



QCMHR
Queensland Centre for
Mental Health Research

State-wide evaluation of Queensland Health's Crisis Support Spaces

FINAL REPORT

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This evaluation was commissioned by the Mental Health Alcohol and Other Drugs Branch (MHAODB), Queensland Health and was conducted by the Mental Health Evaluation Stream at the Queensland Centre for Mental Health Research (QCMHR) and School of Public Health at the University of Queensland (UQ).

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Table of Contents

List of Tables.....	7
List of Figures	7
Acknowledgements	8
Acronyms.....	9
Glossary.....	10
Executive Summary.....	11
Background.....	11
Crisis Support Spaces	11
Evaluation objectives	11
Evaluation methodology.....	11
Summary of Findings.....	12
Consumer reach of CSS	12
Health service adoption of CSS	13
Health service implementation of CSS.....	13
Effectiveness of CSS	13
Maintenance of CSS.....	14
Recommendations	14
1. Introduction	16
1.1 Evaluation background and context	16
1.1.1 Mental health crisis	16
1.1.2 Limitations of current crisis care	16
1.1.3 Crisis Support Spaces	17
1.2 Evaluation Terms of Reference	18
2. Queensland Health’s State-wide Crisis Support Space Model	19
2.1 Key service features	19
2.2 Anticipated service outcomes	19
2.3 Service values and principles.....	19
2.4 Suitability for referral to CSS	20
2.5 Access pathways.....	20
2.6 CSS workforce	20
3. Methodology	22
3.1 Co-designing the evaluation	22



3.1.1	CSS Evaluation Steering Group	22
3.1.2	Lived experience co-researchers	22
3.1.3	CSS site visits.....	22
3.2	Evaluation framework.....	22
3.2.1	Socioecological Model.....	23
3.2.2	RE-AIM Framework	23
3.2.3	Multi-site approach.....	24
3.2.4	Key evaluation questions.....	24
3.3	Data sources	25
3.3.1	Document review	25
3.3.2	Quantitative data	25
3.3.3	Semi-structured interviews	26
3.4	Data analysis.....	28
3.4.1	Quantitative data	28
3.4.2	Semi-structured interviews	29
3.5	Ethics and research governance.....	29
3.6	Strengths of methodology	29
3.7	Limitations to methodology.....	30
4.	Consumer reach of CSS.....	31
4.1	Demographic characteristics of CSS consumers.....	31
4.1.1	Age and sex.....	31
4.1.2	Cultural background	32
4.1.3	Educational attainment.....	33
4.1.4	Income source	33
4.2	Presentation details of CSS consumers	34
4.2.1	Mental health diagnosis.....	34
4.2.2	Reason for presentation.....	35
4.2.3	Referral source	36
4.3	Proportion and representativeness of consumers reached by CSS	36
4.4	Factors impacting consumer reach	38
4.4.1	Referral pathways into CSS.....	38
4.4.2	Referrer awareness of CSS	38
4.4.3	Referrer buy-in and support for CSS.....	39
4.4.4	CSS opening hours	40
4.4.5	Consumer access to transport.....	40



4.4.6	Consumer awareness of CSS.....	41
4.5	Repeat presenters	41
4.6	Appropriateness of presentations to CSS.....	44
4.7	Summary of findings.....	45
5.	Health service adoption of CSS	46
5.1	Setting-up the CSS	46
5.2	Buy-in for CSS from ED and HHS staff	47
5.3	Referral numbers to the CSS.....	48
5.4	Summary of findings.....	50
6.	Health service implementation of CSS	51
6.1	Variability in service delivery across sites	51
6.1.1	Source of peer-worker employment	55
6.1.2	Referral pathways.....	55
6.1.3	Interventions, supports and activities provided.....	56
6.1.4	Data collection	57
6.2	Recent changes to Service Model.....	58
6.2.1	Expansion in operating hours	58
6.2.2	Accepting referrals for youth.....	59
6.3	Factors impacting implementation and sustainability of CSS.....	60
6.3.1	Staffing arrangements and capacity	60
6.3.2	CSS location and space allocation	61
6.3.3	CSS procedures, processes and scope of practice	64
6.3.4	Staff training, supervision, and support.....	64
6.3.5	Relationships between stakeholders	66
6.3.6	Funding	68
6.4	Summary of findings.....	68
7.	Effectiveness of CSS	69
7.1	Impact on psychological distress.....	69
7.2	Impact on ED presentations.....	72
7.3	Impact on ED length of stay	74
7.4	Impact on inpatient admissions.....	75
7.5	Impact on consumer experience with crisis support care	77
7.5.1	Consumer satisfaction with CSS.....	77
7.5.2	Comparison of CSS experience to ED.....	79
7.6	Impact on consumer access to crisis support care	79



7.7	Impacts for carers	80
7.8	Summary of findings.....	81
8.	Maintenance of CSS.....	83
8.1	Impact on consumers' and carers' knowledge and skills.....	83
8.2	Summary of findings.....	84
9.	Recommendations	85
	References.....	92
	Appendix A: Review of global and national models of Crisis Support Spaces	95
	Safe Haven Café, Aldershot UK	95
	St Vincent's Safe Haven Café, Melbourne Australia	96
	The Living Room, Illinois USA.....	96
	Community Crisis Intervention Service, Northern Ireland UK	97
	Dial House, Leeds UK.....	97
	Safe Spaces, Brisbane Australia	97
	Reflection on methodologies	98
	Summary of findings	98
	Appendix B: Steering Group Membership.....	99
	Appendix C: Reach population estimate criteria	101
	Appendix D: Program Logic Model.....	103



List of Tables

Table 1 Overview of the pilot Crisis Support Spaces in Queensland.....	18
Table 2 Definitions of the RE-AIM domains as applied to the state-wide CSS model evaluation.....	23
Table 3 Key evaluation questions mapped against data sources.....	24
Table 4 Overview of state-wide quantitative data sources utilised in the evaluation.	26
Table 5 Demographic characteristics of consumer and carer interview participants.....	27
Table 6 Employment roles of staff and stakeholder interview participants.	28
Table 7 The 10 most common ICD-10 mental health diagnoses of CSS consumers (n = 1,354).	34
Table 8 Chi-square tests comparing demographic characteristics of ED-referred CSS consumers with the potentially eligible ED population.	37
Table 9 Overview of local site's implementation of the CSS model.	52
Table 10 Operating hours of the CSS sites.....	58
Table 11 Within-groups t-test of change in SUDS score from pre- to post- CSS visit.	69
Table 12 Within-groups t-test of change in number of ED presentations from 6-months pre- to post- initial CSS visit.	72
Table 13 Independent samples t-test of difference in ED length of stay for times in which the CSS was opened vs. closed.....	74
Table 14 Within-groups t-test of change in acute inpatient service episodes in the 6-months pre- and post- initial CSS visit.	76
Table 15 Mapping of 'key ingredients' against the CSS outcomes through which they impact change.....	82
Table 16 Detailed recommendations for the future enhancement of the CSS in Queensland.....	85
Table 17 Parameters used to determine the population of individuals presenting to ED who may have potentially been eligible for referral to CSS.....	101
Table 18 Definitions of program logic model elements.	103

List of Figures

Figure 1 Interactions between the micro, meso and macros levels in the state-wide CSS model.....	23
Figure 2 Frequency distribution of age group of CSS consumers (n =2,227).	31
Figure 3 Frequency distribution of sex of CSS consumers (n = 2,227).	32
Figure 4 Frequency distribution of Indigenous status of CSS consumers (n = 2,227).	32
Figure 5 Frequency distribution of highest level of education attained by CSS consumers (n = 2,227).....	33
Figure 6 Frequency distribution of primary income source of CSS consumers (n = 2,227).....	33
Figure 7 Prevalence of ICD-10 mental health diagnosis code groupings for CSS consumers (n = 1,354).	34
Figure 8 Frequency distribution of referral source for initial and subsequent CSS presentations.	36
Figure 9 Number of presentations to the CSS per consumer.....	42
Figure 10 Proportion of services delivered to repeat presenters CSS.	43
Figure 11 Number of visits to the CSS per month from 23/01/2021 to 30/10/2023.	48
Figure 12 Number of consumers accessing CSS per month from 23/10/2021 to 30/10/2023.	49
Figure 13 Distribution of change in SUDS scores at post- CSS (inclusive of all visits to CSS).	70
Figure 14 Distribution of change in SUDS scores at post-CSS (inclusive of initial visits to CSS).	70
Figure 15 Distribution of ED length of stay when CSS opened vs. closed.	75
Figure 16 Distribution of change in acute inpatient service episodes (inclusive of consumers with at least one inpatient admission in 6-months prior to initial CSS visit).	76
Figure 17 Program logic model for Queensland's state-wide Crisis Support Space model.....	104



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Acronyms

Acronym	Definition
ACT	Acute Care Team
CALD	Culturally and Linguistically Diverse
CI	Confidence Interval
CIMHA	Consumer Integrated Mental Health and Addiction
CSS	Crisis Support Space
CYMHS	Child and Youth Mental Health Service
ED	Emergency Department
EDC	Emergency Data Collection
EEA	Emergency Examination Authority
EDIS	Emergency Department Information System
FTE	Full-time equivalent
GP	General Practitioner
HHS	Hospital and Health Service
HREC	Human Research Ethics Committee
ICD-10	International Classification of Diseases – 10 th Revision
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual
MHAODB	Mental Health, Alcohol and Other Drugs Branch
NGO	Non-Government Organisation
PICF	Participant Information and Consent Form
PHA	Public Health Act
PHN	Primary Health Network
RE-AIM	Reach, Effectiveness, Adoption, Implementation, Maintenance
SEM	Socioecological Model
SSA	Site Specific Assessment
SUDS	Subjective Units of Distress Scale
QAS-CORE	Queensland Ambulance Service – Co-responder
QCMHR	Queensland Centre for Mental Health Research
UQ	The University of Queensland



Glossary

Term	Definition
RE-AIM Framework	The RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework provides a practical means of evaluating health interventions. This framework was developed by Glasgow et al. (1999).
Socioecological Model	The Socioecological Model is a framework put in place to understand the multifaceted levels within a society and how individuals and the environment interact within a social system. It was initially developed by Bronfenbrenner (1989).
Thematic Analysis	Thematic analysis is an approach to qualitative data analysis that facilitates the identification and analysis of patterns or themes in a given data set.



Executive Summary

Background

Crisis Support Spaces

Demand for acute mental health services in Queensland has increased over the last decade. This, in addition to a lack of alternative options for individuals experiencing mental distress and/or suicidality, has resulted in an increase in Emergency Department (ED) presentations for mental health crisis. It is widely acknowledged that EDs are not well-suited for many people who are experiencing a mental health crisis, given the nature of the ED environment and the often limited expertise among ED staff in managing mental health needs, contributing to increased consumer¹ distress. Many consumers do not need the services provided by an ED, but often do not have anywhere else to seek assistance or know where to find it.

In response to these issues, the Queensland Government allocated \$10.8 million to Queensland Health over four years (2019-20 to 2022-23) to establish and operate eight Crisis Support Spaces (CSS). The CSS provide a combination of short-term peer and clinical support to people experiencing mental distress and/or suicidality in a what is expected to be a warm and welcoming 'home like' environment. Seven are located on hospital campuses, typically operate out-of-hours, and are intended to provide an appropriate alternative to presenting to ED. The service aims to improve the consumer experience of, and access to, crisis care; prevent avoidable ED presentations and inpatient admissions; and reduce the length of stay in ED.

More recently, expansion of the state-wide CSS was confirmed through Queensland Health's release of *Better Care Together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027* (Queensland Health, 2022b). Under this new strategy, funds have been allocated through the 2022/2023 State Budget to extend the operating hours for the existing CSS and to establish 11 additional CSS in new sites across Queensland.

Evaluation objectives

Queensland Health's Mental Health, Alcohol and Other Drugs Branch (MHAODB) commissioned the Queensland Centre for Mental Health Research (QCMHR) to conduct an independent evaluation of Queensland Health's CSS model. The specific terms of reference were to:

1. **Co-design an evaluation framework** to evaluate the state-wide CSS model; and
2. **Co-produce an evaluation** that assesses the implementation and outcomes of the state-wide CSS model and informs recommendations regarding the future design, delivery, and sustainability of the service.

Evaluation methodology

The evaluation was informed by the RE-AIM Framework (which assesses the Reach, Effectiveness, Adoption, Implementation and Maintenance of programs) and the Socioecological Model. Data were collected from the seven hospital-based pilot CSS sites across Queensland (located in the following hospitals and HHSs: Cairns Hospital (Cairns & Hinterland HHS), Hervey Bay Hospital (Wide Bay HHS), Ipswich Hospital (West Moreton HHS), Mackay Base Hospital (Mackay HHS), The Prince Charles Hospital (Metro North HHS), The Princess Alexandra Hospital (Metro South HHS) and Townsville University Hospital (Townsville HHS). The evaluation was conducted with guidance from

¹ The CSS service typically uses the term 'visitor' to refer to individuals who utilise the service for themselves. For the purpose of this report, the term 'consumer' has been used instead to enable distinction between those visitors who use the service for their own needs, and their carers who accompany them.



a Steering Group comprised of stakeholders involved in the delivery of the CSS in Queensland and included lived experience representation from mental health service consumers and carers.

Multiple data sources and methodologies were employed to answer the evaluation's key lines of enquiry, including:

- **Document review** of the state-wide and local CSS Service Guidelines;
- **Site visits** to the seven hospital-based CSS pilot sites in Queensland;
- **Semi-structured interviews** with consumers and carers who had accessed a CSS (n = 32), CSS staff (n = 29), referring HHS staff (n = 10), and broader staff/ stakeholders (n = 7); and
- **Quantitative data** from Queensland Health's Consumer Integrated Mental Health and Addiction (CIMHA) and Emergency Data Collection (EDC) datasets.

A key strength of this evaluation is that it utilised a robust, mixed-methods research methodology to deliver high-quality findings to Queensland Health regarding the effectiveness of the CSS model; and contributes high-quality evidence to the broader crisis support service literature. Indeed, the present evaluation is the first research to analyse quantitative data on ED presentations, ED length of stay and inpatient admissions to understand the actual impacts of CSS on these intended outcomes (as opposed to relying on consumer self-reported behaviour). In addition, it is the first research to undertake semi-structured interviews with a large sample of service consumers, staff and stakeholders to understand their views and experiences relating to the outcomes and implementation of the service.

The evaluation was undertaken from January 2022 to June 2024; a large portion of this time period coincided with the early, pilot phase of the CSS' implementation (occurring from October 2020 to June 2023). CSS referral pathways, service processes and broader operations evolved during the evaluation period; and will have continued to evolve beyond the evaluation's end-point. Therefore, the findings of this work reflect this snapshot in time of the service's implementation.

Summary of Findings

KEY TAKEAWAYS

- ❖ **Enhanced experience of crisis care:** Consumers have a positive service experience when accessing the CSS and find it a more helpful and safer environment than going to ED.
- ❖ **Reduced psychological distress:** The CSS is helping consumers to feel better emotionally at their end of their visit.
- ❖ **Reduced ED presentations:** The CSS may be having a small impact on reducing the number of times that consumers present to the ED for mental health care.
- ❖ **Reduced length of stay:** The CSS is helping to make the wait times in the ED shorter for those people who need mental health care.
- ❖ **Reduced inpatient admissions:** The CSS is helping to prevent consumers from needing an inpatient admission.

Consumer reach of CSS

- 1 in 5 potentially eligible individuals who present to the ED are reached by the CSS. There are some groups of consumers who are less likely to be reached, including males, middle-aged and older adults, Aboriginal and Torres Strait Islander peoples, and individuals from Culturally and Linguistically Diverse (CALD) backgrounds.



- Consumers are typically representative of the target group whom the service is intended for, with staff reporting that most of those presenting to the service report suicidal ideation, thoughts of self-harm, complex psychosocial issues and situational crisis causing significant distress.
- Two-thirds of consumers (68%) access the CSS on only one occasion. However, a small group of consumers (~5%) use the service very frequently and a large portion of overall service delivery is being delivered to repeat attendees of the CSS.
- Key factors impacting the reach of the CSS are referrer and consumer awareness of the CSS, referrer buy-in and support for the CSS, referral pathways into the CSS, and the service's opening hours. Areas for improvement were identified across each of these domains.

Health service adoption of CSS

- Co-designing the CSS with consumer representatives, peer-workers and community organisations is of significant importance when establishing the service and to ensure that service design and implementation is aligned with consumer needs.
- Buy-in and support for the CSS from referring ED and HHS staff was initially limited but has improved over time as CSS staff have made concerted efforts to educate referring teams about the value and nature of the service and built strong working relationships with these teams.
- Data show a steady increase over time in the number of consumers accessing the CSS and the number of services delivered. This trend is reflective of the services becoming more established, the expansion in operating hours, and improved awareness and buy-in for the service among referring teams.

