crisis. The design sought to draw out the personal realities of an individual's experiences and sought to allow participants to construct their own interpretation, views and understandings of their accessing the Safe Haven, the ED and where indicated the community and in-patient care when in a crisis.

After Ethics committee approval was granted – approval number 2024/STE01195 (see appendix Fig.1), people meeting the inclusion criteria, who had accessed the Safe Haven and possibly other mental health facilities in crisis, were asked to participate.

Table 1: Inclusion and Exclusion Criteria for qualitative study on accessing a rural Safe Haven

Inclusion Criteria	Exclusion Criteria
Persons aged 18 and above Persons who have accessed mental health care at the identified Safe Haven in Western NSW Persons who have a documented or self-reported mental health condition, which may include, but is not limited to mood disorders, anxiety disorders, psychotic disorders, or other psychiatric conditions, which may also include a prior suicidal crisis Persons who are not presently in crisis and can provide a valid consent to participate in the study	Persons who are unable to provide a valid consent e.g. diminished capacity, severe cognitive impairment, sub-optimal health literacy or similar conditions that prevent them from participating meaningfully in the study Persons who are not proficient in English language and for whom translation services are not available Persons already recruited into a similar study Participants not willing to be audio recorded Persons that Safe Haven staff are aware have become psychologically distressed when previously discussing their past presentations to the ED, Community Mental Health or another facility.

Recruitment to the study was achieved by the Team Leader/Senior Peer Worker at the Safe Haven identifying appropriate persons as per the criteria and answering any questions they had about the study, before providing a participant information sheet, which outlined the goals and nature of the study, and the ethical rigour around data protection and privacy. Participants were provided the choice of receiving a full version of this sheet (see Appendix Fig 2) or an abridged version (see Appendix Fig 3).

Participants were then asked for consent to their being contacted by, or meeting in person with myself as the principal investigator and I then again provided a verbal overview of the study and its' goals and answered any questions, before obtaining a signed consent form from the person to participate. Participants were offered support to read and understand the participant information to ensure study requirements were understood, but this was not needed by participants.

Semi-structured interview questions and prompt questions were drafted by the principal investigator (MD), based on the aims and objectives of the study. These questions were then pilot tested by being shared with the Safe Haven Peer Workers who provided feedback on the wording of the questions to best reflect recovery orientated, trauma informed language when asking persons about their experiences of receiving mental health care (see Fig 5).

Fig 5: The Semi-Structured Interview Questions with prompts

Opening statement / question:

Can you please share with me the types of healthcare settings you have sought mental health care from? **Prompt:** pick up on all areas of service e.g. the Safe Haven, Emergency Department, Community Mental Health or mental health in-patient care

Semi-structured follow-up questions:

What does it mean to you to receive good mental health care?

Tell me about a memorable experience you have had of asking for help in the Safe Haven?

Prompt question: what made this experience particularly memorable?

Tell me what it was it is like receiving care from staff in the Safe Haven?

Prompt question: How did this compare with care in (individually refer to interviewees list of each of the other services encountered) in ED, CMHT or in-patient care)?

Can you describe the place where you had this experience? **Prompt:** identify the service(s) in question as above

Describe to me the ED Drs and Nurses'/ staff's knowledge of mental health care **Prompt question:** were there either Drs or nurses who had more knowledge than others? Can you please give me some examples?

How was the experience different from other times you have asked for help?

> **Prompt question:** how was the Safe Haven experience different to the ED?

Describe how these experiences may have an impact on how you seek help in the future?

> **Prompt question:** What would you be likely do if the Safe Haven was not open and you were feeling suicidal **Prompt**: would you go back to the ED if this was the case?

What are your expectations of a person providing you mental health care?

What do you think they should know and do? **Prompt:** do you think the ED / Safe Haven staff know enough about mental health and what it is they need to learn more about?

Participants were also given a copy of the interview sheet outlining the potential questions they might be asked, with the recognition they could pass on answering any questions they did not feel comfortable in doing so and could withdraw from the study at any time, including if the interview was underway and that any data collated would remain in the data analysed. They were made aware they could bring a support person to the interview.

They were also informed they would be paid for participating in the study in line with the Local Health District's remuneration for persons not employed by the LHD. This was set at two hours pay to allow for travel to the appointment. Participants were informed they would still be paid if they were to withdraw from the study mid-interview.

All interviews were conducted by the male principal investigator and audio-recorded in a private, sound proofed room at the Safe Haven to provide a confidential, non-clinical space to encourage open disclosure of participants' experiences. The room was set up with interview chairs arranged side by side to promote better interview technique(22) and participants were provided water and/or a hot drink and access to tissues should they become tearful, along with sensory modulation equipment being at hand.

Fig 6: The interview space at the Safe Haven (photograph included with permission)

Persons were reminded again that they could refrain from answering any questions they felt uncomfortable with and that their names would be de-identified by the audio recording being sent to an independent company for transcribing. The recordings will be held on a password encrypted laptop for 5 years and the transcriptions will be held in a locked environment, also for 5 years post study, before being destroyed.

Participants were also aware that no responses regarding care received at the Safe Haven would be identifiable as coming from a specific interviewee other than by the principle investigator conducting the interviews i.e. Safe Haven Staff would not be aware of who provided certain responses to promote open discussion around care received there.

During the interviews both verbal and non-verbal responses e.g. the person's body language and facial expressions in responding to the questions were observed and guided the interviewer's follow-up questions to better clarify those experiences. Field notes were taken on a copy of the interview questions to highlight nuances from responses and gestures which might not transfer to transcript.

An interpretive thematic analysis was then completed from the transcripts by the principal investigator and also independently by another member of the research team (MG) to outline key and connective responses from the interviewees and draft preliminary codes. Both then met to gain initial consensus on the coding and themes were developed. The transcripts, codes and themes were then shared with the 3rd and 4th research team members (SL & KD) who both provided advice on refining the themes to guide the narrative report.

Figure 7: the Safe Haven main area

Seven participants were all interviewed alone by the principal investigator at the Safe Haven for the study, with a mean age of participants of 54yrs (range 27yrs-68yrs). All participants had previously visited the Safe Haven after becoming psychologically distressed. Three of the participants had previously accessed mental health care when in crisis and under the age of 18y.