Health service implementation of CSS

- The implementation of the CSS is relatively consistent across sites, however some variations were identified in the source of peer workforce employment, referral pathways, types of supports and activities offered, and the data collected by sites.
- The evaluation identified several factors which are critical to successful implementation and sustainability of the CSS including sufficient workforce capacity; adequate staff training and supervision; appropriate CSS space allocation; quality relationships between stakeholders; and clear procedures, policies, and scope of practice. Gaps and areas for improvement were identified across several of these factors.

Effectiveness of CSS

- Interviews with consumers and carers showed that the CSS has enhanced their experience of crisis support care, with the majority highly satisfied with their experience of the service. Furthermore, consumers and carers consistently reported that the CSS provides a more appropriate option for crisis support than the ED.
- Emerging evidence from the interview findings suggests the CSS has enhanced consumers' access to crisis support care and is meeting a core gap in out-of-hours crisis support.



- The interviews undertaken with carers indicate that the CSS provides valued support for carers, which helps them to maintain their own mental health and wellbeing while caring for a loved one experiencing mental health concerns.
- The CSS is effective at reducing consumers' experience of psychological distress, with consumers' experiencing a statistically significant and large reduction in their Subjective Units of Distress scale scores (average change of -2.86 points) from pre- to post- their visit to CSS.
- There is emerging evidence that the CSS may be helping to reduce the number of mental health presentations to the ED for those consumers with a history of presenting to ED. A small, but statistically significant reduction was observed in the number of times these consumers presented to the ED with a primary diagnosis of mental illness, suicidality and/or self-harm (average change of -0.35 visits) in the 6-month period following their initial visit to the CSS when compared to the 6-month period prior.
- Findings suggest that the CSS may be helping to reduce ED wait times, with the average length of stay in ED for consumers with a mental health presentation being statistically significantly shorter (average difference of -24 minutes) during times in which the CSS was open compared to when it was closed.
- The CSS may be helping to prevent avoidable inpatient admissions; those consumers with a history of inpatient admissions had a statistically significant and large reduction in their number of inpatient admissions (average change of -1 acute service episode) in the 6-month period following their first visit to CSS in comparison to the 6-month period prior.
- Interview data suggest several 'key ingredients' underpinning the effectiveness of the CSS, including the nature of the CSS environment, talking to peer-workers with lived experience, the interventions and supports provided (e.g., safety planning, distraction techniques), the person-centred approach to care, the referral pathways into the service, the service's opening hours, and service's visitor capacity (i.e., the number of consumers the service can host at a given time while open).

Maintenance of CSS

- Interview data indicates that CSS is helping consumers to develop knowledge and skills that they use to manage their mental health and prevent them from escalating to the point at which they experience crisis. In addition, carers learnt techniques at the CSS which they then used to support a loved one experiencing mental health crisis.

Recommendations

1. Provide ongoing and regular education about the CSS to referring staff.
2. Continue to build positive working relationships with referring teams.
3. Explore opportunities to further expand the operating hours of the CSS.
4. Identify and implement local strategies for increasing presentations to the CSS from under-represented



groups of consumers (e.g., Aboriginal and Torres Strait Islander peoples and individuals from CALD backgrounds).

5. Develop appropriate support pathways to accommodate the needs of 'repeat presenters' to the CSS.
6. Explore opportunities to increase the number of guests the CSS can host at a time during opening hours
7. Ensure the physical spaces allocated to CSS sites are fit-for-purpose.
8. Review current staffing arrangements to identify workforce barriers, enablers and solutions.
9. Develop and implement a set of standards outlining minimum training requirements for CSS staff.
10. Clearly define the scope of practice for the CSS workforce.
11. Develop and implement supervision models that are consistent with best practice.
12. Establish and implement a standardised set of data indicators across CSS sites to enhance state-wide evaluation and monitoring capabilities.
13. Commission an economic evaluation of the state-wide CSS to understand its' cost-effectiveness and cost-utility.
14. Undertake further service experience research using a representative sample of CSS consumers and carers.



1. Introduction

1.1 Evaluation background and context

1.1.1 Mental health crisis

The most recent National Study of Mental Health and Wellbeing (2020-2021) showed that among Australians aged 16-85 years, one in five experienced mental illness in the previous year, and more than two in five had experienced a mental illness during their lifetime. The most common mental illnesses were anxiety disorders (16.8%), mood-affective disorders, including depression and bipolar (7.5%) and substance use disorders (3.3%) (Australian Bureau of Statistics, 2022). In Australia, it is estimated that the economic cost of mental illness is approximately \$200-220 billion per year (Australian Government Productivity Commission, 2020).

A mental health crisis can be described as when the thoughts and behaviours arising from an individual's mental disorder or situational life crisis prevent them from functioning or indicate that they might harm themselves or others. Mental health crises are transient and are not only triggered by mental disorders but also by stressful life events which may occur throughout an individual's lifespan (Caplan et al., 2000). A Cochrane review of the literature noted that when exposed to excessive stress, coping skills or tools can break down, leading to mental health crisis and a possible emergency situation (Murphy et al., 2015). When mental health crises become an emergency, this can lead to physical self-harm and/or an attempt/death by suicide.

Potential stressors that may trigger a mental health crisis vary widely and include grief and loss, traumatic events, feeling alone or without a support system, discrimination, and precarity of employment and accommodation (National Alliance on Mental Illness, 2018). With environmental, economic, and social challenges, natural disasters, as well as the recent COVID-19 pandemic, the mental health and wellbeing of Queenslanders is being challenged across many fronts. Consequently, the burden of mental illness and demand for mental health crisis care has increased and placed significant pressure on emergency services, emergency departments (EDs) and state-funded mental health services (Queensland Health, 2022a).

1.1.2 Limitations of current crisis care

EDs are the main pathway within the health system for individuals seeking care for acute mental health crisis. In 2020-21, 3.5% of all presentations to public Australian EDs were mental health related (Australian Institute of Health and Welfare, 2023). EDs have been experiencing rising numbers of visitor presentations and admissions due to mental health crisis, which alongside limited inpatient bed capacity, contributes to service access block (Duggan et al., 2020) or ED boarding (Nordstrom et al., 2019). This occurs when multiple visitors who need to be admitted to a hospital inpatient unit are delayed for at least eight hours from leaving EDs. These delays, combined with staff whose clinical expertise sit outside of mental health, and the tension of a busy ED environment, are associated with significantly poorer clinical outcomes for visitors presenting at ED with mental health crisis (Broadbent et al., 2014; Duggan et al., 2020; Judkins et al., 2019).

Another factor that plays an important role in increasing the pressure on EDs is that mental health-related calls to emergency numbers are transferred to police and ambulance services, who are the default mental health first responders, both in Australia and globally, and typically transport people in crisis to EDs (Every-Palmer et al., 2022). In Queensland, almost all (96%) individuals who had a suicide related contact with police or paramedics also had contact with an ED. However, often these first responders are not trained to provide mental health first aid, which



can lead to the use of force and, additional stress and trauma to the person in crisis (Queensland Forensic Mental Health Service, 2020).

This reliance on EDs and police has been found to be less effective and more expensive than community-based mental health crisis intervention models of care (Queensland Government Mental Health Select Committee, 2022). Furthermore, up to 20% of all mental health presentations at EDs in Queensland are repeat presentations, which suggests that the care provided in these spaces may not be sufficient to address more complex issues underlying mental health crisis support, including biological, psychological, social, cultural, and spiritual factors (Meehan et al., 2021).

A systematic review by Sacre et al. (2022) examined the experiences of people attending EDs for mental health crisis and found that the environment was perceived as inappropriate and a contributing factor to increased distress. Visitors often describe the ED environment as overstimulating, unwelcoming, hurried, frightening, and intimidating, whilst also associated with unpleasant smells, noisy equipment, and excessively bright lighting that some visitors found distressing (Harris et al., 2016). In addition, these spaces are often not culturally appropriate, which is important when considering the needs of Aboriginal and Torres Strait Islander peoples, whose suicide rates are more than double the rate of other Australians (Australian Government Productivity Commission, 2020). People attending ED for a mental health crisis also reported experiences of being stigmatized, with a lack of compassion and flexibility in treatment approaches associated with an exacerbation in symptoms (Sacre et al., 2022).

In addition to EDs not being an ideal place for people in mental health crisis, some individuals do not need the services provided by the ED, but often do not have anywhere else to seek assistance nor know where to find it (Queensland Government Mental Health Select Committee, 2022). Furthermore, half of the people in Queensland with mental health crises who accessed an ED during their crisis and were discharged without being admitted, did not have any follow-up or receive referrals after discharge and some attempted suicide, or suicided, after discharge (Kaine & Lawn, 2021).

1.1.3 Crisis Support Spaces

In response to these issues, the Queensland Government allocated \$61.9 million to Queensland Health over four years (2019-20 to 2022-23) as part of the 2019/20 State Budget to deliver key initiatives that will drive crisis system reform and support the implementation of *Shifting Minds: Queensland Mental Alcohol and Other Drugs Strategy Plan 2018-2023* (Queensland Mental Health Commission, 2018; Queensland Treasury, 2019). This allocation included an investment of \$10.8 million to establish and operate eight Crisis Support Spaces (CSS) to provide support for adults experiencing mental health crisis and/or suicidality.

The CSS are based on the successful experiences of the “*Safe Haven Café*” model from Aldershot in the United Kingdom and Saint Vincent’s hospital-based model that has been implemented in Melbourne, Victoria (a review of these models is presented in Appendix A). The CSS model consists of a peer-led environment for people experiencing mental health crisis, where trained mental health professionals and peer workers are available for supportive conversations or professional help if required. These services generally operate out-of-hours, which is when the mental health crisis demand at EDs is typically higher. They are designed to be warm, culturally respectful environments based on a person-centred approach to care where the person experiencing a mental health crisis is the focus of service delivery and aim to provide an appropriate alternative to presenting to ED.

The CSS aims to enable better access to mental health crisis services for adults aged 18 years and over who are experiencing mental distress and/or suicidality, including where substance use is part of these presentations, and where recovery is better supported through an alternative/adjunct setting to the ED. These services seek to prevent ED presentations and/or inpatient admissions to an acute mental health unit when alternative/adjunct support is



required that can be provided in a complementary service to the ED. Queensland's state-wide CSS model has been trialled for proof-of-concept in eight locations across Queensland (see Table 1).

Table 1 | Overview of the eight pilot Crisis Support Spaces in Queensland.

HHS	Crisis Support Space Name	Hospital	Affiliated NGO	Commenced operations
Cairns and Hinterland	Crisis Support Space	Cairns Hospital	Mind Australia	February 2021
Gold Coast	Mental Health Safe Space	N/A	Primary and Community Care Services (PCCS)	October 2021
Mackay	The Space	Mackay Base Hospital	Mind Australia	December 2020
Metro North	Safe Space	The Prince Charles Hospital	N/A	January 2021
Metro South	Crisis Support Space	The Princess Alexandra Hospital	BrookRED	April 2021
Townsville	Wadda Mooli – The Welcome Space	Townsville University Hospital	Selectability	June 2022
West Moreton	Emu Café	Ipswich Hospital	Richmond Fellowship Queensland (RFQ)	September 2021
Wide Bay	The Oasis	Hervey Bay Hospital	N/A	February 2022

More recently, expansion of the state-wide CSS was confirmed through Queensland Health's release of *Better Care Together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027* (Queensland Health, 2022b). Under this new strategy, funds have been allocated through the 2022/2023 State Budget to extend the operating hours for the eight existing CSS and to establish 11 additional CSS in new sites across Queensland.

1.2 Evaluation Terms of Reference

Queensland Health's Mental Health, Alcohol and Other Drugs Branch (MHAODB) commissioned the Queensland Centre for Mental Health Research (QCMHR) to undertake an independent evaluation of Queensland Health's CSS model. The specific terms of reference were to:

1. Co-design an evaluation framework to evaluate the state-wide CSS model; and
2. Co-produce an evaluation that assesses the implementation and outcomes of the state-wide CSS model, drawing upon data from the seven hospital-based pilot sites ².

The rationale for undertaking this evaluation was to develop recommendations that will inform the future design, delivery, and sustainability of these services.

² The evaluation collected and analysed data from seven of eight CSS pilot sites located within the following Hospital and Health Services: Cairns & Hinterland, Mackay, Metro North, Metro South, Townsville, West Moreton, and Wide Bay. Gold Coast was not included in the evaluation as their model of service is substantially different to the other CSS.



2. Queensland Health's State-wide Crisis Support Space Model

2.1 Key service features

The CSS delivers a combination of short-term peer and clinical support to people experiencing mental distress and/or suicidality and their significant others, in a warm and welcoming 'home like' environment. Co-designed with consumers and their significant others, the state-wide CSS model is designed to be located on hospital campuses, near the ED, and operate as an alternative or adjunct service to the ED.

2.2 Anticipated service outcomes

The MHAOD Branch has identified several key outcomes which it aims to achieve in establishing the CSS across Queensland, including improved consumer experience of, and access to, crisis care, enhanced consumer outcomes; preventing avoidable ED presentations and inpatient admissions; and reducing length of stay in ED.

2.3 Service values and principles

A state-wide co-design process was undertaken to identify the value statements and key practice principles to underpin service provision of the CSS. As outlined below, the service values and principles are firmly grounded in a person-centred model of care that is centred around self-determination, autonomy, connectedness, mutual respect, empathy, and compassion.

Service values

1. Values peer-to-peer connections as being essential to healing, hope and understanding.
2. Believes that people are the experts of their life, acknowledging that seeking support is an act of self-determination.
3. Values being led by lived-experience wisdom, and the strength and diversity that these healthy partnerships can offer.
4. Values each person's unique needs and circumstances and meets them where they are at.
5. Believes that connection, compassion, kindness, and mutual respect fosters wellbeing.

Overarching practice principles

- Provide a space where people are warmly welcomed, hosted, and validated.
- Recognise and respect the universal experience of human distress along with contributing wisdoms gained from diverse knowledge bases.
- Adopt a partnering approach. People ultimately benefit when they have access to a service that is a healthy and productive partnership stemming from shared beliefs, vision, and purpose.
- Connect with people through its ability to deeply empathise, be compassionate and provide a place of safety and support.
- Meet people where they are at, providing a place to settle and transform their distress, with or without additional support.
- Uphold the rights-based principle, 'nothing about us without us' and is transparent and open in all its interactions with people.
- Provide opportunities for people to self-direct the nature of their supports. The validity of being in crisis is



solely determined by the person experiencing it.

- Actively support people to self-direct, navigate and engage with the level and types of support they may require.
- Recognise that the experience of distress can also impact significant others and seek to support their unique needs and wellbeing.
- There is an expectation that each CSS will further co-design the service with people with lived experience and staff, to ensure the service reflects the agreed values and principles.

2.4 Suitability for referral to CSS

Queensland Health's CSS are for adults (aged 18 years and older) in need of mental health crisis care and support, whose recovery is better supported through an alternative/adjunct setting to the ED. This includes people experiencing mental distress and/or suicidality; people presenting to the ED; and people accessing the service as part of a recovery/crisis/safety plan. The service is unsuitable for people presenting as agitated and/or aggressive; people presenting with delirium or dementia; people presenting with a level of intoxication that would not enable them to safely participate; and people requiring immediate medical treatment.

CSS sites may also accept referrals for young people (aged 16 and 17 years old) if this is mutually agreed by the relevant Child and Youth Mental Health Service (CYMHS), Acute Care Team (ACT), ED and the NGO provider working in the CSS; and other governance requirements are met.

2.5 Access pathways

Access to the CSS is voluntary and occurs via referral from the ED or other HHS acute and crisis care services (e.g., 1300 MH Call, ACT, Community Care Teams or co-responders). Some HHSs offer the option for individuals to self-refer to the CSS and accept referrals from other service providers (e.g., GPs, NGOs). All access to the CSS is considered from the needs perspective of the person experiencing mental distress and/or suicidality, with established referrals processes and eligibility checklists in place to support this.

CSS are expected to offer after-hours support. During the pilot phase, the sites operated on a model in which they were open 25 hours per week over 4-days (on average). The implementation of *Better Care Together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027* has seen the expansion of the service's operating hours to 7-days per week. They are now funded to operate on one of two models, determined by the volume of ED presentations at the HHS. Model 1 is open to visitors at least 45 hours per week over 7 days, while Model 2 is open to visitors at least 65 hours per week over 7 days.