Six had visited an ED for this same reason. A total of three separate EDs were referenced by participants. Six participants had also been previously under the care of Community Health/Mental Health and four had been previously admitted to a mental health in-patient unit after reporting during interview that they had been suicidal. These admissions were across two sites.

Mean interview time was just over 37 minutes (range15mins-68mins 32 sec). No participants withdrew from the study during interview, nor decline to answer any of the questions. All were offered support from a Safe Haven peer worker immediately following the interview.

Thematic saturation was adjudged to have been achieved after the evaluation, coding, theme development and subsequent refining of the themes.

Codes and Themes - see Appendix fig 4

Familiarisation with the data revealed five preliminary codes:

1. Positive practices and supportive approaches through interpersonal kindness
2. Opening options and possibilities, empowering change and the availability of choices in care
3. A safe Haven: a place that feels different, safe, welcoming and human-centred
4. What good support should or should not look like to imagine better care
5. What leads a person to accessing a service

Initial codes were revised and re-reviewed to refine into the following four themes:

i. **Kindness and Support**
ii. **Options and Choice**
iii. **Rejection**
iv. **Deciding and Access**

Figure 8: *Themes/factors influencing the decision to accessing care in crisis*

Kindness and Support

Kindness and support saw an emerging and continuing theme of participants' acknowledging the importance of staff demonstrating genuine kindness, respect, meaningful listening, empathy, being non-judgemental, with validating responses in the delivery of care:

"I was in a really dark place. I was quite inconsolable and not once did I feel judged. They were so respectful and they just wanted to help me at a time when I felt really alone and didn't have anyone, they helped make the situation a little bit more bearable" (Participant a)

This kindness allowed the participant feeling a sense of calm when sat alongside the health professional, or that person otherwise imparting empathy:

"a worker enables you to just feel relaxed…their aura, their personality, it just oozes gentleness, even if you were panicked, concerned…they don't make you feel like you are penned in, like when she helped me when I sat in the carpark, she came out, she slowly came over to talk to me, she would (come and do) check-ups. She rang (the mental health unit) to speak to them, to make sure I was all right (during my admission), there was that ongoing care (after discharge from hospital) as well" (Participant e)

Participants also reported feeling validated by the kindness and support they experienced:

"staff saying 'come on in' you know, that first moment of admitting to myself that I needed to come in and speak to someone, was them seeing me the previous day as a bit anxious out the front, I don't know whether they put the welcoming on a bit more, but I really felt like I mattered and it's what I needed that day, to know that I mattered to somebody, so now I come back regularly" (Participant b)

There was a sense that this engagement is best received when carers are non-judgemental and understand a visitor/consumer may initially be distressed in communicating their anxiety.

"to have people that you can come and talk to, like here, when you're feeling that way, it just helps. I can leave here and I feel better because there's no judgement when I walk in the door (distressed)" (Participant b)

There was recognition of the importance in listening, to better understanding the person's distress by allowing them to explore this without the carer being quick to provide advice on what they feel the person in crisis is experiencing.

"I can come in here and I can be in tears and ropable and angry and frustrated and then however long it takes, I've calmed down, (they've) calmed me down, nobody sits there and goes, 'this is my qualification, this is my experience, if there's just somebody here to listen, they just always seem to have the best approach to things. All they have to do is listen really and not say stupid things" (Participant d)

A participant spoke to care needing to be provided from a trauma-informed lens, to include a person being informed of what physical contact and care will entail prior to it occurring:

"the staff would say trauma informed care is just normal care, being polite. (I disagree as) I would say trauma informed care is actually taking it a step further, .so if somebody is going to wake me up, if somebody is going to take my blood pressure, then I want them to make sure I'm awake and I know that they've got a hold of my arm" (Participant g)

Importance was placed on staff being a presence and instilling warmth in helping the person move forward:

"human action, interaction, face to face cannot be compared with any other form of care, even when there is little conversation, the visual of a smile and a cheerful dialogue just does something to an aching soul" (Participant f)

Where the presenting needs of the person were identified and addressed, this also provided sense of hope for recovery:

"they genuinely care and they want to help you in any way that they can, every time I come here and they're always trying to find things that can help me to move forward, and it's a non-clinical space, it's non-judgemental" (Participant a)

And also the importance of staff not necessarily needing to be engaged with the person, but there if they were needed:

"she stays in the common room, just on the peripherals, bringing her work and just hovering around. That's been very helpful just having someone else in the room" (Participant e)

Appreciating the experience of staff and balancing ideas around care:

"*so yes we would sometimes disagree about things, but that's ok he had a huge amount of practice experience and I never felt judged by him and that's what's required in a mental health professional"* *(*Participant g)

Workers who are actively engaged in spending time with the person in the care pathway are appreciated, from the time of presenting in crisis, through to the ongoing care process:

"I spent about two hours with her….and it really opened my eyes" (Participant b)

"the two workers drove me to hospital. I was very foggy in the head, but I remember one worker sat in the back with me. My time in hospital gave me a second chance, I absolutely love them. Like there is nothing worse than being confused within your own mind…that time in hospital and then that continuous support afterwards has led me here" (Participant f)

The sharing of Peer lived experience in a measured way may inform the person that they are being listened to by a person who has been on a similar journey themselves.

"Because the staff tell you 'we've been there, we've done it'…they've been through it, so you're talking to people who understand on a personal basis what (we're going through), you can come in and say, 'I'm feeling like that' and they understand straight away exactly where you're at" (Participant b)

The way that care is perceived as being kind lends itself to a sense the staff have been truly empathic:

"their smiles, the way they talk, interactions for support…their support is amazing, they just care and not a lot of people do…….I see that they have empathy the moment you walk through the door they have care, they have support…I'm told (by other areas of health) the same things every time like 'you're doing a good job (with my mental health)' and I want more than that" (Participant c)

Overall, participants acknowledged the importance of receiving what they perceived as being basic acts of human kindness when they were in psychological distress. This included staff going to the person rather than expecting the person to come to them and staff also initially focussing on listening to the person and giving them time to take a breath and gather their thoughts, rather than rush into clinical care.