2.6 CSS workforce

A key element of the CSS is that it is an environment where care is led by peer support workers and delivered in close collaboration with mental health clinicians. The partnership of peer workers and clinicians within CSS provides support for people to develop self-management skills and explore alternative support options, while also providing the option of accessing clinical mental health interventions as required. A summary of the shared and unique roles and responsibilities of peer-workers and mental health clinicians within the CSS is provided below.



Roles and responsibilities of CSS staff

Shared	<ul style="list-style-type: none">• Provide compassionate and person-centred support to consumers in crisis and their carers;• Support consumers and carers to access the space by accompanying them from the ED to CSS;• Implement sensory and other brief therapeutic interventions that are within their scope of practice;• Use empathetic dialogue to normalise and validate the situation of distress and crisis as part of life and/or coping with difficult circumstances;• Provide hope to consumers through conversations that are strengths-based, focused on accepting the current situation and identify meaningful actions and supports that the consumer can provide to themselves;• Identify what risk is to the consumer individually, and develop a meaningful safety plan that they will actually connect to and use in future times of crisis;• Encourage the consumer to self-identify their risks and to work towards managing those risks in a way that is dignifying, strengths-based and allows for collaborative support (and not just intervention); and• Support warm referrals to other support services in the community.
Peer-workers	<ul style="list-style-type: none">• Use their own lived experience to provide a positive example of recovery and support and empower people in their recovery.
Clinicians	<ul style="list-style-type: none">• Identify and facilitate suitable referrals to the CSS in consultant with ED, ACT and other referrers;• Undertake risk assessments and facilitate further review in the ED where indicated;• Facilitate referrals to specialised aftercare services, including ED and ACT if required; and• Oversee appropriate record keeping and clinical documentation.



3. Methodology

3.1 Co-designing the evaluation

To ensure that the evaluation was feasible, acceptable, and meets the needs of Queensland Health’s Mental Health, Alcohol, and Other Drugs Branch (MHAODB), the research team collaborated with several key stakeholders and experts throughout the course of the evaluation.

3.1.1 CSS Evaluation Steering Group

The research team convened a Steering Group of individuals from stakeholder groups across the delivery of CSS in Queensland (see Appendix B for Steering Group membership). The role of the CSS Evaluation Steering Group was to provide guidance to the research team as they undertook the evaluation. Members were asked to use their expertise and experience within the space of CSS and across wider mental health services in Queensland to inform, guide, reflect, and enhance the evaluation’s design, methodology (feasibility and acceptability), data collection, and findings. The CSS Evaluation Steering Group members attended and actively participated in monthly Steering Group meetings for the duration of the project.

3.1.2 Lived experience co-researchers

Four co-researchers with lived experience of mental illness and/or caring for someone with a lived experience of mental illness contributed to the co-design of the evaluation. Specifically, these co-researchers assisted with the development of the evaluation framework and questions; provided input on project documentation, including recruitment materials, interview schedules and Participant Information and Consent Forms (PICF); and reviewed the findings from the evaluation to provide a sense check and ensure face validity. They also attended the monthly Steering Group meetings and provided guidance out-of-session, as required.

3.1.3 CSS site visits

As part of the project’s stakeholder engagement work, the team embarked on site visits to each existing CSS in Queensland between August and November 2022 to meet with CSS staff. The information collected through these site visits informed logistics for conducting the evaluation at these sites, including processes for participant recruitment; and provided important context to areas such as nuances in service delivery and challenges experienced by CSS staff that were then formally captured through the semi-structured interview questions.

3.2 Evaluation framework

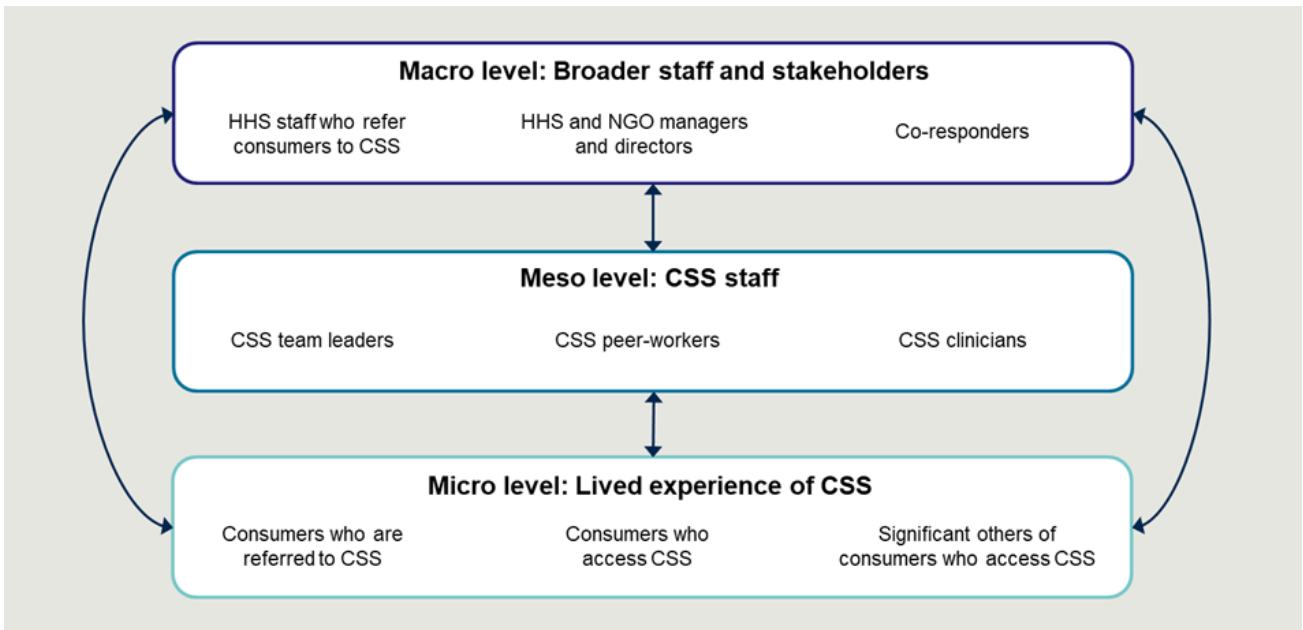
The evaluation framework was designed to enable QCMHR to undertake a mixed-methods process and outcomes evaluation of the state-wide CSS model to understand how well the model has been implemented to date, the extent to which it has achieved its intended outcomes, and how the service design and delivery can be enhanced and sustained in the future. The resulting evaluation framework drew upon the key tenets of two robust, empirically validated and widely used evaluation models: the Socioecological Model (Bronfenbrenner, 1989) and the RE-AIM framework (Glasgow et al., 1999).



3.2.1 Socioecological Model

The Socioecological Model provides a useful framework to structure interventions and evaluations through understanding how the micro-, meso- and macro- levels of a system interact with each another and their environment to work effectively (Bronfenbrenner, 1989; World Health Organization, 2002). Queensland’s CSS forms one part of a complex mental health care system for individuals within Queensland. As shown in Figure 1, the micro-level consists of individuals with lived experience of CSS; the meso-level is comprised of the CSS staff who deliver the service; and the macro-level contains broader staff and stakeholders within the health system that interact with and influence the delivery of CSS. The evaluation of the state-wide CSS model was designed to consider the complex, bi-directional interactions between each of these socio-ecological levels.

Figure 1 | Interactions between the micro, meso and macros levels in the state-wide CSS model.



3.2.2 RE-AIM Framework

The RE-AIM framework is an empirically validated and widely used model for planning and evaluating public health and community services (Glasgow et al., 2019). It provides structure and depth to evaluations by examining five key domains: Reach, Effectiveness, Adoption, Implementation and Maintenance. The RE-AIM framework complements the Socioecological Model through assessing the RE-AIM domains at the micro, meso and macro levels (Holtrop et al., 2021). An overview of the RE-AIM domains applied to the evaluation of the state-wide CSS model is provided in Table 2.

Table 2 | Definitions of the RE-AIM domains as applied to the state-wide CSS model evaluation.

RE-AIM domain	Definition
Reach	The absolute number, proportion and representativeness of individuals who are willing to participate in the CSS, and the reasons why or why not.
Effectiveness	The impact of the CSS on individual and system outcomes, including the reasons why or why not the CSS was effective.
Adoption	The extent to which staff and settings have adopted the CSS, and the reasons why or why not.



Implementation The extent to which sites have implemented the CSS model with fidelity, local adaptations that have been made to the service, and the use of implementation strategies.

Maintenance The extent to which the individual effects of the CSS are sustained, and the CSS model becomes integrated within routine mental health crisis support practices and policies across sites.

3.2.3 Multi-site approach

The evaluation framework used a multi-site approach in which quantitative and qualitative data was collected and analysed from the seven hospital-based trial sites across Queensland where the state-wide CSS model has been piloted (Straw & Herrell, 2002). To ensure that the findings were generalisable and relevant to the state-wide CSS model (rather than focused on the individual trial sites), the evaluation used a consistent set of measures across each of the trial sites to enable the data to be pooled and then analysed at the state-wide level. These data sources are described in detail in Section 3.3.

3.2.4 Key evaluation questions

The key evaluation questions that guided this research were co-designed with members of the Implementation Advisory Group and the project’s lived experience co-researchers. These key evaluation questions, mapped against the RE-AIM domains, levels of the Socioecological Model (SEM) and the data sources that were used to assess them, are presented below in Table 3.

Table 3 | Key evaluation questions mapped against data sources.

RE-AIM Domain	SEM Level	Key Evaluation Question	Data source		
			Document review	Quantitative data	Semi-structured interviews
Reach	Micro	What are the demographic characteristics of consumers?		<input checked="" type="checkbox"/>	
		What are the details of consumers’ presentation to the CSS?		<input checked="" type="checkbox"/>	
		What proportion of eligible consumers are reached by the CSS, and how representative are they of the eligible population?		<input checked="" type="checkbox"/>	
		What are the factors impacting the reach of the service?			<input checked="" type="checkbox"/>
		What proportion of consumers are repeat presentations and why are they re-presenting?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		Are CSS consumers representative of the target group?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adoption	Meso/ Macro	What are the key lessons learnt from the process of setting up the CSS across pilot sites?			<input checked="" type="checkbox"/>
		What is the extent to which there is buy-in and support for the CSS from referring ED and HHS staff, and why/ why not?			<input checked="" type="checkbox"/>
		Has there been an increase in referral numbers to the CSS over time, and why/		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



RE-AIM Domain	SEM Level	Key Evaluation Question	Data source		
			Document review	Quantitative data	Semi-structured interviews
Implementation	Meso/ Macro	why not?			
		How does the CSS function in practice, and what are the variations in service delivery across the seven pilot sites?	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
		What are the factors impacting the implementation and ongoing sustainability of the CSS?			<input checked="" type="checkbox"/>
Effectiveness	Micro/ Meso/ Macro	Has the CSS reduced consumers' experience of psychological distress, and why/ why not?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		Has the CSS improved consumers' experience of crisis support care, and why/ why not?			<input checked="" type="checkbox"/>
		What impacts has the CSS had for carers, why and how?			<input checked="" type="checkbox"/>
		Has the CSS improved consumers' access to crisis support care, and why/ why not?			<input checked="" type="checkbox"/>
		Has the CSS led to a reduction in ED presentations, and why/ why not?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		Has the CSS led to a reduction in average length of stay in ED for consumers, and why/ why not?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		Has the CSS led to a reduction in mental health admissions, and why/ why not?		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Maintenance	Micro	To what extent did consumers and carers develop knowledge and skills during their time at the CSS, and have they use these knowledge and skills since?			<input checked="" type="checkbox"/>

3.3 Data sources

3.3.1 Document review

To evaluate the implementation of the CSS, QCMHR reviewed the state-wide Service Guidelines, Model of Care documentation for each of the seven CSS sites, and monitoring and evaluation indicators collected by each site.

3.3.2 Quantitative data

To evaluate the reach, adoption and effectiveness of the CSS, de-identified individual-level quantitative data was accessed from Queensland Health's Consumer Integrated Mental Health and Addiction (CIMHA) and Emergency Data Collection (EDC) datasets for each of the seven pilot sites. CIMHA is a consumer-central clinical information system designed to support Queensland mental health, alcohol, and other drug services in the provision of safe and quality health services; and is the primary source of data for the activity of community and residential MHAOD services, clinical and consumer rated mental health outcome measures and Queensland' Mental Health Act 2016.



The EDC is a dataset of patients who have had an emergency stay at an ED in one of Queensland’s public hospitals; and collects demographic, service provision and performance information required to meet national reporting requirements. A description of the cohorts and data items that were accessed through the CIMHA and EDC data sets is provided in Table 4.

Table 4 | Overview of state-wide quantitative data sources utilised in the evaluation.

Data source	Cohort	Data items
CIMHA	All consumers aged 16+ years who accessed a CSS between 01/01/2020 and 31/10/2023.	<ul style="list-style-type: none"> • Consumer demographics at time of CSS presentation (sex, gender, date of birth, Indigenous status, income source, educational level, country of birth, preferred language, interpreter required) • Presentation details (date, treating facility, HHS) • Primary and additional ICD-10-AM mental health diagnosis at time of CSS presentation • Referrals and service episodes in the 6-months pre- and post- CSS presentation • Referral source for CSS presentation • Subjective Units of Distress Scale (SUDS) pre- and post- CSS presentation
EDC	All consumers aged 16+ years who accessed an ED with a diagnosis of mental illness, self-harm and/or suicidality (based on ICD-10 codes) between 01/07/2019 and 31/10/2023.	<ul style="list-style-type: none"> • Consumer demographics at time of ED presentation (sex, date of birth, Indigenous status, country of birth) • Primary and additional ICD-10-AM mental health diagnosis at time of ED presentation • Encounter details (presentation date and time, arrived at, triage date and time, length of stay, triage category, departure date, departure status, delivery mode, discharge/ departure date, departure reason, facility name, HHS)

3.3.3 Semi-structured interviews

To evaluate the reach, adoption, implementation, effectiveness and maintenance of the CSS, semi-structured interviews were undertaken with several participant groups, including: consumers and their carers who had accessed the CSS, CSS staff, HHS staff who refer consumers to the CSS, and broader staff and stakeholders involved in the delivery and/or management of the service. Semi-structured interviews enabled the gathering of specific information, while providing scope to explore additional lines of enquiry raised by participants.

3.3.3.1 Recruitment

Across the different groups of stakeholders, individuals were eligible to partake in an interview if they were aged 18 years or older and demonstrated capacity to consent. Consumers and carers were recruited through each of the



CSS sites, with CSS staff acting as gatekeepers. Recruitment posters and flyers advertising the evaluation were displayed at the seven hospital-based CSS locations. In addition, CSS staff informed consumers and carers of the evaluation while visiting the CSS. CSS staff were recruited via an email sent from the research team to relevant individuals who were identified by the CSS team leaders. Similarly, referring HHS staff and broader staff and stakeholders were invited to participate via an email sent by the CSS team leaders to relevant individuals they identified.

All participants provided informed consent to partake in the semi-structured interviews and completed a Participant Information and Consent Form (PICF) through the online platform Qualtrics. In addition, consumers and carers completed a demographics survey as part of this consent process.

3.3.3.2 Participant characteristics

A total of 78 interviews were completed with a convenience sample of consumers and carers who had accessed a CSS (n = 32), CSS staff (n = 29), referring HHS staff (n = 10) and broader staff/ stakeholders (n = 7). The demographic characteristics of the 32 consumers and carers who participated in the interviews is provided in Table 5. A breakdown of the roles for the staff and stakeholders that were interviewed is provided in Table 6.

Table 5 | Demographic characteristics of consumer and carer interview participants.

Characteristic	N (%)
Participant sub-group	
Consumer	27
Carer	5
Gender	
Female	19 (60%)
Male	13 (40%)
Age	
18-24	7 (22%)
25-34	7 (22%)
35-44	5 (16%)
45-54	8 (25%)
55-64	3 (9%)
65-74	0 (0%)
75-84	2 (6%)
85+	0 (0%)
LGBTQIA+	
Yes	7 (22%)
No	24 (75%)
Not stated	1 (3%)
Aboriginal and Torres Strait Islander	
Yes	0 (0%)
No	32 (100%)
Culturally and Linguistically Diverse	



Yes	2 (6%)
No	30 (94%)

Table 6 | Employment roles of staff and stakeholder interview participants.