Spending time with a person or purely being a presence were also seen as providing a sense the staff member understood the person's distress as the staff member may well have been in a similar crisis previously themselves. Where a visitor might be visibly distressed it was appreciated when this was acknowledged as being part of their imparting their crisis.

Options and Choice

Participants spoke of the fundamental importance of options and choice in decision making processes to address distress in a given situation. This would include the option of some care provided initially being non-clinical.

Being provided a choice of what care might look like e.g. does the person wish to be initially alone before talking with the carer and how this may differ from one presentation to the next, with the person feeling they are the centre of their care:

“they’ll ask me ‘do you want peace and quiet, or do you want a chat?’...especially when you’re at that stage where you just want to sit out the back and listen to the music…they’ll pop their head in in every half hour or so and ask if you’re all right, or if you want a drink. When people are feeling the way we are, just coming and sitting here helps” (Participant a)

Choice may include the types of engagement which is offered:

“having group days (as well as 1-to-1 support) those days are just amazing, you forget about all the stress and everything that was on your mind and you go to laughing” (Participant c)

Participants also spoke of needing to sense their voice was being heard throughout the care journey:

“having a voice in the care that you receive and a voice in the outcomes and the care that I want (is so important)” (Participant a)

Alternatives to Emergency Department care or improvements in existing emergency care were seen to change participants’ opinions on what healthcare should look like and the options which should be included in planning care:

“coming here has really changed my point of view about health services and that there really are people out there that’ll help you” (Participant a)

Mention was made to the importance of the initial welcome and interaction by staff being more important than a perceived rush to carry out clinical care. The way in which this care is holistically delivered also influenced the quality of the experience:

“I wish other services were like this, if they had more interaction with you rather than bringing you in to do a clinical report on you” (Participant e)

Participants referenced the option of talking to staff at the Safe Haven when otherwise they might require a readmission to hospital. They felt the discreet entrance to this service further eased anxiety around potential stigma in accessing mental health care:

“a couple of weeks back, I was feeling a bit flat, and I actually thought to myself, maybe I should see if I can get back to the mental health unit for a couple of weeks, but I came down and I spoke to the Safe Haven staff and felt better” (Participant b)

Some participants reported that becoming distressed in the middle of the night might be further heightened by the thought that this could require an ED presentation the following morning. Knowing they had the option of alternatively visiting the Safe Haven reduced that distress.

“things like here give you a bit of space to go; if I’m feeling really bad at midnight, I can go back and see the staff at the Safe Haven (and it reduced my distressed during the night)” (Participant d)

Collaborative holistic care was identified as including addressing physical, medical concerns as well as mental health and social needs and that when this was covered, it provided increased satisfaction in experiences. This was spoken to for persons admitted to hospital as well as being warm referred to other services by the Safe Haven:

“if I looked a bit shaky, a nurse would come straight up to me, check me over, it was like having 24 hours care, I just thought it was a little bit like your average public hospital, but there was more attention to care there, I went in there for a complete overhaul, I got blood pressure tablets, I got dental work. I

gained so much from it, I even got my appetite back, I was too scared to eat, I thought I'd choke and die. Just little things like that but to me they were big things at the time" (Participant f)

Options of seeing different service for given needs:

"I'm very grateful for having this here. I'm very grateful to the (staff) at the Department of Housing who bent over backwards and also (name of a non-governmental organisation), which is another association who are linked in quite strongly with here. So I'm very grateful to the whole team…. I've also spent time in a (sub-acute) mental health unit' they are lovely there…the staff that work over there, they absolutely bend over backwards… and then the social worker. I wouldn't be where I am today, in a (housing) unit, without her" (Participant b)

Overall participants sensed that options and choice in where to turn to/visit when in crisis were in many ways dependent on the staffing skill-set and the environment itself. Prior experiences of how specific staff had been helpful (in all areas of health) were also a contingent of guiding choice.

Rejection

Participants spoke of having at times experienced a sense of rejection and the need to feel better engaged with their health staff and for respect to be perceived as being provided. Rejection was generally seen as a person believing their needs to have been unmet and in some cases the perceived lack of skills in staff broaching the person's mental health concerns and emotional distress, rather than merely the opposite of kindness:

"The care just wasn't consistent. I had a case worker that I just didn't really have a rapport with, which made it really hard to open up and be honest. My medication scripts weren't turning up for two or three weeks at a time so I was going without medication, which made it really difficult to try and stay stable and then when I voiced my concerns and they didn't treat me respectfully and were very degrading, it's also very difficult for me to access psychiatrists to get help" (Participant a)

There was a need to feel validated when anxious and distressed rather than being told how well they were doing. A perceived lack of staff empathy was often described. This was at times attributed to the disconnection in seeing a carer over a video-link.

"they're there to listen to you and that's it. They don't give you any answers for anything. In the years I've been counselled I can nearly repeat every word they say to me, which is not much, but it's nearly always, okay, yes, you're doing a good job, and it's not empathy to me and I don't get anything out of that. They help to a certain point because they'll give you homework things and stuff to do which is always good and helpful" (Participant c)

"it was very clinical, very clinical, and at the time I just had no connection, I had no connection with the people that were in those services., I think it just boiled down to that for me it was just too impersonal. I just need face to face (rather than via video-link), something about seeing people" (Participant e)

When basic needs such as the provision of test results were not provided this sullies a sense of trust:

“we had an appointment with the psychiatrist, it didn’t really achieve anything, they ordered some blood tests but we never saw them again, so I don’t know about those results” (Participant d).