Role	N
CSS Staff	
Team Leader	5
Clinician	10
Peer-worker	14
HHS Referring Staff	
ED Clinician	4
ACT Clinician	3
Co-responder	2
Other referring staff	1
Broader Staff/ Stakeholders	
NGO Manager	3
CSS Project Officer	1
CSS Principal Policy Officer	1
Consumer Engagement Facilitator	1
Senior Peer Coordinator	1

3.3.3.3 Interview procedure

Once informed consent was obtained, participants were contacted via phone call and/or email to organise an interview at a time and location of their convenience. Five members of the evaluation team who were experienced in qualitative research conducted the interviews, which were guided by semi-structured schedules. Participants completed the interviews either in-person (n =26), over-the-phone (n = 11) or via video conferencing (n = 41). The interviews lasted from 30 to 60 minutes, were audio-recorded, and then transcribed verbatim by a professional transcription company. Consumers and carers who participated in an interview were given a \$40 gift card as a thank you for their time.

3.4 Data analysis

3.4.1 Quantitative data

Quantitative data were analysed in R (Version 4.2.3) using the *tidyverse*, *gtsummary*, *performance* and *lmerTest* packages. Extensive data cleaning and manipulation was undertaken to transform the CIMHA and EDC data into a usable format and to compute new variables as required by the evaluation plan. Descriptive statistics (e.g.,



frequency counts, proportions, averages) were generated for demographic characteristics and presentation details. Chi-square tests were used to assess the representativeness of consumers reached by the CSS. Within-groups t-tests were run to examine pre- to post- changes in SUDS scores, ED presentations and inpatient admissions. A between-groups t-test was run to examine differences in ED length of stay when comparing the times in which the CSS was open compared to closed. Multiple regression analyses were run to explore and identify those demographic characteristics and presentation details which moderated change in SUDS scores and ED presentations. An a priori criterion of $p < .05$ was determined as the threshold for statistical significance. Effect sizes were generated to facilitate interpretation of results.

3.4.2 Semi-structured interviews

The semi-interviews were analysed in NVivo (version 14) using thematic analysis (Braun & Clarke, 2006; Guest, MacQueen & Namey, 2012). The interviews were coded independently by two QCMHR research staff (ZP and HP) who each analysed a portion of the interviews. First, a deductive approach was used to code the interview data against the key domains of the RE-AIM framework and their corresponding evaluation questions. A deductive coding framework was developed by the coders to guide this initial phase of the analysis and maintain inter-coder consistency. Second, an inductive approach was used to open-code the data within each of the RE-AIM domains and evaluation questions. This process involved generating codes to describe data content, then collating similar content into potential themes and sub-themes. The coders met to discuss and agree upon the final set of themes, which were those most cited in the data and providing the most significant information to answer the evaluation questions.

3.5 Ethics and research governance

Ethics approval was obtained from the Metro South Human Research Ethics Committee (HREC/2022/QMS/89728) and The University of Queensland Human Research Ethics Committee (2023/HE000243). Site Specific Assessments (SSAs) were obtained with each of the HHSs involved in the evaluation. Public Health Act (PHA) approval was obtained to access the CIMHA and EDC data from Queensland Health.

3.6 Strengths of methodology

A key strength of this evaluation is that it utilised a robust, mixed-methods research methodology to deliver high-quality findings to Queensland Health regarding the effectiveness of the CSS model; and contributes high-quality evidence to the broader crisis support service literature. Indeed, the evaluation framework was informed by the key tenets of two robust, empirically validated and widely used evaluation models: the Socioecological Model (Bronfenbrenner, 1989) and the RE-AIM framework (Glasgow et al., 1999). Furthermore, the evaluation framework was designed in collaboration with four co-researchers with lived experience of mental illness and/or caring for someone with a lived experience of mental illness. This approach ensured that the research asked the right questions, and collected and analysed the right data in an appropriate way.

The present evaluation is also the first research to analyse quantitative data on ED presentations, ED length of stay and inpatient admissions to understand the actual impacts of CSS on these intended outcomes (as opposed to relying on consumer self-reported behaviour like previous studies have done). Furthermore, it is the first research to undertake semi-structured interviews with a large sample of service consumers, staff and stakeholders to understand their views and experiences relating to the outcomes and implementation of the service. In light of the limitations of previous evaluations undertaken on CSS models of care (see Appendix A), the present evaluation



provides the first high-quality, mixed-methods study in this field and as such, provides a major contribution to the current evidence-base.

3.7 Limitations to methodology

There are several limitations to the evaluation data and methodology that are important to consider when reviewing the findings of this report. First, there was an absence of available, state-wide quantitative data on several key indicators that were needed to answer some of the key evaluation questions initially proposed when the first iteration of the evaluation framework was developed. These include data on referrals, consumer presentation details (e.g., reason for presentation) and consumer satisfaction. Consequently, some of the initial key evaluation questions were unable to be answered through this research, or where possible, interview data was utilised to supplement absent quantitative data. Recommendations for future data collection are provided later in the report. Those questions that could not be answered were removed from the final version of the evaluation framework.

Second, there were some issues with the quality of the state-wide quantitative data recorded in CIMHA. CSS data collection has been designed to capture 'Research Variables' using 'free-text' fields, resulting in considerable variability in how data was entered by CSS staff. This poses challenges for analysis - for both evaluation and ongoing monitoring purposes. Broader discussions with Mental Health Information Managers also indicate that the accuracy of the data entered in CIMHA is inconsistent, and cited issues where staff were frequently entering incorrect values for key indicators that were utilised in this evaluation (e.g., diagnosis code, referral source).

Third, the evaluation had lower than expected participation in the semi-structured interviews. The research completed 78 interviews, although initially planned to conduct 126 interviews (18 per site). Recruitment was challenging as appropriate consents were not in place at the CSS to enable staff to contact consumers and carers after they had left the service. This meant that recruitment opportunities were limited to those consumers and carers who physically presented to the CSS during the four-month recruitment period. In addition, staff could only invite consumers and carers to participate in an interview if they were not experiencing a heightened state of distress when accessing the CSS. This was rarely the case given the nature of the service.

Fourth, there are limitations to the representativeness of the views and experiences collected through the semi-structured interviews. The evaluation sought to interview consumers and carers from a range of cohorts. However, despite best efforts the research was unable to recruit any Aboriginal and Torres Strait Islander people or individuals who were referred to the CSS but chose not to participate in the service. In addition, carers, individuals from Culturally and Linguistically Diverse (CALD) communities and older adults (aged 65 years and older) were under-represented in the interview sample. Furthermore, all but one of the consumers who were interviewed through this evaluation were repeat presenters to the CSS - however the evaluation found that most consumers only present on one occasion to the service. Recruiting consumers who presented to the service on only one occasion was challenging, with staff reporting consumers to be in an acute state of crisis during their first visit to the service. Consequently, it is not appropriate to invite individuals to participate in research when they are experiencing an acute state of distress. The implications of this are that the qualitative findings may not be generalisable nor reflective of the overall population of CSS consumers.

Fifth, there may be a positive response bias evident in the interview data collected from consumers, carers, and staff; as CSS staff acted as gatekeepers to recruitment. Indeed, when using gatekeepers there is a risk that they may only invite people who have positive things to say about the service to participate in the evaluation. Additionally, the majority of consumers who were interviewed were repeat presenters to the CSS - who presumably are returning to the service because they have had a positive experience with the service. Therefore, the findings regarding the effectiveness of the service need to be interpreted with this limitation in mind.



4. Consumer reach of CSS

Defining and evaluating consumer reach

Reach explores the extent to which the CSS reaches the eligible population and any barriers or enablers to service reach. It considers who is accessing the service, how and why; and examines whether users are representative of the target group and if there are groups not reached by the CSS.

This section of the report answers the following key evaluation questions:

- What are the demographic characteristics of consumers?
- What are the details of consumers' presentation to the CSS?
- What proportion of eligible consumers are reached by the CSS, and how representative are they of the eligible population?
- Are consumers representative of the target group?
- What are the factors impacting the reach of the service?
- What proportion of consumers are repeat presentations, and why are they re-presenting?

4.1 Demographic characteristics of CSS consumers

4.1.1 Age and sex

The age distribution of CSS consumers is presented in Figure 2; and the sex distribution of consumers is provided in Figure 3. The data showed that just over half of CSS consumers are younger than age 35 years (56%) and the majority are female (64%).

Figure 2 | Frequency distribution of age group of CSS consumers (n =2,227).

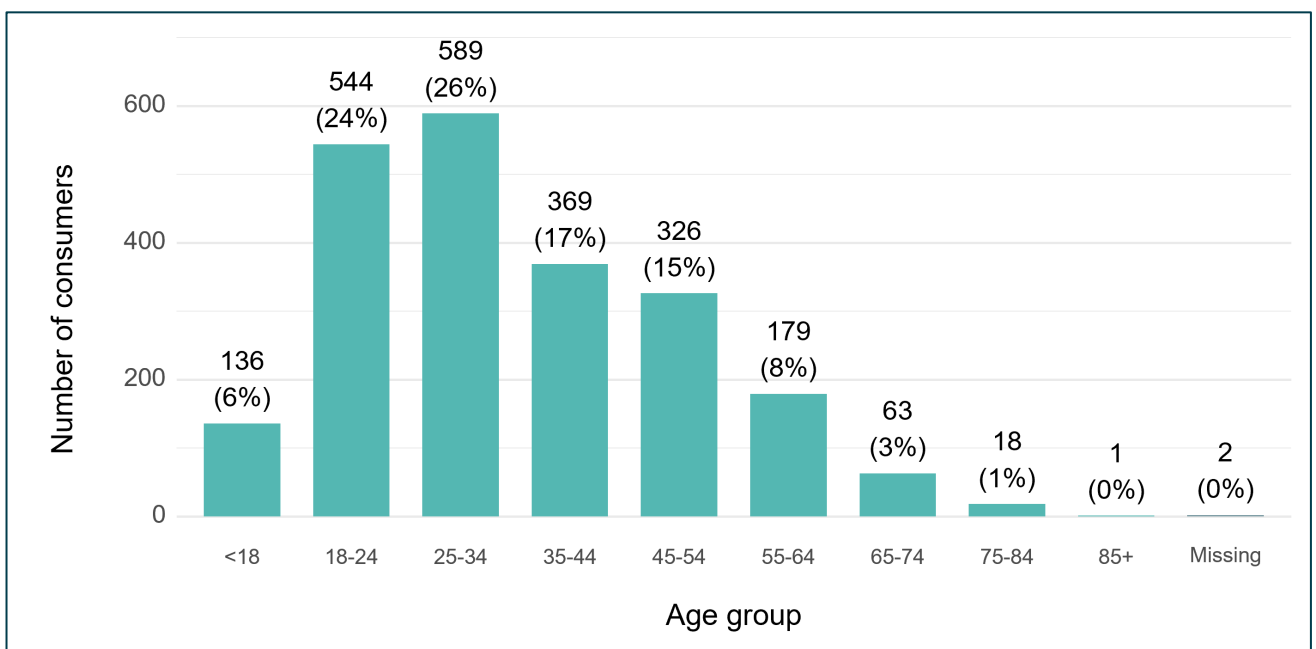
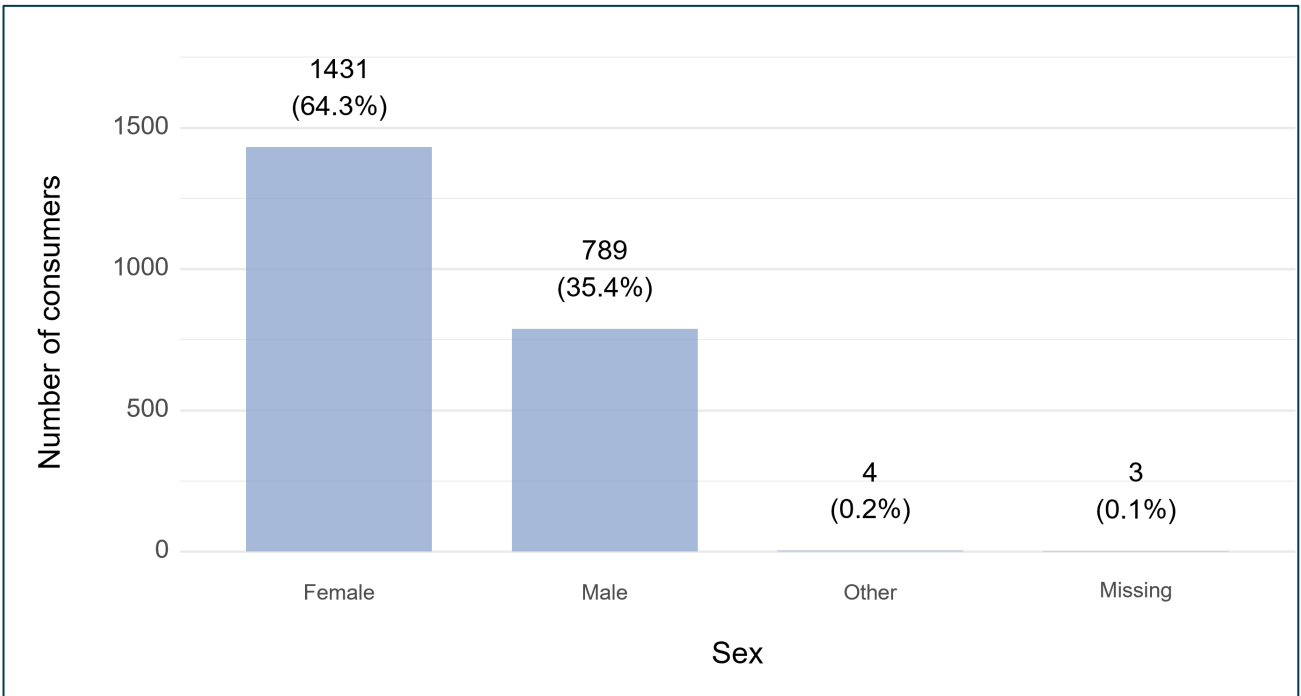




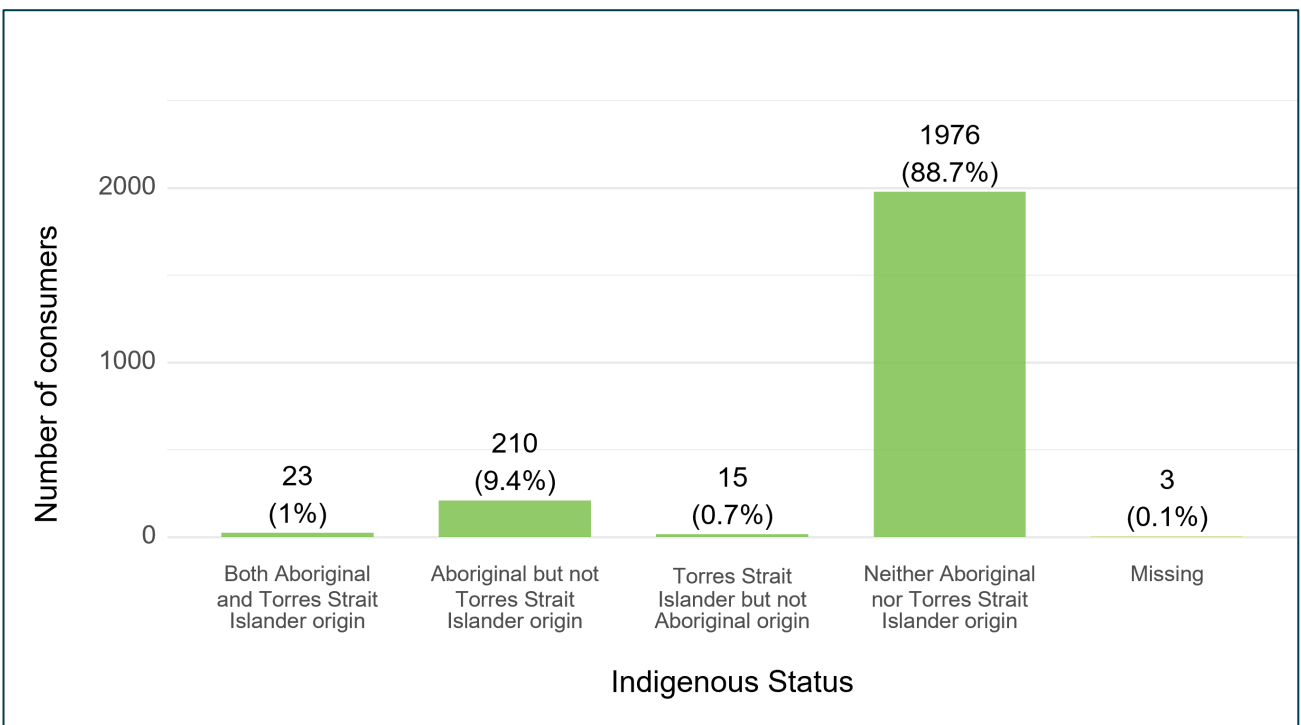
Figure 3 | Frequency distribution of sex of CSS consumers (n = 2,227).



4.1.2 Cultural background

As shown in Figure 4, 11% of CSS consumers are Aboriginal and Torres Strait Islander people. Furthermore, the data showed that 13% of consumers were from a Culturally and Linguistically Diverse (CALD) background in that they identified as having been born in a country overseas.

Figure 4 | Frequency distribution of Indigenous status of CSS consumers (n = 2,227).

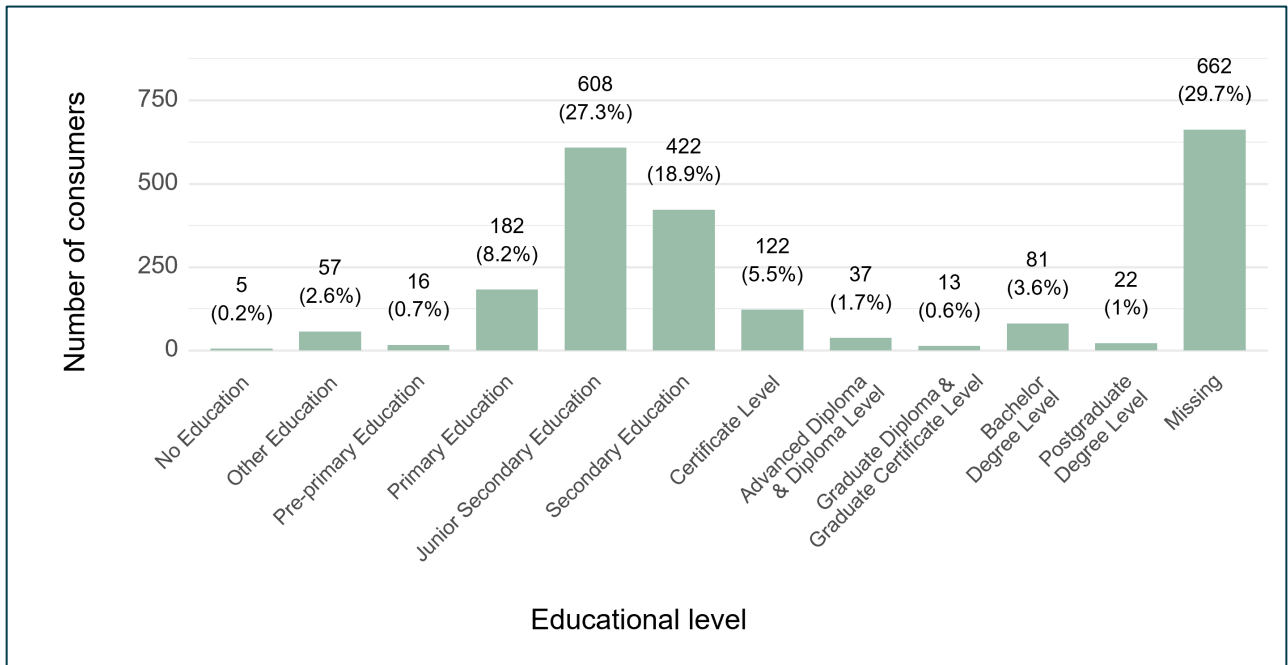




4.1.3 Educational attainment

The highest level of completed education by CSS consumers is shown in Figure 5. The data indicate that close to one-third (31%) of consumers have attained a level of education equivalent to secondary school or higher.

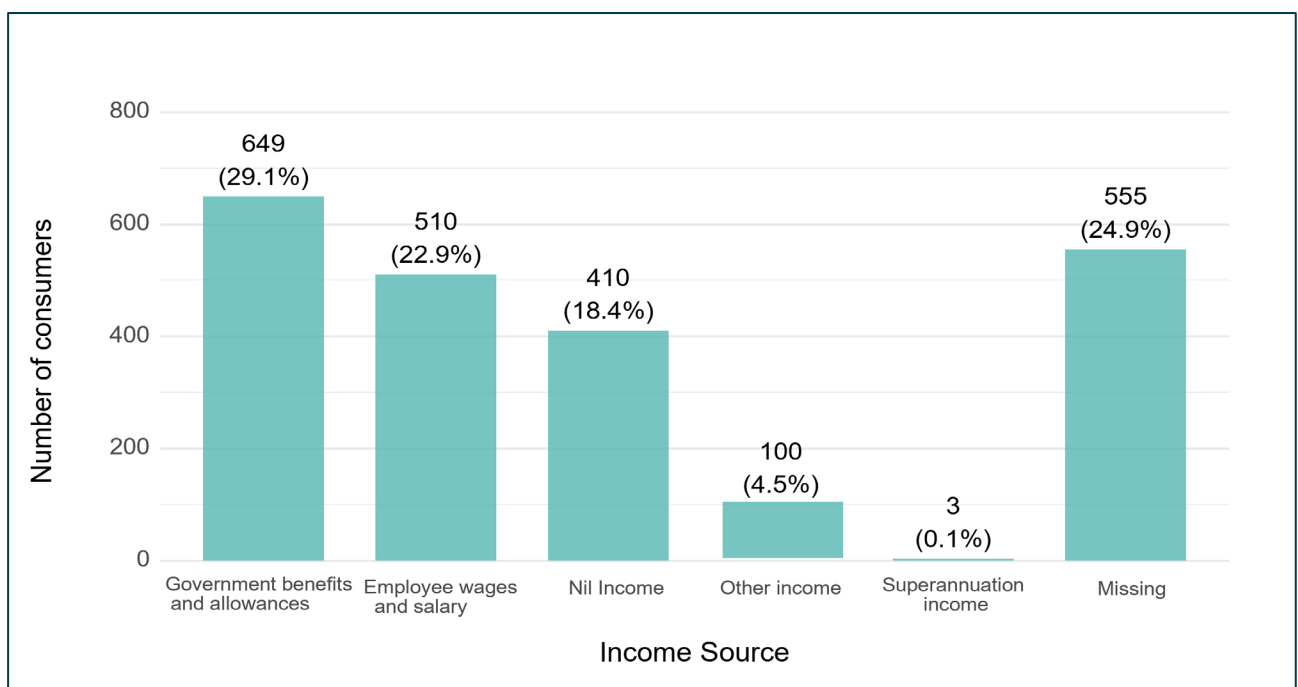
Figure 5 | Frequency distribution of highest level of education attained by CSS consumers (n = 2,227).



4.1.4 Income source

The primary income source of CSS consumers is shown in Figure 6. Nearly one-third (29%) of consumers are receiving Government benefits as their primary source of income, and a further 18% have no source of income.

Figure 6 | Frequency distribution of primary income source of CSS consumers (n = 2,227).





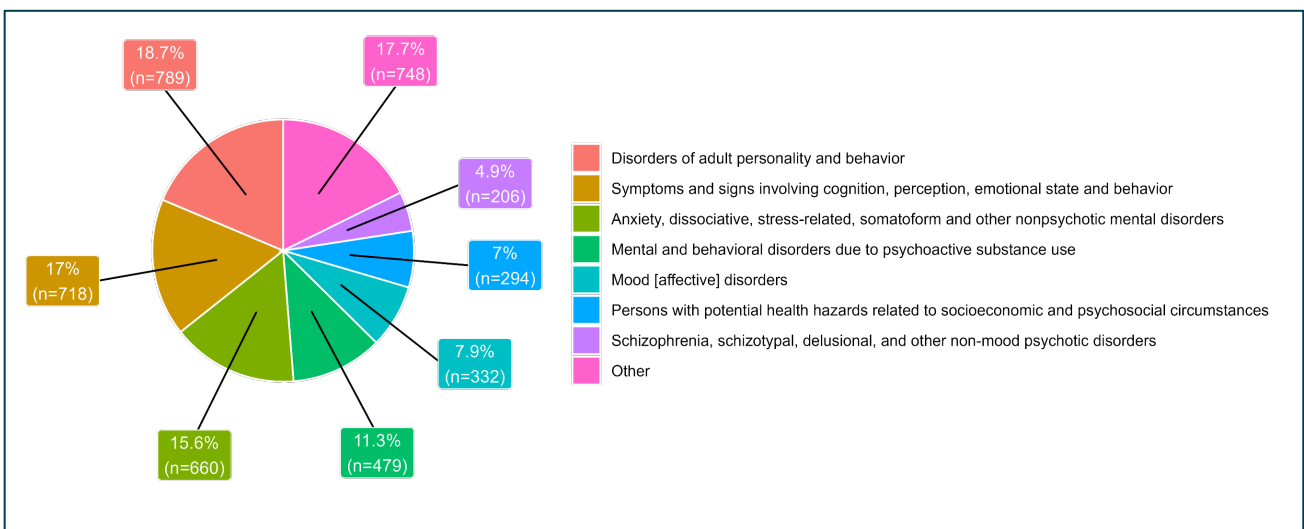
4.2 Presentation details of CSS consumers

4.2.1 Mental health diagnosis

Mental health diagnosis is not routinely entered in CIMHA at the time of a consumer’s presentation to the CSS. As a proxy measure of the consumer’s mental health diagnosis at the time of CSS presentation, the evaluation analysed the diagnosis code entered within CIMHA at the date closest to the consumers’ presentation at the CSS. Given it is possible that an individual’s reason for visiting the CSS may not be connected to the diagnosis code entered in CIMHA on an occasion most proximal to their presentation date, accuracy of this data is therefore limited.

Figure 7 shows the frequency at which CSS consumers had a diagnosis code in CIMHA that aligned with the ICD-10 mental health diagnosis code groupings. This data showed that ‘disorders of adult personality and behaviour’ and ‘symptoms and signs involving cognition, perception, emotional state and behaviour’ were the most common diagnosis code groupings.

Figure 7 | Prevalence of ICD-10 mental health diagnosis code groupings for CSS consumers (n = 1,354).



Further analysis of the specific diagnosis codes of CSS consumers showed considerable variability in these diagnoses and a large number of different diagnosis codes allocated. Table 7 below shows the top ten most common diagnosis codes for CSS consumers; with borderline personality disorder and suicidal ideation being the most prevalent.

Table 7 | The 10 most common ICD-10 mental health diagnoses of CSS consumers (n = 1,354).

Diagnosis	N	%
Emotionally unstable personality disorder, borderline type	568	13.4%
Suicidal ideation	375	8.9%
Unhappiness	287	6.8%
Adjustment disorders	186	4.4%
Post-traumatic stress disorder	133	3.1%
Emotionally unstable personality disorder	108	2.6%



Moderate depressive episode	91	2.2%
Generalised anxiety disorder	75	1.8%
Accentuation of personality traits	74	1.8%
Mental and behavioural disorders due to use of alcohol, dependence syndrome	61	1.4%

4.2.2 Reason for presentation

While data on the reason for presentation is not routinely collected, insights were possible through interviews with CSS staff and consumers. The qualitative data suggest the most common reasons consumers present to the CSS are due to suicidal ideation, thoughts of self-harm, psychosocial issues and situational crises causing distress (e.g., relationship breakdown, financial stressors). Other reasons which consumers present are mood disturbances, anxiety, and substance or alcohol abuse.

“There’s certainly a big number of presentations who have suicidal ideation or come in for those sorts of concerns. But then there’s other presentations as well, in terms of mood disturbance, depression and anxiety. But I think a big proportion of our presentations are for suicidal or self-harm concerns.” **Team Leader, Mental Health**

“The most common reason would be social stressors. At the moment there’s a lot with the cost of living and accommodation crises and all the stress that comes with just people being able to afford those basic necessities. Financial situations, stresses of those that you’re living with, family dynamics – anything that makes up the social environment of our consumers.”
Clinician, CSS

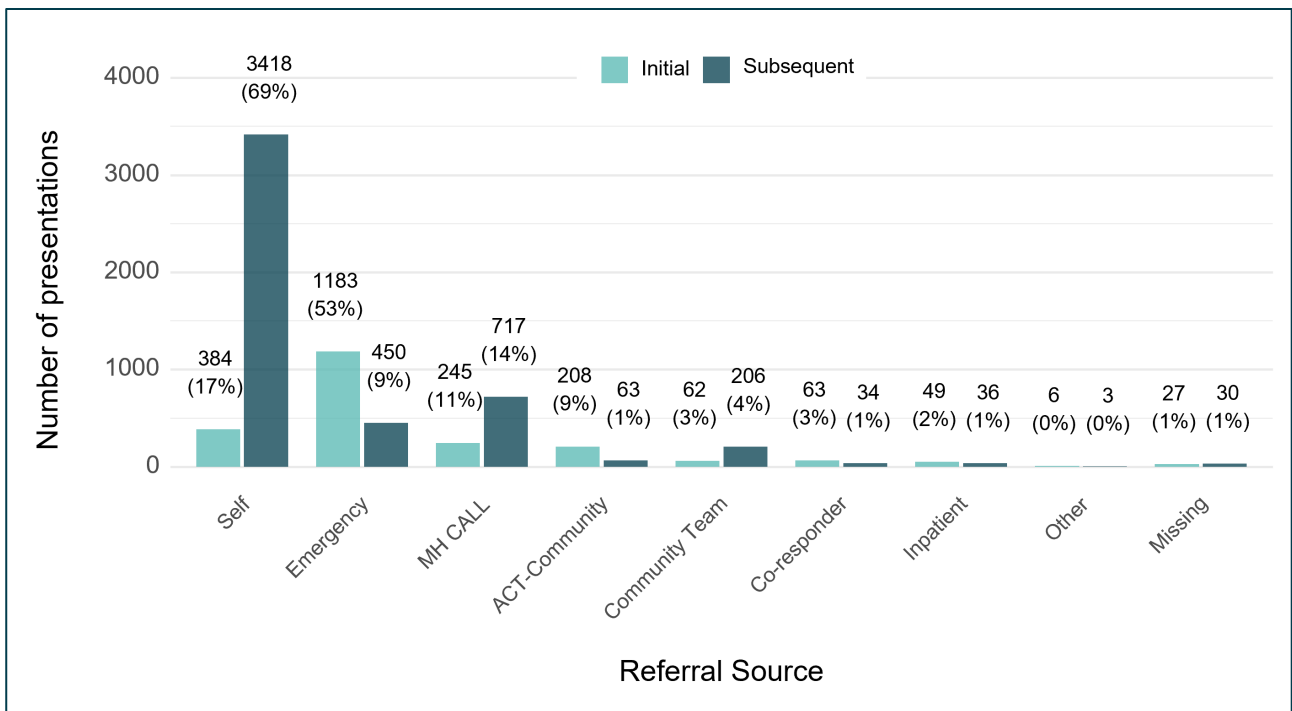
“We certainly have a huge variety in presentations. We have some who self-harm severely. Then we have people who may be struggling with bipolar, like elevated mood. We also have people who are feeling suicidal. We also have people who have drug addictions, so they’ll come in as well, but we don’t deal with them when they’re intoxicated. Then we have people who might have alcohol issues.” **Clinician, CSS**



4.2.3 Referral source

Figure 8 provides an overview of the referral source through which consumers accessed the CSS on their initial and subsequent visits. For consumers' first presentation at the CSS, the ED referral pathway is most common (53% of consumer presentations), while for subsequent presentations to the CSS it is the self-referral pathway that is most common (69% of consumer presentations).

Figure 8 | Frequency distribution of referral source for initial and subsequent CSS presentations.



4.3 Proportion and representativeness of consumers reached by CSS

To determine the proportion and representativeness of consumers reached by the CSS, the evaluation compared the number and demographic characteristics (age, sex, Indigenous status, country of birth) of consumers who accessed the CSS that were referred from the ED (n = 1,177) to those consumers who presented to the ED who may have potentially been eligible for a referral to the CSS (n = 5,992). These analyses showed that 1 in 5 (20%) consumers were reached by the CSS via the ED referral pathway. In addition, a series of Chi-square tests (see Table 8) showed that males, adults aged 35-45 years and 75-84 years; Aboriginal and Torres Strait Islander people and those who were born overseas were under-represented in the CSS cohort. In contrast, females, adults aged 18-24 years, individuals who were neither Aboriginal nor Torres Strait Islander and people who were born in Australia were over-represented in the CSS cohort.

Consistent with the quantitative data, interviews with CSS staff identified several consumer groups that may not be adequately reached by the CSS – including males, middle-aged, and older adults, First Nations people and individuals from CALD backgrounds. However, the reasons as to why these groups are not being reached was not reported or known by staff. Further work is recommended to understand why these groups are harder to reach and to explore strategies to enhance service accessibility for these specific populations.



Table 8 | Chi-square tests comparing demographic characteristics of ED-referred CSS consumers with the potentially eligible ED population.