Recognition was given to a sense that rejection was actually due to services being overwhelmed and staff were not intentionally providing poor healthcare:

“the department with the amount of pressure they’ve got, and then you’ve got someone who’s just sitting there, who’s not feeling well inside their head” (Participant c)

Or alternatively…

“they bent over backwards, so I couldn’t complain, they were coming in every 20 minutes” (Participant b)

Waiting times and the isolation of being left alone in a (safe assessment) room and not being updated on the plan of care:

“I think some ED staff are probably not trained in mental health maybe, you just get put into a room by yourself for a few hours with little information and just wait for someone to call you on a computer and it’s really uncomfortable not knowing what the outcome’s going to be. Staff will ask if you’re getting sent back to the mental health unit and that’s a very big trigger for me, it’s really scary” (Participant a)

Also the fear of being readmitted to a locked in-patient setting:

“the first time I went into ED they said to me straight away, ‘we’re going to send you off to (the mental health unit) for a couple of days’ and because of the wait., trying to organise transport, that was the hardest part…it was 24 hours before they’d organised transport, so sitting up there in their little room they’ve got up there was a bit hard” (Participant b)

A participant spoke of their own trauma and how they did not feel this was acknowledged or that they were even chastised for mentioned this to staff:

“I (spoke about my trauma) and the nurse said to me ‘trauma, trauma, trauma! that’s all we hear about around here’, I couldn’t believe it that she could be so cruel” (Participant g)

Other problematic experiences of having previously accessed care included the sense that staff were putting up a barrier to the person’s request to be re-admitted to hospital and that they did not meet the criteria for admission, or that decisions were being made in part due to bed block:

“Lots of excuses (for not being admitted to hospital) ‘we’re too full, you’re not unwell enough, you’re already seeing other services’” (Participant d)

An interviewee spoke of it being further distressed by hearing staff laughing and discussing their private lives that could be overheard when the person wanted reassurance that staff were there to care:

“and you get in there and they're talking and laughing behind the desk and that upsets you….they should be there to do their job and yet that's what you see” (Participant c)

Participants reported a sense of being judged or triggered in this situation and setting:

“there was this nurse stood in front of me shouting at another nurse (about my illicit drug use)” (Participant g)

Overall, participants described a feeling of rejection when they were emotionally unsupported, which contributed to distress and a diminished sense of trust. Importantly, factors that contributed were actionable, and included staff's lack of empathy, poor communication, and the impersonal nature of telehealth consultations.

While some acknowledged that overwhelmed services may explain these experiences, others felt invalidated, judged, or ignored—especially when basic needs were unmet or their trauma was not acknowledged.

Deciding and Access

Participants spoke of feeling thankful for knowing the ED was available if their crisis was at a point where they felt unsafe, however there was reference to the perceived stigma of going to an ED and that the accessibility of the Safe Haven was seen as a less confronting venue to enter and informed several participant's decision making process, as to where to access help. The availability of the Mental Health Access Line was also referenced:

*"I feel it's a very private type of entrance, no problems (with privacy) when attending" (*Participant g)

"the access is good, like you know, I'm not so much a jittery person now but even if I was I could handle going from the Big W carpark to the hallway. Once you get to the corridor you are safe. That's just the old me thinking about it, you are safe and just like a quick walk down the hallway, press the button and in you go. I would never have thought they have a place like this in my lifetime, but I'm so happy that there is" (Participant f)

The decision-making process around accessing care was also guided by memories of other patients' distress during an admission and how this impacted on the person's own experience:

"It's a high-risk area (the acute mental health unit) you know, it's for people who are thinking about harming themselves. The hardest thing I found was other clients who are in ten times a worse state than I am, and they're yelling and screaming and I just found that really overwhelming, it was really hard out there, it was frightening" (Participant b)

Sometimes deciding the best option is dealing with the problem alone.

"I now deal with it home alone (rather than attending the Emergency Department) which can be hard at times but I don't think I'm able to access anything else" (Participant a)

The mental health access line was seen as an additional alternative than going straight to ED, though there was some fear this would still lead to restrictive care as had occurred previously.

"I'd probably (return to the ED), but I've actually got the mental health line on the fridge, so if I'm not feeling right, that's the first thing, (but) that's how I got locked up the second time when I rang" (Participant b)

Emergency services were seen as a necessary place to go when things get to an acute crisis point and where the person may feel unsafe.

"the hardest part is admitting to yourself, in your own head, that yes, I'm twisted, I need to be helped and I think that if you speak to a thousand people, they'd all say the same thing, admitting to ourselves is the hardest part" (Participant b)

"I had a poor experience with my psychologist and got on the grog that night and then staggered into the hospital" (Participant g)

Deliberate self-harm behaviours influencing where to seek help:

"I running the a blade up and down my arm and that scared the shit out of me (so I went to ED)" (Participant b)

The environment and its' potential for raising or lowering anxiety:

"there's a little courtyard, but obviously being high-risk, you can't get out of the (mental health unit), if I was still stressed, I could go outside and sit in the front garden, or go down to the cafeteria and get a bottle of coke or a pie" (Participant b)

Memories of past visits to the ED influencing decision making:

"nobody's ever going 'I'll go down to Emergency in the morning', it winds you up. It's not the right environment, this is the (Safe Haven) environment that people with mental health issues need to be in and around people that are informed and appropriate" (Participant d)

"I come here when I'm not in crisis mode and what I've done when I have really hit a crisis (gone to the ED) hasn't always worked for me, because by the time I've hit the crisis it's too late (to not go to the ED)" (Participant g)

Overall participants sensed that the ED was a much needed avenue to access clinical care when in a heightened crisis, only the Safe Haven was their go-to before that crisis necessarily moved to a level which required acute clinical care. The thought of returning to ED and the subsequent possibility of going back to a locked environment, meant that participants often avoided the ED wherever possible.

DISCUSSION

This research highlights that people accessing care in a mental health crisis perceive kindness and empathic support as an integral part of their recovery process and influence decision making processes around where to access future care. In the absence of this kindness being present, a sense of rejection may be experienced and that options and choice were welcomed in forming the decision making process of where to present.

Strengths

In drawing on strengths the interviews were semi-structured and intentionally worded in what was believed to be recovery orientated language, which was informed by the Safe Haven peer workers' own lived or living experience and which was seen to guide open a candid conversation, supported by prompt questions, also guided by behaviours and mannerisms exhibited by the participant's and their responses.

Limitations

Reflecting on limitations, the small sample size of interviewees potentially placed bias on the study around it being based on those persons' experiences.