Characteristics	CSS cohort N (%)	CSS population N (%)	Chi-squared statistic	p-value
Age group				
<18 years	74 (6.3)	430 (7.8)	3.12	0.08
18-24 years	309 (26.3)	855 (15.5)	78.54	<0.001
25-34 years	317 (26.9)	1425 (25.8)	0.55	0.042
35-44 years	189 (16.1)	1184 (21.4)	17.19	<0.001
45-54 years	152 (12.9)	816 (14.8)	2.70	0.10
55-64 years	91 (7.7)	449 (8.1)	0.20	0.64
65-74 years	37 (31%)	234 (4.2)	2.98	0.08
75-84 years	7 (0.6)	108 (2.0)	10.64	<0.01
85+ years	0 (0)	24 (0.4)	3.99	<0.05
Sex				
Female	747 (63.5)	2647 (47.9)	93.95	<0.001
Male	425 (36.1)	2871 (52.0)	97.59	<0.001
Not specified	4 (0.3)	7 (0.1)	1.55	0.21
Indigenous status				
Both Aboriginal and Torres Strait Islander origin	12 (1.0)	126 (2.3)	7.65	<0.01
Aboriginal but not Torres Strait Islander origin	126 (10.7)	729 (13.2)	5.40	<0.05
Torres Strait Islander but not Aboriginal Original	7 (0.6)	85 (1.5)	6.38	<0.05
Neither Aboriginal nor Torres Strait Islander origin	1031 (87.6)	4575 (82.8)	16.39	<.001
Country of birth				
Australia	1027 (87.3)	4652 (84.2)	7.01	<0.01
Overseas	149 (12.7)	871 (15.8)	7.25	<0.01

Note. To meet the assumption of independence of the Chi-Square test, individuals who accessed the CSS (and are therefore represented in the CSS cohort group) were removed from the CSS population group.

It is important to note the following limitations regarding this analysis of reach. In line with the RE-AIM framework, reach examines the proportion and representativeness of individuals who accessed a particular intervention compared to the total eligible population. Data on the total eligible population for the CSS does not currently exist,



and so the EDC data (which provided the best available information) was used to calculate an estimate of reach. However, using the EDC data meant that the evaluation could only assess the potential reach of consumers who accessed the CSS through the ED referral pathway, and so the overall reach of the CSS remains unknown. In addition, the evaluation was only able to identify those individuals who presented to ED who were potentially eligible for the CSS. This is because variables in the EDC dataset did not make it possible to determine whether an individual met all CSS eligibility criteria. The criteria used to estimate the potentially eligible population is provided in Appendix C.

4.4 Factors impacting consumer reach

4.4.1 Referral pathways into CSS

Having a range of referral pathways into the CSS is an important facilitator of consumer reach. While the main pathway into the service is through referrals via the ED (as per the Service Guidelines), several staff reported that the number of presentations to the service had increased once they had expanded their referral pathways to other avenues. Furthermore, referral source data (as presented in Section 4.2.3) shows that 46% of initial presentations and 91% of subsequent presentations to the CSS are coming via referral pathways alternative to the ED.

“We do now have a pretty consistent rotation of clinicians who refer fairly regularly, and now that we have opened up our referral pathways out of just direct presentations to ED, we do get way more folks in.” Peer Worker, CSS

Some consumers also expressed it was important for them to be able to access the CSS without needing to go through the ED first. They explained their unwillingness to access the CSS through the ED was due to previous adverse experiences in the ED. A positive finding was that all CSS sites now provide alternative entry pathways in addition to access through the ED, which serves to address this access barrier.

4.4.2 Referrer awareness of CSS

Referrers’ awareness of the CSS impacts number of referrals made and therefore service reach. However, increasing referrer awareness of CSS has been challenging for sites to achieve in practice. During interviews, several consumers and carers who presented to the ED in crisis, reported that HHS and ED staff were not aware of the CSS existence. Similarly, CSS staff interviewed for the evaluation described that referring clinicians’ lack of awareness of the CSS was a major barrier to increasing presentations and maximising service reach.

“A lot of the staff in the hospital don’t know about it. Every nurse we spoke to was like ‘oh what’s that?’ They’re in the ED and they’re right across from it and they don’t even know what the Crisis Support Space is. So they couldn’t direct anybody over there.” Carer

“I went to the Emergency Department. I knew about the Crisis Support Space and I said, ‘While I’m waiting, can I sit in the Crisis Support Space?’ The nurse didn’t actually know what I was talking about, which is a bit of a problem.” Consumer

“A lot of nurses and emergency staff actually had no idea about the space. So it took a really long time to start getting the amount of people we were seeing through the space. Some night we would have absolutely no one. So it was mainly breaking through that barrier of people not knowing about us.” Peer Worker, CSS



Therefore, many staff interviewed emphasised the importance of promoting the CSS and educating ED and broader HHS staff about the service and its referral pathways. To achieve this, sites have used numerous different strategies. For example, Mackay and Metro North deliver regular in-services to ED staff and HHS teams to provide an orientation to the CSS; while Cairns and Mackay developed a brochure about the CSS for distribution throughout the health service. Staff reported that this promotion of the CSS needs to occur regularly, due to the vast number of staff working in the ED and other referring HHS teams, and to remind busy clinicians that the service is available for referral of appropriate consumers.

“I think it has to be an ongoing thing. I think if you don’t continue to advertise it, with the nature of our work, everyone’s work across the health services, there’s such high demand and difficulty with staff numbers and people always seem to be under the pump. I think if you’re not in their face or in the conversation or making people aware of what’s out there, then you fall of. It falls out of their mind and that’s when you see a drop-off in numbers. It’s definitely an ongoing thing where we’ll continue to have to push the CSS as an option for people, so it continues to be used.” **Clinician, CSS**

ED in-reach has been used by several sites to increase referral numbers to the CSS from the ED, particularly in cases where referral numbers from the ED were limited due to lack of clinician awareness about the CSS. In Mackay and Wide Bay, ED in-reach involves the CSS clinician monitoring the Emergency Department Information System (EDIS) to identify patients waiting in ED who may be suitable for the CSS, and then calling or visiting the ED to let relevant staff know a referral to the CSS might be appropriate. Similarly, Metro North has peer-workers who work in the ED and identify people who might be appropriate or interested in visiting the CSS. In addition, West Moreton have ‘huddles’ with ED staff every 3-hours to track potential referrals to the CSS.

Other sites have also expanded their promotion of the CSS beyond the HHS in which they are situated. For example, Cairns staff undertook a roadshow in which they delivered presentations about their service to community mental health organisations in their local region. In addition, West Moreton are going to extend their in-services to include local NGOs.

4.4.3 Referrer buy-in and support for CSS

The number of referrals to the CSS from the ED and other HHS-based referring teams was found to be dependent upon their extent of buy-in and support. For sites who reported having good buy-in from the ED and referring HHS teams (e.g., ACT), this was underpinned by strong working relationships that were developed through regularly attending meetings, networking, and providing ongoing feedback about the benefits that the service is having. This is discussed further in Section 5.2.

“I think you really need to have a good relationship with your Emergency Department and your Acute Care Team. You just can’t be a standalone service and expect people to refer to you or use you, or even know about you, if you’re not constantly attending those meetings or in-reaching to ED and networking. Also the feedback loop, so our presentations are also discussed in the Acute Care Team and DT, so they know who’s present and who’s been supported through the service.”

Team Leader, CSS

In contrast, other sites who received low numbers of referrals from the ED believed this was because the ED staff held negative perceptions of the service or had ongoing concerns around clinical governance and risk.



“It was really hard to get buy-in from the Emergency Department. There was a lot of concerns about governance of people accessing the CSS. For example, if they come through to the ED there was a lot of barriers in the ED wanting to refer them to the CSS. They were just concerned that it would be too risky for them to come here.” **Team Leader, CSS**

4.4.4 CSS opening hours

CSS opening hours impact whether consumers can access the service, which in turn affects consumer reach. Several consumers reported being unable to access the CSS when needed because it was closed or because they found it difficult to visit the CSS during its opening hours due to other commitments. Similarly, CSS staff spoke about occasions where they could not take a consumer to the CSS from the ED because the service was closing soon.

“To start with, it wasn’t open very much. Only three or four days a week with limited hours. And so I wasn’t able to visit much, because I started working two jobs.” **Consumer**

“Sometimes people are referred quite late in the evening, so they might be referred at 9:45pm and we shut at 10:00pm, so we might have to turn people away.” **Team Leader, CSS**

The recent expansion in the opening hours of the CSS has helped to address this access barrier, with data showing that it has increased the reach of the service. It has also been well received by consumers and staff alike. This is discussed further in Section 6.2.1.

There’s quite a lot of people who go through to the Crisis Support Space, especially now that they’ve extended the hours. What we were finding, with the 3:00pm start, an awful lot of people missed out. Now it’s open at 8:00 in the morning it’s a lot more accessible.” **Clinical Nurse Consultant, ED**

“Opening up those extra hours is just so much better, knowing on the weekend I can go in there in the morning, like if I’ve had a bad night, I can go there in the morning and that’s really comforting. I think the extended hours are great.” **Consumer**

There is an opportunity to further enhance the reach of the CSS through expanding the operating hours more. Indeed, this was a common recommendation from consumers, carers, and staff; with many interviewees believing that operating the CSS 24 hours a day/ 7 days per week would be optimal as ‘crisis doesn’t happen on a timeline’.

“I would say in an ideal world, it would be a 24-hour service. Because mental health, you know it doesn’t stay between the hours of 11:00 and 8:00. If you’re sitting there for six hours and they give you a headspace card and your appointment is three days away, what the hell are you meant to do?” **Consumer**

4.4.5 Consumer access to transport

All interviewed stakeholder groups reported the lack of access to transport being a barrier for some consumers in being able to visit the CSS. This is particularly problematic in regional areas, where the availability of public transport is limited and disproportionately affects those from lower socio-economic backgrounds who do not have access to a car or the financial means to pay for a taxi. To address this barrier, some sites like Wide Bay and West Moreton



provide taxi vouchers to consumers to assist them in getting home; however, only consumers who arrive at the hospital via ambulance or on an Emergency Examination Authority (EEA) are eligible to receive these vouchers.

“Something we’ve come up against is that sometimes people can’t afford a taxi to come see us if they don’t have their own car. Also, the only consumers who are able to get a taxi from the Crisis Support Space are people that have come in through an EEA. So, they’ve been picked up by the ambulance and brought in under a treatment order. They’ll get a voucher from the hospital to get home, but people that don’t come in that way, sometimes they might not have a way home.” Peer Worker, CSS

In addition, Mackay offers phone calls to a select group of consumers who are unable to access the CSS in-person due to transport barriers. These consumers are well-known to the service and are typically seeking social connection, rather than support for an acute mental health crisis. To access the CSS, these consumers call the ACT who triages them and determines if it is appropriate for them to be put the call through to the CSS. If the peer-workers are available, they will then take that phone call and speak to the consumer. In the instance that the conversation changes or indicates that the person is experiencing an acute crisis, the call will be referred to the ACT.

4.4.6 Consumer awareness of CSS

Several consumers, carers and staff interviewed felt that awareness of the service among potential consumers in the community was lacking, and consequently a need exists to improve public-facing promotion and advertising of the space. This, in turn, would help to enhance the number of consumers reached by the service, particularly through the self-referral pathway.

“I think there’s a shortage of information out there for everyone. So I think more advertisement of the space would probably catch more people.” Peer Worker, CSS

“There needs to be better awareness. People don’t really know about it. Maybe that’s deliberate, I don’t know. But it’s a great service and I just think people need to know about it and who can use it and when. They definitely need to improve that.” Carer

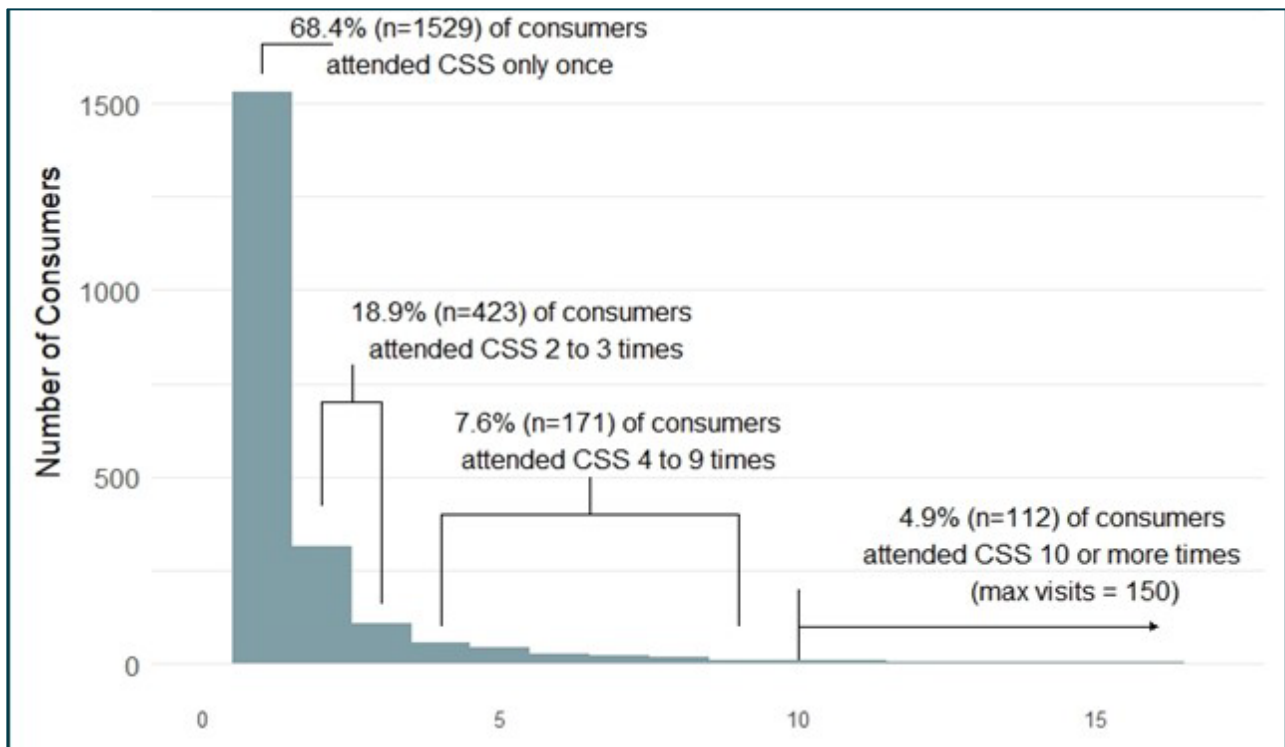
Some consumers reported that it was challenging to find information about the services online and felt information should be easily available about the what the service is, where it is located, and how they can access it. The different groups of stakeholders interviewed also recommended the use of social media marketing and the placement of advertising materials in areas frequented by potential consumers (e.g., GP surgeries, private psychology practices, emergency relief services, housing services).

4.5 Repeat presenters

Data on the number of presentations to the CSS per consumer are presented in Figure 9. Approximately two-thirds of consumers (68%) accessing the CSS visited the service on only one occasion, while one third (32%) use the service on more than occasion. Most of these ‘repeat presenters’ will visit the CSS on two occasions. However, there appears to be a small group of consumers who attend the CSS very regularly, with 5% having visited on more than 9 occasions and 1% having visited the service 50 or more times. The maximum number of visits was 150 occasions.



Figure 9 | Number of presentations to the CSS per consumer.



Stakeholder interviews indicated that in most cases, repeat presenters were using the CSS to prevent a crisis or manage ongoing crises in a calm environment where they felt cared for and connected to staff, thus helping to keep them out of hospital. Less commonly, repeat presenters were visiting the CSS to check-in with staff, have a chat and let them know how they were going.

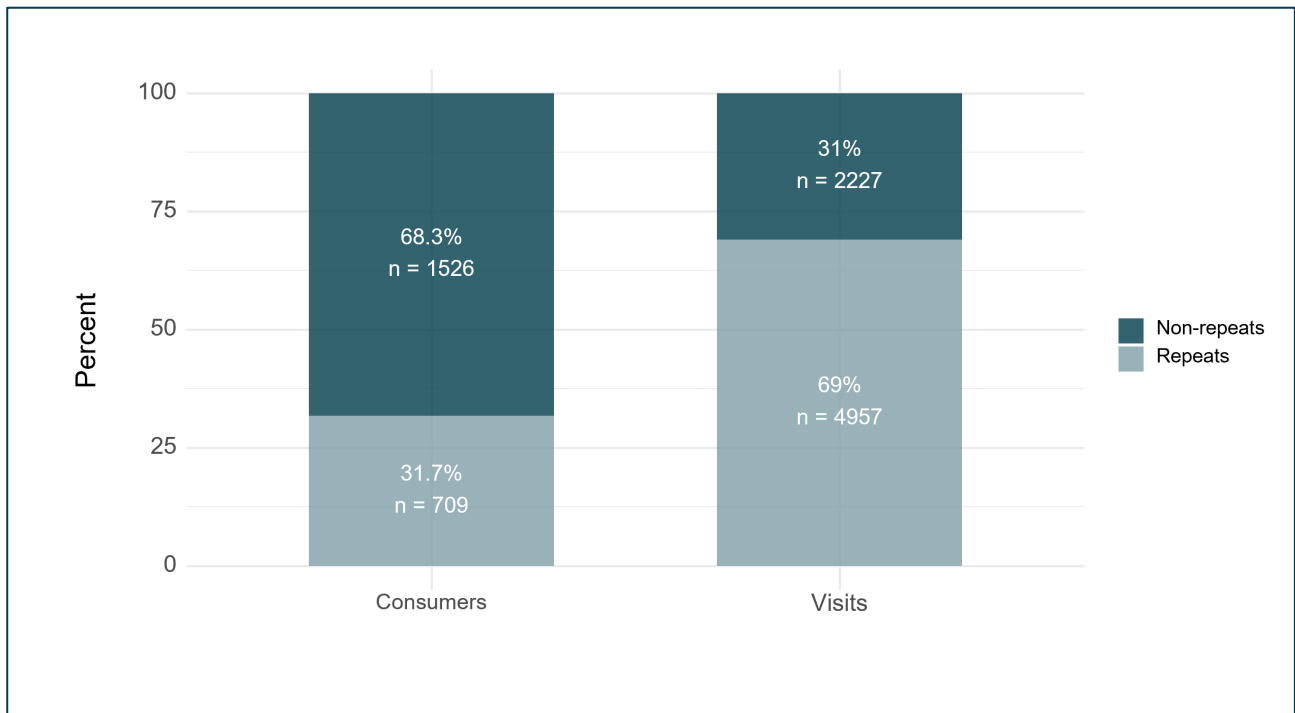
“When I first started going there, I was still pretty cautious and was only showing up when it was getting to a really bad point. Whereas towards the end of it, I knew if things were getting bad, so I would go in there to stop it from getting too far. I almost feel like that’s a better kind of thing, to stop in, have a coffee, have a chat with someone, and not get to the point where you’re in crisis.” Consumer

“When I re-present, it’s just because of situations and stress that comes up or when I’m feeling particularly depressed. Usually, I’m in a crisis state and I’m suicidal, not likely extremely suicidal but I’m having the thoughts and I’m just not coping, that’s usually why I’d go there.” Consumer

Although most people were presenting to the CSS only once, the data showed that the majority (69%) of service delivery was for subsequent (rather than initial) visits to the CSS (see Figure 10). In other words, most service delivery is being allocated to consumers who are repeat presenters (as opposed to the 68% of consumers who only present to the service once).



Figure 10 | Proportion of services delivered to repeat presenters of the CSS.



Staff and stakeholders had conflicting views on whether repeat presenters are appropriate for the CSS. Many staff acknowledged that crisis prevention is an important feature of the service and repeat presenters should be encouraged to use the CSS, otherwise they may present to an ED if they are not able to re-present to a CSS. This suggests that the service is still meeting its goal of ED avoidance through allowing repeat presentations. Allowing people to re-present was also seen as a way for the CSS to support repeat presenters in progressing on their road to recovery from chronic distress. However, some staff interviewees reported that some repeat presenters are accessing the service for reasons they feel are inappropriate (such as a place to socialise). In addition, staff felt that some repeat presenters were becoming dependent on the CSS for support as opposed to being connected to other services in the community that are more appropriate for ongoing care. Consequently, they highlighted the need to set clear expectations and boundaries with consumers from the outset to outline what the service is and isn't for, and to ensure that the CSS empowers consumers by referring them to appropriate mental health services when support needs strayed from CSS service delivery scope.

"The frequent presenters should be encouraged to come seek support, especially if it means that they don't do something – like they self-harm or turn to alcohol or present to the emergency, which is the purpose of the space in the first place. It's a diversion to people from presenting to the emergency department." **Peer Worker, CSS**

"There's an aspect of crisis prevention. But if it's becoming a crutch where someone is just re-presenting all the time, then I think we're probably not approaching it right and we're not having the conversations around growth and resilience that we need to have. I think it's really important for people not to be discouraged to come back to us if they need us, but we need to be really clear that it is about crisis support." **Project Officer, CSS**

"Now we've been really kind of firm in saying like, this is the role of the space. Like maybe you could try these alternative services. Those repeat people that were coming initially, I think it was more for like a social kind of thing. But now that we've kind of really explained and established our roles it's been a lot better in terms of curbing the inappropriate referrals".

Clinician, CSS



"I think at the end of the day we're always very mindful of wanting to ensure that our visitors to the space are not going to purely rely on us, you know, we want to make sure that we're assisting them and empowering them to develop those connections with other services or supports in the community as well." **NGO Manager**

4.6 Appropriateness of presentations to CSS

Staff and stakeholders reported during interviews that in most cases, consumers accessing the service are representative of the target group as stipulated by the state-wide CSS Service Guidelines (i.e., are experiencing mental distress and/or suicidality, but don't require medical intervention provided by the ED).

"I think the people that use the space are definitely suitable for it. There might be people who come up through ED because they've been brought in by the police because of domestic violence. Or job losses, relationship breakdown, just people who need someone to talk to. I think the people who are accessing it are suitable." **Peer Worker, CSS**

"I think the people that I've seen in the space and am aware of that utilise the space would be the target group that I think is who we are aiming to support." **Clinician, CSS**

"I think the right demographic of people are accessing the service. So, people that are in crisis, but not necessarily at the point where they need to be admitted or anything like that." **Peer Worker, CSS**

However, sites have received some inappropriate referrals to the CSS at times, such as people who hadn't been medically cleared, were acutely unwell, were highly intoxicated or were experiencing active psychotic symptoms. Sometimes, this occurred when new ED staff were on shift who didn't fully understand the scope of the service provided by the CSS and which consumers were appropriate for referral. Inappropriate referrals have caused issues for CSS staff and consumer safety as well as negative service experiences for consumers sent back to the ED. To address this, some sites have implemented strategies to filter out inappropriate referrals, such as providing ongoing education about the eligibility criteria to the referring teams and undertaking co-dual eligibility assessments between ED and ACT.

"I guess in terms of inappropriate referrals are probably more people who haven't been medically cleared. People who have been referred, who have been quite acutely unwell, that I've known of, including maybe experiencing even psychotic symptoms. Which is not the way the space is set up in our HHS, it's not really equipped to deal with that. It's also very traumatic for the person too, because they've just been told that they need to go to this certain part of the hospital and you'll be able to get help there and then they turn up and we actually have to go, oh no, you can't be here, then we have to send them back to ED." **Clinician, CSS**

"I think that's probably improving and has improved over the last few months when we've been sending the clinicians from the CSS into ED. There is still some inappropriate pushing of referrals onto us, but generally, I think we're kind of really – we're doing more promotion, we're doing education with our team here. We're doing co-dual assessment. So, somebody from ACT ED will take somebody from – like they will get the referral from ED and they will read it and they will go, oh, hang on, maybe this sounds more like sort of lower end, nothing psychotic going on, and then they will call down to the café and say, look, I think that this might be for you, but let's go and assess them together, just in case it turns out that it is for us, more acute kind of side of things". **Team Leader, CSS**



As discussed in Section 4.5, there were also situations reported by staff in which some consumers had been using the CSS as a drop-in centre, where they were not in crisis but presented to the service as a space to “hang out” and socialise. This was perceived by staff as an inappropriate use of the space and thought to be driven by an absence of drop-in centres available in the region.

“Yeah, there used to be more community access spaces, places people could drop in and just have a chat with someone if they were lonely or bored or whatever. We can't have it used as a drop-in space, people just turning up because they're wanting some noodles and having a chat and playing a game sort of thing. We do have a few people that have tried to use it as that over time. We just have to be really clear that we are a crisis space and we can't really have people using us like that. But there does need to be places like that out in the community”. **Clinician, CSS**

4.7 Summary of findings

- 1 in 5 (20%) potentially eligible individuals who present to the ED are reached by the CSS via the ED referral pathway. There are some groups of consumers who are less likely to be reached including males, middle-aged and older adults, First Nations people and individuals from CALD backgrounds.
- Key factors impacting the reach of the CSS are referrer and consumer awareness of the service, referrer buy-in and support for the service, referral pathways into the service, service opening hours, and consumer access to transport. Gaps and areas for improvement were identified across several of these factors.
- Consumers who are accessing the CSS are typically representative of the target group, with staff reporting that the majority of visitors are presenting to the service with suicidal ideation, thoughts of self-harm, psychosocial issues and situational crises.
- Two-thirds of consumers (68%) access the CSS on only one occasion. However, there is a small group of consumers (~5%) who are using the service very frequently and a large portion of service delivery is being delivered to these repeat visitors of the service.



5. Health service adoption of CSS

Defining and evaluating health service adoption

Health service adoption of the CSS examines the extent to which broader HHS staff have adopted (i.e., buy-into and support) the CSS model and the reasons why/ why not. From a process evaluation perspective, adoption also looks at how the CSS were established at each of the sites.

This section of the report answers the following key evaluation questions:

- What are the key lessons learnt from the process of setting up the CSS across the pilot sites?
- What is the extent to which there is buy-in and support for the CSS from referring ED and HHS staff, and why/ why not?
- Has there been an increase in referral numbers to the CSS over time, and why/ why not?

5.1 Setting-up the CSS

There were limited staff and stakeholders interviewed through the present evaluation that were working at the CSS when it was first established and/or were involved in the process of setting up the CSS. This made it difficult for the evaluation to assess the process which sites undertook to set-up the CSS at the local level and to identify key lessons learnt from this implementation process which future sites can draw upon.

However, it was evident from the few interviews undertaken with relevant staff and stakeholders that co-designing the CSS with consumer representatives, peer workers, and community organisations is of significance when establishing the service and was highlighted as key lesson for future CSS services. Indeed, staff and stakeholders interviewed through the evaluation reported how adopting a co-design process when establishing their local CSS helped to ensure that the CSS was aligned with consumer needs, was accessible and culturally appropriate, and helped consumers and peer workers take ownership of the space. Wide Bay undertook an extensive co-design process when setting up their local CSS and is highlighted below as a case study.

Case study: Wide Bay | Co-designing the CSS

The establishment of the CSS at Wide Bay involved thorough and in-depth consultation with stakeholders across the HHS regarding design of the building, location and proximity to ED, and local models of care. Staff from both emergency and mental health settings were involved in developing the operational guidelines and initiating steering committees and working groups with a range of stakeholders from clinicians to executive directors, team leaders, peer workers and consumer representatives.

The design of the new CSS space involved a local artist who conducted workshops with peer workers, clinicians, consumers, and consumer representatives who each had individual input to develop the final colour scheme and mural on the front of the building. This co-design process also involved picking a name for the CSS, with “The Oasis – Crisis Support Space” receiving the most votes. The co-design of the physical space ensured a non-clinical and relaxed environment with lounges, sensory bean bags, aromatherapy, and dim lighting.



5.2 Buy-in for CSS from ED and HHS staff

Interviews with staff and stakeholders showed that buy-in from ED and HHS staff was initially limited across sites when the CSS was first established. The service was met with some scepticism and hesitation, as staff had concerns about the service being non-clinical and peer-led and had a lack of awareness and understanding about the purpose and value of the service. This meant that referrals to the CSS from these avenues were initially limited. Indeed, CSS staff at some sites reported issues where ED clinicians would not refer consumers who would benefit from the CSS as they held negative perceptions of the CSS or had concerns about clinical governance and risk.

“A lot of people at the beginning, were very sceptical about it...Is it a place to go for a cup of tea and then go back to ED?”

Clinical Nurse Consultant, ED

“...There wasn't a buy in. Something new, something I don't know about. It probably relates to a lot of different human factors is that they need to build some trust up knowing that the reference point they're referring to is going to be beneficial to clients...I also think there was also the aspect of, no, this is our space. Why are you encroaching on our space? What are we doing wrong? What are you taking away from us? So this could have been some thoughts in some people's heads as being reluctant to refer to the space.” **Team Leader, CSS**

Fortunately, the level of buy-in for the CSS has improved over time as the service has become more established within the HHS and awareness and understanding of the service has increased. ED and HHS staff buy-in has increased as they have become more aware of and have experienced the benefits of the CSS firsthand for both consumers (e.g., relieving their distress) and the system (e.g., relieving burden on ED for the local service). In addition, the establishment of smoother referral pathways and processes has reduced referrer frustration and confusion and facilitated buy-in from ED and HHS referring teams.

“So, we started to get consumers slowly, more consumers, more consumers. The work that we were doing this time, the feedback, the outcome was a lot bigger. They started to share with the other consumers, we started to relieve a lot of consumers from ED. ED started to send us more consumers, they started to trust in us for a good outcome.” **Peer Worker, CSS**

Building and developing relationships between CSS staff, ED staff, and broader mental health staff is critical to increase buy-in of the service. These relationships were fostered through CSS staff in-reaching to ED and educating staff about the CSS (including the clinical and social profiles of appropriate consumers, what the referral pathways are, and how a peer-led service works). Interviews with staff revealed that the practice of CSS peer workers and clinicians going to the ED at the start or end of a shift and speaking to ED staff is an important part of strengthening these relationships and increasing buy-in. As reflected in the quotes below, staff reiterated the importance of networking and in-reaching with ED staff to build strong working relationships which enabled greater referrals and adoption of the CSS.

“...ED staff are really practical people and if they can see that people are being moved out of ED and into the Crisis Support Space that will increase buy-in and what it might do also is that it might improve the relationship where a nurse, a triage nurse or someone sees somebody and they're able to go, actually, you know what, they could be quite suitable for the Crisis Support Space.” **Social Worker, ED**



“Even upon, like, shift rotations, times, like I know our clinicians and peer workers would ensure that they go down to the ED once the new staff had come on board for their shifts. Just making sure that there was that consistent messaging I think was really something that was really valuable for us.” NGO Manager

Additional strategies used to enhance buy-in for CSS is meeting with ED, ACT and broader HHS referring teams on a monthly basis to present data about the different types of presentations to the CSS, frequency of visits, risk management and escalation, and feedback from consumers. These meetings have increased communication between teams, showcased the benefits of the service and therefore, facilitated an increase in referrals and reach to consumers. Similar to these monthly meetings, CSS staff found it beneficial to close the feedback loop and update ED, ACT and broader staff about the positive outcomes consumers have had at CSS.

“I guess that just gives a little bit of a feedback loop for the ACT clinicians to know that this service actually works for people. They can go and spend an hour and a half or so in CSS and then they go home with a better outcome, rather than sitting in the ED for three hours and waiting for an assessment and then going home or being admitted.” Team Leader, Mental Health

5.3 Referral numbers to the CSS

A total of 2,235 individuals made a total of 7,184 visits to the CSS across Queensland from the period of 23/01/2021 (when the first CSS was established at Metro North) to 30/10/2023. The number of visits to the CSS per month is shown in Figure 11 and the number of consumers who accessed the CSS per month is shown in Figure 12. These data show a general trend towards an increased number of consumers accessing the service and an increased number of services delivered over time.

Figure 11 | Number of visits to the CSS per month from 23/01/2021 to 30/10/2023.