Another potential limitation was the location of the study which took place within a Safe Haven, rather than on neutral ground and saw all participants compare the Safe Haven very favourably in comparison to varying experiences around past clinical care received, though it should also be stated this environment paradoxically saw those participants on the whole feeling relatively comfortable in exploring their experiences.

Although open to all service users meeting the inclusion criteria, recruitment did not lead to any persons identifying as Aboriginal or Torres Strait Islander people joining the study, which given the relatively high (circa 11%) proportion of Aboriginal persons living in the area, missed an opportunity to hear from the Aboriginal community.

What was already known about the subject matter?

Prior research has drawn on persons presenting to mental health, drug and alcohol services when in a crisis may perceive stigma and judgement from staff around their mental health, and/or drug and alcohol use, self-harm and re-presentations to hospital.

Furthermore, there may be perceived deficits in staff cultural competency, being trauma informed, showing compassion and a sufficient level of therapeutic engagement when providing care.

There may be a fear from the person in crisis of being admitted/re-admitted to hospital, to include fear based in past experiences of a person having been physically restrained and/or locked in a seclusion room

What this research might add?

Participants in the study consistently reported their verbal and behavioural expressions of distress in a mental health crisis as being often based in underlying fear, anxiety and a need for safety, both in the psychological and physiological sense, which I could not find referenced in any previous studies in this area.

Rather than being viewed as challenging behaviours, such expressions may be better supported through compassionate, attuned responses from health staff. Small but meaningful gestures such as a welcoming gaze, active listening, empathy and respect, can create a calm, non-threatening environment, which may foster a sense of psychological safety. These humanising interactions may play a significant role in reducing distress and encourage help-seeking, particularly in rural crisis settings.

Previous findings have demonstrated persons presenting to mental health services when in crisis may feel a sense of being poorly judged for their behaviours and actions, feeling coerced, disempowered, disrespected and fearful of the repercussions in reaching out for help e.g. the fear of readmission to a locked environment and being environmentally secluded and physically restrained.

Persons whom re-present to hospital in crisis have also reported feeling guilty for having done so, due to the perceived negative response from staff. The majority of persons who end their life by suicide in NSW have sought health care in the last year of their lives.

To address these factors there should be the opportunity for persons to access support in a welcoming environment from persons with their own lived or living experience of similar crisis as this may well be of comfort to a person’s distress. Participants believed this was likely to be at the Safe Haven. Appropriate time spent with the person and returning to the person to check-in on their progress adds to this sense of being valued and in the absence of peer workers may be unavailable in emergency services where staff may feel overwhelmed and untrained in mental health crisis intervention.

Staff stepping over the threshold of the service entry in going out to the person, supporting them and transporting them to where they require care, or merely walking alongside them into care may have a profound effect on the ensuing relationship between persons accessing health care and health care providers.

Being provided options and choice on how care is received will likely add to a person in crisis' sense that their needs are being met, which may often be physical as well as psychological.

When distress is encountered during the night, the knowledge a safe space may well be available in the morning, may lower anxiety and could prevent a need to return to the ED environment. This adds to a sense that care is consumer-centred and not solely based in a clinical framework. Phone assistance may also assist in this decision making process.

Persons in crisis may well recognise an ED is the required level of care when that person is feeling unsafe and will typically require a higher level of acute care. Those persons also often understand the constraints on a system, which may include low staffing levels, a lack of access to mental health staff and crisis education and the pressures of working within emergency care.

Perceived rejection and ensuing discontent as opposed to prior positive experiences may have an enduring effect on decision making processes for health seeking. This may include staff being mindful of their own projected behaviours, which have included reference to the person in crisis feeling belittled, betrayed, laughed at, their trauma being disrespected and these occasions of care making the person less likely to re-attend services appropriate to their level of acuity.

Building rapport, trust and inclusion of the person in their care might alternatively rebuild that trust and influence the service user's decision making.

EDs should also promote a culturally safe and welcoming environment, which includes calming safe spaces for service users to be seen. Service users expect staff to be trained in MHDA crisis care to deliver that care, and visitors expect a level of training and competency from staff providing crisis care. Options in care further assist the person in deciding on where and when or whether to present in crisis.

These barriers and enablers shape the decision making process of a person accepting or declining healthcare and should inform structural and organisational mechanisms to promote help-seeking in crisis.

EXECUTIVE SUMMARY

At a Local Health District LHD service provider level:

Findings from this study are to be shared its' participants, alongside the LHD Executive, Health Service Managers, ED and Community Health Teams, the Safe Haven staff and where available Official Visitors. This should be conveyed in a manner which is understanding of the internal the external factors which influence staff crisis care provision.

Regular reflective spaces such as individual and group supervision should be embedded into service structures to support staff well-being and effective means of processing the emotional demands of crisis work. Trauma-informed, compassionate care cannot be reliably offered if staff well-being is compromised. Supporting staff is essential to promote safe, effective care and should be considered to be integral to future service delivery models.

Key components of these findings are considered in the implementation of future training and education programs for all staff working in the teams referenced in this study. It is recommended that where feasible training is delivered to a cross section of both mental health, drug and alcohol and general health teams with the mantra of 'training together, learning together and working together'.

The Safe Haven and associated crisis services must continue to develop culturally safe and affirming approaches to care, particularly for Aboriginal and Torres Strait Islander peoples and LTGBQI+ individuals who may have experienced historic or recent harm within health systems. Engagement with community leaders, Elders and lived experience advocates should inform improved service design, the environment and staff training to ensure culturally responsive care, which in turn may contribute to barriers and enablers to assisting persons' in crisis accessing care.

Where not already established peer support staff, to include Aboriginal peer workers should be actively recruited and integrated into multi-disciplinary teams. Future research may look at Aboriginal people and their experiences of presenting to the rural Safe Haven or other rural health facility when in crisis.

Individuals who present to any LHD service in crisis should be offered the opportunity for appropriate follow-up support, in both supporting their ongoing well-being and be given the opportunity to provide de-identified feedback on their experience of receiving care. This feedback not only informs service improvement but signals to the individual that their voice and their experiences matter.

At a Ministerial level

The findings of this report are made available through the Towards Zero Suicides Initiatives and Emergency Care programs, with inclusion of the Agency of Clinical Innovation where deemed appropriate. The findings provide important direction for service refinement, policy development and workforce strategy in rural and regional contexts.

RECOMMENDATIONS

1. Training and Resource Development

- **Recommendation:** Develop a trauma informed, recovery orientated training package for Rural EDs and Community Health Teams. This can be adapted from the existing HETI suicide prevention training and be embedded into all staffs' orientation to working in the rural and remote crisis intervention setting. This could be provided by existing peer workers and nurse educators.

- **Justification:** Service users in this study have perceived a lack of MHDA training in some staff and seek a more trauma informed, recovery orientated response to their distress when presenting in a crisis and have consistently reported a deficit in this area of emergency healthcare.
- **Expected Outcomes:** Increased self-sufficiency in staff providing trauma informed and recovery orientated intervention to patients presenting in a crisis, to include persons who may be suicidal

2 Clinical Supervision for Staff in the Emergency Setting

- **Recommendation:** Staff working in EDs and other acute care settings to be offered clinical supervision in an individual or group setting.
- **Justification:** Participants in the study have furthermore expressed their concerns as to at times the lack understanding in some front line staff's ability to meet the needs of persons presenting in a mental health crisis and that this may in part be due to those staff feeling overwhelmed and reactions may be based In their own experiences working in an ED. These opportunities provide staff with much needed support in working with persons who have experienced their own trauma and potential further hardship in presenting to acute services when in a crisis.
- **Expected Outcomes:** Greater staff expertise in meeting the needs of persons presenting in a MHDA crisis. Better mental health care for staff in dealing with service-user trauma.

3. Peer Staff Integration into Crisis Intervention Teams

- **Recommendation:** Peer staff are to be included in multi-disciplinary teams providing crisis intervention.

- **Justification;** This study has consistently shown that services users presenting in a mental health crisis would further benefit from emergency teams including peer workers with their own lived or living experiences to provide service users' purpose in their trauma informed and recovery orientated health pathway.

- **Expected Outcomes:** Service users experience better health outcomes in their recovery journey and a sense that these carers understand what they are going through, due to peer past experience.

4. Policy and Governance Integration

- **Recommendation:** A trauma informed, recovery orientated framework to be embedded into future rural and remote service delivery frameworks and operational policies and reflect training and support responsibilities in job descriptions and performance evaluations.
- **Justification:** Participants continually referenced this area being deficient in some areas of acute care. This will embed support for rural and remote health staff in providing trauma informed, recovery orientated care for persons presenting in a crisis.
- **Expected Outcomes:** A systematic and sustained focus on supporting staff delivering a trauma informed, recovery orientated positive culture and enable the alignment of individual and team efforts in promoting optimal mental health care.

5. Follow-up support for persons who have presented in crisis

- **Recommendation:** all service users presenting to a rural and remote health care setting in MHDA crisis to be offered a follow up phone call from an independent peer source to garner the person's experience in accessing acute care. Feedback to be provided to those services that have provided the acute care.
- **Justification:** This research has highlighted the need for the voice of persons presenting in a crisis to emergency services to be heard so that they able to provide de-identified feedback on their experience. People presenting to mental health services indicate they would benefit from this opportunity.
- **Expected Outcomes:** Service users receive appropriate support following a crisis, which in turn informs health services in best crisis care and enables staff to reflect on their crisis interventions and recovery orientated best practice.

CONCLUSION

This report has provided insight into the decision making process and factors which might influence persons presenting to a rural Safe Haven or other emergency services when in a mental health, drug and alcohol crisis, to include persons who may be suicidal. Participants in the study have reported how they value basic kindness and support received by staff working in this area, along with being provided options and choice in the way in which care is provided. Without these values there can be a sense of rejection and apprehension around a person seeking further support. The Safe Haven has been identified as providing those positive aspects and should be seen as an essential suicide prevention service as an alternative to the ED in NSW. Findings of this research will be useful for best practice, clinical governance, training and further guidance for all persons working in crisis intervention.

REFERENCES

1. Fitzpatrick S et al. Suicide in rural Australia: A retrospective study of mental health problems, health-seeking and service utilisation. PLOS ONE. 2021, 16(7).

2. Murphy R et al. Service users' experiences of involuntary hospital admission under the Mental Health Act 2001 in the Republic of Ireland. Psychiatric Services. 2017, 68(11):1127-35.

3. Corrigan P. How stigma interferes with mental health care. APA PsycNet. 2017, 59(7), Oct 2004, 614-625

4. Corrigan P, Druss B, Perlick D. The Impact of Mental Illness on Seeking and Participating in Mental Health care. Association for Psychological Science. 2014,15(2):37-70.

5. Davis M, Juratowitch R, Lamont S, Brunero S. Mind the gaps: identifying opportunities in mental health certificate completion in rural and remote NSW, Australia. Australasian Emergency Care. 2020, 23, 137-141.

6. Williams A, Nielsen E, Coulson N. "They aren't all like that": Perceptions of clinical services, as told by self-harm online communities. Journal of Health Psychology. 2020, 25 (13-14) 2164-2177.

7. Vandyk A, Young L, Macphee C, Gillis K. Exploring the Experiences of Persons Who Frequently Visit the Emergency Department for Mental Health-Related Reasons. Qualitative Health Research. 2018, 4,587-599.

8. Sacre M, Albert R, Hoe J. What are the experiences and the perceptions of service users attending Emergency Department for a mental health crisis? A systematic review. Journal of Mental Health Nursing. 2022, 31(2), 400-423.

9. VanWeeghel, J.; van Zelst, C.; Boertien, D.; Hasson-Ohayon, I. Conceptualizations, assessments, and implications of personal recovery in mental illness: A scoping review of systematic reviews and meta-analyses. Psychiatric Rehabilitation. 2019, 42, 169.

10. Pawaskar R et al. Staff perceptions of the management of mental health presentations to the emergency department of a rural Australian hospital: Qualitative study. BMC Health Serv Res. 2022, 22:87.

11. Innes K et al. Caring for the mental illness patient in emergency departments – an exploration of the issues from a healthcare provider perspective. Journal of Clinical Nursing. 2013. 23, 2003-2011.

12. Woodland R, Morgan P, MacLean S, Downey H. The experiences of a regional Aboriginal community accessing primary health care during times of crisis. Australian Journal of Rural Health. 2024. 32, 80-89.

13. Wand A, McKay R, Pond D. Towards zero suicide: need and opportunities to improve implementation of clinical elements for older adults. Australasian psychiatry. (2022). 290-293.

14. McDermotta E, Hughes E, Rawlings V. Norms and normalisation: understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking. Culture Health and Sexuality. 2018. 20, 2, 156-172.

15. Wong A, Ray J et al. Experiences of Individuals Who Were Physically Restrained in the Emergency Department. JAMA Network Open. 2020, 3(1).

16. Dixon L, Holoshitz Y, Nossel I. Treatment engagement of individuals experiencing mental illness: review and update. World Psychiatry. 2016, 5,13–20

17. Newman D, O'Reilly P, Lee S.H, Kennedy C. Mental health service users' experiences of mental health care: an integrative literature review. Journal of psychiatric and mental health nursing. 2025, 22(3),171-182.

18. Clement S et al. What is the impact of mental health-related stigma on help-seeking? A systemic review of quantitative and qualitative studies. Psychological Medicine. 2015, 45, 11-27.

19. Austin E et al. Improving emergency department care for adults presenting with mental illness: a systematic review of strategies and their impact on outcomes, experience and performance. Frontiers in Psychiatry. 2024, 15

20. Poremski D et al. Improving continuity of care for frequent users of emergency departments: service user and provider perspectives. General Hospital Psychiatry. 2016. 40, 55-59.

21 Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology. 2006, 3(2), 77-101.

22. Rickard E, Hevey D, Wilson C. The impact of seating arrangement and therapy task on therapeutic alliance formation. Counselling & Psychotherapy Research: Linking Research With Practice. 2021. 21(3), 683-696

Appendix fig 1: *Ethics Approval*

Date of Decision Notification: **20 May 2024**
Greater than low risk review pathway

Dear Martin Davis,

Thank you for submitting the following Site Specific Assessment (SSA) for governance review;

2024/STE01195: What is the experience of people seeking help for emotional distress in regional NSW?

The Application has been reviewed by the Chief Executive/Delegate who has determined the application has been **AUTHORISED** to begin at this site:
Mental Health, Drug and Alcohol Services

The following documentation is included in this authorisation:

- **Application Attachment, 2024_ETH00388.zip**
- **Application Attachment, ProjectRegistration**
- **Application, SSA**

Application Documents (Please note : Due to security reasons, this link will only be active for 14 days. The approved documents are also available to download from forms section of this project in REGIS)

The Site Specific Assessment reviewed/authorised is:
Version: 1.00
Date: 16 May 2024

Site authorisation with cease on the date of HREA expiry **26/03/2029**.

The Principal Investigator will:

- Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are provided to the office through REGIS.
- Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to this office, via REGIS.
- The appropriate documentation must be submitted for authorisation before any external researcher is authorised to conduct research procedures at this site.

We wish you all the best with the study and remind you that any changes to the application and safety reports will need to be submitted via REGIS and acknowledged prior to implementation.

Please contact us if you would like to discuss any aspects of this process further, as per the contact details below.

Yours Sincerely,

Colette Robinson

Acting Manager Research Ethics and Governance

Research Office | Western NSW Local Health District

Ward 22, Level 1 – Bloomfield Hospital

Email: colette.robinson@health.nsw.gov.au | Mobile: 0455 189

Appendix fig 2: *Participant Information Sheet (full version)*

Participant Information Sheet

Study Title	Study Title: What are the factors influencing adults visiting a rural Safe Haven or other mental health services when in crisis?
Principal Investigator **Associate Researchers**	Martin Davis District Coordinator Towards Zero Suicides Initiatives | **Innovations and Performance Network** Moonya Cottage, Bloomfield Campus, PO Box 6008, ORANGE, NSW, 2800 Tel 0419 504 308 Martin.Davis@health.nsw.gov.au Monica Guha Registered Nurse monicaguha@gmail.com Dr Scott Lamont Allied Health Research Unit University of Central Lancashire | UCLAN · Allied Health Research Unit SLamont@uclan.ac.uk Dr Kerith Duncanson Rural Research Education Manager, Health Education Training Institute (HETI) kerith.duncanson@health.nsw.gov.au
Main Study Contact Person	Martin Davis District Coordinator Towards Zero Suicides Initiatives | Innovations and Performance Network Moonya Cottage, Bloomfield Campus, PO Box 6008, Orange, NSW 2800 Tel 0419 504 308 Martin.Davis@health.nsw.gov.au

1. Introduction

You are invited to take part in a research study titled “What are the factors influencing adults visiting a rural Safe Haven or other mental health services when in crisis?”

This study will take place at the Parkes Safe Haven and the research team will be based in the Mental Health Drug & Alcohol Service at Orange Health Service.

This information sheet tells you what the study involves, to help you decide if you want to take part. Please read this information carefully and you can ask questions about anything that you don’t understand or want to know more about.

Participation in this research is voluntary. If you do not wish to take part, you do not have to. You don’t need to give a reason if you do not wish to take part.

2. What is the purpose of this study?

The purpose of this study is to gain an understanding of the experiences of visitors to the Parkes Safe Haven when accessing mental healthcare.

We hope that the results from this study will help us to improve Mental Health, Drug & Alcohol services.

The study is being completed with support from the Health Education and Training Rural Research Capacity Building Program.

3. Why have I been invited to this study?

You are invited to take part in this study because you have been identified as someone who has visited the Parkes Safe Haven. We believe that you may have opinions and experiences about the role of Mental Health, Drug and Alcohol services to include the Safe Haven and other areas of mental health care that will help us improve our services.

4. Do I have to take part in this study?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage, up until interview transcripts are collated together.
Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine care, your relationship with the Safe Haven staff or your relationship with Mental Health, Drug & Alcohol services within Western NSW Local Health District.

If you do decide to take part, you will be given a consent form to sign and you will be given a copy to keep.

5. What does participation in this study involve?

If you decide to take part in this study, you will be asked to participate in an interview at the Safe Haven with one of the researchers. We expect this interview will take up to 60 minutes.

We will ask you a series of questions about your experience of presenting to Mental Health, Drug & Alcohol services. We would like to ask you about what you see as the role of Mental Health, Drug & Alcohol care, and what a good mental health service should look like.

The interview will be recorded and later typed up. Notes may be taken during the interview to document important issues raised. The recordings and notes will be kept securely and destroyed after 5 years. You can bring a support person to sit with you if you wish.

You will continue to receive your routine care from the Mental Health, Drug & Alcohol service you attend, and anything you discuss in the interview will remain confidential and not influence this care in any way. Safe Haven staff will **not** be part of the interview process and will not be able to attribute your responses to you personally.

Should you partake in the interview you will be paid $80 to acknowledge your contribution and value the time you have volunteered to this study.

6. What are the possible risks and disadvantages of taking part?

Taking part in the interview may cause distress, as discussing your experiences may bring up some distressing memories.

We will provide you support prior to the interview in the form of the Safe Haven staff including this as part of their initial conversation with you, before we also support you during the consent process.

You are provided with the 1800 011 511 number of our Mental Health Line which is staffed 24/7 by clinicians who can offer you further support and refer you to counselling if desired. You will also be provided other non-health support lines e.g. Lifeline 13 11 14 and 13Yarn 13 92 76.

Support will be available to you on the day from the Safe Haven staff who will check in with you after the interview has occurred and you can bring a support person with you if you wish to do so.

7. What are the possible benefits of taking part?

We cannot promise that you will receive any benefits from this research; however we hope that you may gain a sense of satisfaction in sharing your story and that there will be future improvements to services based on the study outcomes.

8. What will happen to my information?

By signing the consent form you consent to the research team collecting and using personal information about you for the research project. Your privacy and confidentiality will be protected at all times. Your information will only be used for the purpose of this research study, or similar studies and it will only be disclosed with your permission, except as required by law. For example, researchers are required to report if a participant is believed to be at risk of harm.

In order to protect your privacy, the study team will remove any information that may be used to identify you from any study documents, and instead of your name appearing on the documents, you will be identified by a specific study code number that applies only to you. Only this code number will be used on any research-related information collected about you for this study, so that your identity as part of the study will be kept completely private.

Only the study team will have the ability to link this code number with your personal information, and the linking information will be kept securely. Your data will be stored for 5 years after the study finishes.

If you withdraw from the study, we will not collect any more information about you. We would like to keep the information we have already collected about you to help us ensure that the results of the research project can be measured properly.

9. How will the results of the study be distributed?

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.
Once written up a copy of the report will be available at the Safe Haven for you to read.

10. Who should I contact if I have any questions?

If you have any questions or want more information about this study before or during participation, you can contact Martin Davis on 0419 504 308.

11. Who do I contact if I have concerns about the study?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). This study has been approved by the Greater Western Area Human Research Ethics Committee.

If you have any concerns or complaints about the conduct of the research study, you may contact the Executive Officer of the Ethics Committee, on (02) 6330 5948 and quote reference: 2024/STE01195

This Information Sheet is for you to keep. We will also give you a copy of the signed consent form.

Appendix fig 3: *Participant Information Sheet (abridged version)*

Western NSW
Local Health District

Participant Information Sheet

Study Title: What are the factors influencing adults visiting a rural Safe Haven or other mental health services when in crisis?

You are invited to take part in a research study about people's experience of seeking help at the Parkes Safe Haven or other health services.

What does this research involve?

- You will be asked to participate in an interview to discuss how you came to seek help at the Safe Haven and other areas of our health service and your experiences in doing so.
  The interview will be audio-recorded.

What choices do you have?

- Participating is voluntary
- You can withdraw any time before or during the interview. Information you have already provided will be included in the research findings. You will not need to give a reason for withdrawing.
- Participating or not participating will not affect the care you receive in the future

Benefits

- You potentially gaining a sense of satisfaction from contributing and sharing your story
- The potential to contribute to improved design and delivery of mental health programs within our local community.
- You will be paid $80 for your participation.

Risks

- Taking part in the interview may cause distress, as discussing your experiences may bring up some distressing memories.
- We will provide you support prior to the interview in the form of the Safe Haven staff including this as part of their initial conversation with you, before we also support you during the consent process. You are provided with the 1800 011 511 number of our Mental Health Line which is staffed 24/7 by clinicians who can offer you further support and refer you to counselling if desired. You will also be provided other non-health support lines e.g. Lifeline 13 11 14 and 13Yarn 13 92 76.
- Support will be available to you on the day from the Safe Haven staff who will check in with you after the interview has occurred and you can bring a support person with you if you wish to do so.

Privacy

- All personal details and information you provide will be kept anonymous and confidential and will be stored securely in a locked cabinet by the researchers who are not Safe Haven staff.
- The content of your interview will be de-identified so staff and others will **not** attribute it to you.

Your details

- Your information will only be used for the purposes outlined on this sheet and in future related research.

Please see over

Further information: If you would like further information, please contact:

Principal researcher: Martin Davis

Email: Martin.Davis@health.nsw.gov.au

Telephone: 02 6369 7959

Ethics approval

- This research has been reviewed and approved by the Western NSW Local Health District Human Research Ethics Committee (HREC). The approval number is 2024/STE01195.

Complaints about this research

If you are concerned about the way this study is being conducted or wish to make a complaint to someone independent from the study, please contact the Western NSW LOCAL Health District Human Research Ethics Committee Executive Officer on: (02) 6330 5948 WNSWLHD-EthicsCommittee@health.nsw.gov.au and quote:

2024/PID00448

Thank you for taking the time to consider this study. This information sheet is for you to keep

Appendix fig 4 – *Coding Tree*