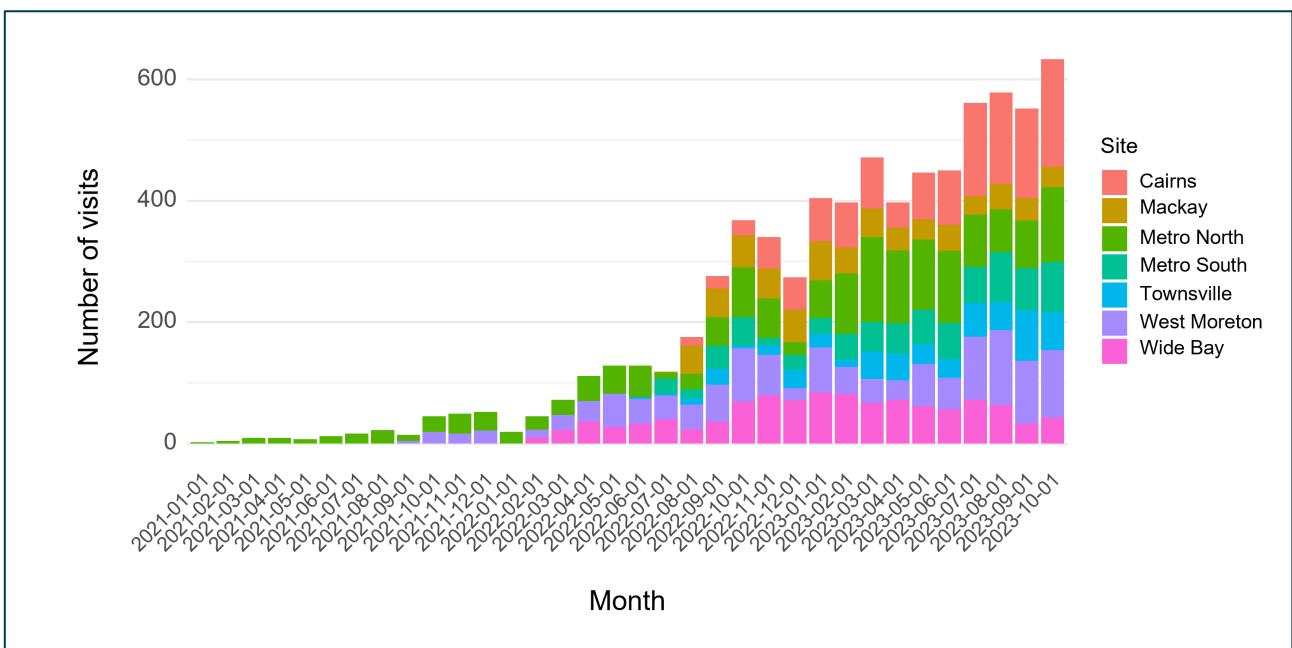
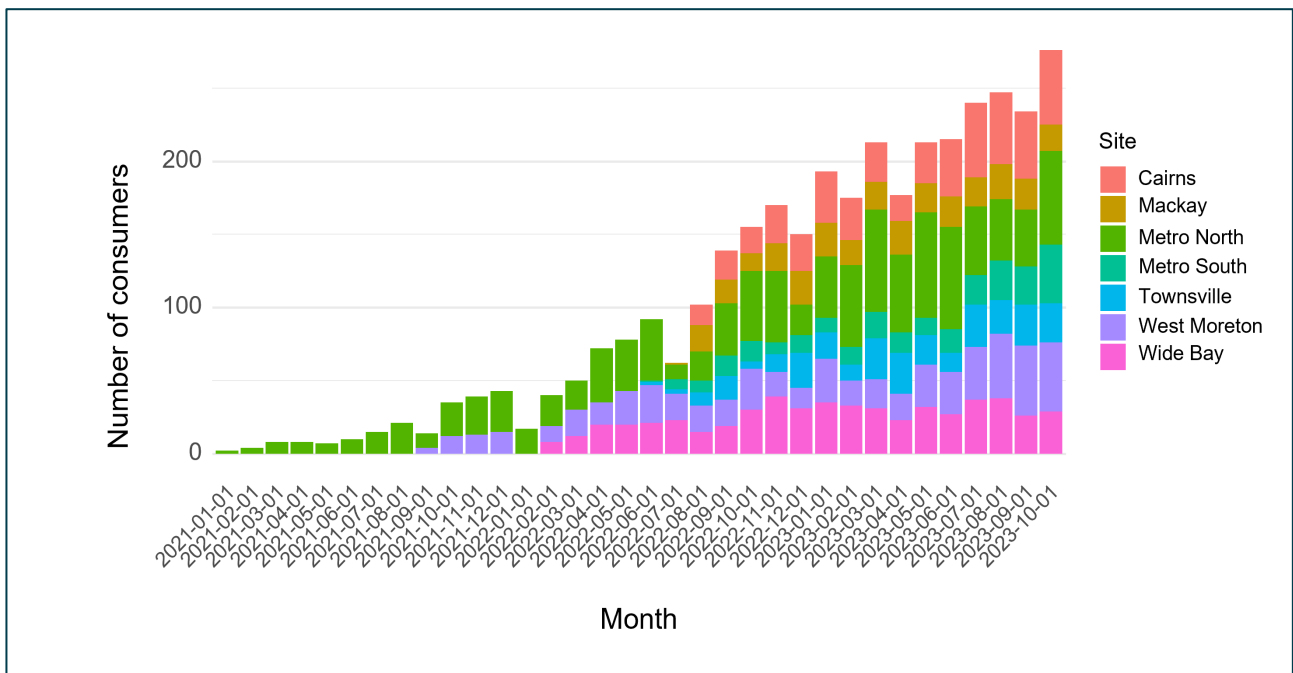




Figure 12 | Number of consumers accessing CSS per month from 23/10/2021 to 30/10/2023.



Consistent with this, during interviews staff and stakeholders reported an increase in referral numbers to the CSS over time, as the services have become more established and well-known by members of the community and referrers. Furthermore, the expansion in CSS operating hours (which is discussed further in Section 6.2.1) increased service availability and led to an increase in referral numbers.

“Yeah, I mean the numbers have increased. I would say that. When we started, we used to have bare minimum, maybe one, two if we’re lucky. Sometimes some nights zero. But these days we do have quite a number of regular clientele that are coming in and some of these clients are clients that are really finding the strong benefit of being involved in Crisis Support Space.” **Clinician, Mental Health**

“So I think just over time the clinicians that work in the ED have found out about the space more, and we’ve put our brochures in the emergency department as well and in the team meetings as well...it’s just over time more people have started to know about us and refer people to us. Also, just in terms of the consumers, over time more people have found out about us in the community.” **Peer Worker, CSS**

“I think it’s just more knowledge of the space...worked really hard to push the space in a way just to make people aware of it, or make us aware of it as different teams in the community. Then also make the hospital staff aware, not only ED but across the division too, through in services and things like that.” **Clinician, CSS**



5.4 Summary of findings

- Co-designing the CSS with consumer representatives, peer workers and community organisations is of great importance when establishing the service and ensures that service design and implementation is aligned with consumer needs.
- Although initially limited, buy-in and support for the CSS from referring ED and HHS staff has improved over time as CSS staff have made concerted efforts to educate referring teams about the value and nature of the service, and build strong working relationships with these teams.
- Data show a steady increase over time in the number of consumers accessing the CSS and the number of services delivered. This trend was attributed to services becoming more established, the expansion in operating hours, and improved awareness and buy-in of the service among referrers.



6. Health service implementation of CSS

Defining and evaluating health service implementation and sustainability

Health service implementation of the CSS explores local site implementation and adaptations that have been delivered to enhance the CSS model at each site. It also looks at the factors which impact the successful implementation and ongoing sustainability of the CSS from a service delivery (i.e., process) perspective.

This section of the report answers the following key evaluation questions:

- How does the CSS function in practice, and what are the variations in service delivery across the seven pilot sites?
- What are the factors impacting the implementation and ongoing sustainability of the CSS for health services?

6.1 Variability in service delivery across sites

Variability in the delivery of the CSS is inherent in the application of the state-wide service model, with local sites adapting the state-wide Service Guidelines to meet the needs of the communities they serve. Mapping of the key elements of service delivery for each of the seven CSS sites, was informed by a document review of the site-specific Models of Care documentation, in addition to interviews with CSS staff (see Table 9).

The evaluation found implementation of the CSS to be relatively consistent across sites, with some variations identified with respect to how the peer workforce is sourced and employed, referral pathways, types of interventions, activities and supports offered, and the data collected by sites. These variations are discussed in more detail below.



Table 9 | Overview of local sites' implementation of the CSS model.

Service Element	HHS Site						
	Cairns	Mackay	Metro North	Metro South	Townsville	West Moreton	Wide Bay
Name	Crisis Support Space	The Safe Harbour (formerly known as The Space)	Safe Space	Crisis Support Space	Wadda Mooli – The Welcome Space	Emu Café or Crisis Support Space	The Oasis (“Crisis Support Space”)
Source of peer-workforce employment	MIND Australia	MIND Australia	QLD Health	BrookRED	selectability	Richmond Fellowship Queensland	QLD Health
Location	Located on G/Floor, A/Block, at Cairns Hospital.	Temporary location in K Block at Mackay Base Hospital.	Located near ED at The Prince Charles Hospital next to the Common Good Café.	Located on ground floor of the Princess Alexandra Hospital (PAH), next to Russell Strong Auditorium.	Located at Townsville University Hospital campus on the first floor, above ED.	Located in in the Jubilee Building at Ipswich Hospital.	Initial operation from a temporary building located at Hervey Bay Hospital outside ED.
Eligibility criteria	<ul style="list-style-type: none"> • 18+ years. • Experiencing suicidal ideation or thoughts of self-harm without active plan or intent, in a personal or situational crisis. • Do not require medical treatment. • People experiencing homelessness able to attend. 	<ul style="list-style-type: none"> • 16+ years. • Experiencing suicidal ideation or thoughts of self-harm without active plan or intent, in a personal or situational crisis. • Do not require medical treatment. 	<ul style="list-style-type: none"> • 18+ years. • Experiencing suicidal ideation or thoughts of self-harm without active plan or intent, in a personal or situational crisis. • Do not require medical treatment. • C-G MH triage scale. 	<ul style="list-style-type: none"> • 18+ years. • Experiencing suicidal ideation or thoughts of self-harm without active plan or intent, in a personal or situational crisis. • Do not require medical treatment. 	<ul style="list-style-type: none"> • 18+ years. • Experiencing suicidal ideation or thoughts of self-harm without active plan or intent, in a personal or situational crisis. • Do not require medical treatment. 	<ul style="list-style-type: none"> • 18+ years. • Experiencing suicidal ideation or thoughts of self-harm without active plan or intent, in a personal or situational crisis. • Do not require medical treatment. • People experiencing homelessness able to attend (as long as they have a plan for where they will go after). 	<ul style="list-style-type: none"> • 16+ years. • Experiencing suicidal ideation or thoughts of self-harm without active plan or intent, in a personal or situational crisis. • Do not require medical treatment.
Exclusion criteria	<ul style="list-style-type: none"> • <18 years. • Under an EEA. • Intoxicated or under the 	<ul style="list-style-type: none"> • <16 years. • Under an EEA. • Intoxicated or under the 	<ul style="list-style-type: none"> • <18 years. • Under an EEA • Intoxicated or under the 	<ul style="list-style-type: none"> • <18 years. • Under an EEA. • Intoxicated or under the 	<ul style="list-style-type: none"> • <18 years. • Under an EEA. • Intoxicated or under the 	<ul style="list-style-type: none"> • <18 years. • Under an EEA. • Intoxicated or under the 	<ul style="list-style-type: none"> • <16 years. • Under an EEA. • Intoxicated or under the



	<p>influence of drugs and unable to participate safely.</p> <ul style="list-style-type: none"> • Psychosis or acute psychiatric episode requiring formal assessment. • Aggressive behaviour. • Requiring immediate medical treatment. 	<p>influence of drugs and unable to participate safely.</p> <ul style="list-style-type: none"> • Psychotic episode or acute symptoms of mental illness. • Aggressive behaviour. • Requiring immediate medical treatment. • Complex social support needs requiring significant ED social worker input. 	<p>influence of drugs and unable to participate safely.</p> <ul style="list-style-type: none"> • Suicidal plan and intent or other high suicide risk factors. • Aggressive behaviour. • Requiring immediate medical treatment. • Complex social support needs requiring significant ED social worker input. 	<p>influence of drugs and unable to participate safely.</p> <ul style="list-style-type: none"> • Acute psychosis or acute symptoms of mental illness. • Aggressive behaviour. • Requiring immediate medical treatment. • Complex social support needs requiring significant ED social worker input. • Resides outside of PAH catchment area. 	<p>influence of drugs and unable to participate safely.</p> <ul style="list-style-type: none"> • Psychosis or acute psychiatric episode requiring formal assessment. • Aggressive behaviour or agitation. 	<p>influence of drugs and unable to participate safely.</p> <ul style="list-style-type: none"> • Psychosis or acute psychiatric episode requiring formal assessment. • Aggressive or predatory behaviour. • Requiring immediate medical treatment. 	<p>influence of drugs and unable to participate safely.</p> <ul style="list-style-type: none"> • Acute psychosis or acute symptoms of mental illness. • Aggressive behaviour. • Requiring immediate medical treatment. • Complex social support needs requiring significant ED social worker input.
Referral pathways	<ul style="list-style-type: none"> • ED • ACT • Case managers from ATODS and MH community teams • Self-referral direct to CSS • Inpatient ward 	<ul style="list-style-type: none"> • ED • ACT • Case managers from MH community teams • Self-referral direct to CSS • QAS CORE 	<ul style="list-style-type: none"> • ED • ACT • Case managers from Continuing Care Teams (CCT) and MH community teams • Self-referral through MH CALL (repeat visitors only) • Inpatient ward • QAS CORE 	<ul style="list-style-type: none"> • ED • ACT • Case managers from MH community teams • Self-referral direct to CSS (repeat visitors only) • Inpatient ward 	<ul style="list-style-type: none"> • ED • ACT • Case managers from ATODS and MH community teams • Self-referral direct to CSS (repeat visitors only) • Inpatient ward • QAS/ QPS CORE 	<ul style="list-style-type: none"> • ED • ACT • Case managers from MH community teams • Self-referral direct to CSS (repeat visitors only) • QAS CORE • Other community-based referrers (GPs, NGOs) 	<ul style="list-style-type: none"> • ED • ACT • Case managers from CCT • Self-referral direct to CSS • Inpatient ward • QAS CORE



Interventions and supports offered	<ul style="list-style-type: none"> Brief clinical/therapeutic support Non-clinical, person-centred peer-support Safety planning Psychosocial education Linkage to community resources Warm referral to community-based supports 	<ul style="list-style-type: none"> Brief clinical/therapeutic support Non-clinical, person-centred peer-support Safety planning Psychosocial education Linkage to community resources Warm referral to community-based supports 	<ul style="list-style-type: none"> Brief clinical/therapeutic support Non-clinical, person-centred peer-support Safety planning Psychosocial education Linkage to community resources Warm referral to community-based supports Follow-up care 	<ul style="list-style-type: none"> Brief clinical/therapeutic support Non-clinical, person-centred peer-support Safety planning Psychosocial education Linkage to community resources Warm referral to community-based supports 	<ul style="list-style-type: none"> Brief clinical/therapeutic support Non-clinical, person-centred peer-support Safety planning Psychosocial education Linkage to community resources Warm referral to community-based supports 	<ul style="list-style-type: none"> Brief clinical/therapeutic support Non-clinical, person-centred peer-support Safety planning Psychosocial education Linkage to community resources Warm referral to community-based supports 	<ul style="list-style-type: none"> Brief clinical/therapeutic support Non-clinical, person-centred peer-support Safety planning Psychosocial education Linkage to community resources Warm referral to community-based supports
Other activities and amenities provided	<ul style="list-style-type: none"> Food and drinks Phone charger Weighted chair 	<ul style="list-style-type: none"> Drinks Weighted chair Games Colouring in Fidget toys/sensory items Music Magazines 	<ul style="list-style-type: none"> Drinks Weighted chair Games Colouring in Self-help books and handouts Fidget toys/sensory items 	<ul style="list-style-type: none"> Food and drinks Weighted chair Outdoor space Games Colouring in Self-help books and handouts Fidget toys/sensory items Music Magazines Aromatherapy 	<ul style="list-style-type: none"> Food and drinks Phone charger Massage chair Outdoor space Colouring in Self-help books and handouts Fidget toys/sensory items 	<ul style="list-style-type: none"> Drinks Massage chair Outdoor space Games Colouring in and other art activities Self-help handouts Fidget toys/sensory items 	<ul style="list-style-type: none"> Food and drinks Phone charger Games Colouring in Self-help books and handouts Fidget toys / sensory items Guitar
Data collection	<ul style="list-style-type: none"> Entry and Exit SUDS Consumer Survey 	<ul style="list-style-type: none"> Entry and Exit SUDS Consumer Survey 	<ul style="list-style-type: none"> Entry and Exit SUDS Consumer and Carer Survey 	<ul style="list-style-type: none"> Consumer and Carer Survey 	<ul style="list-style-type: none"> Entry and Exit SUDS Consumer Survey 	<ul style="list-style-type: none"> Entry and Exit SUDS Consumer and Carer Survey 	<ul style="list-style-type: none"> Consumer survey



6.1.1 Source of peer-worker employment

The source of peer worker employment differs across sites, with five of the seven hospital-based CSS sites (Cairns, Mackay, Metro South, Townsville, and West Moreton) partnering with a local NGO; and two sites (Metro North and Wide Bay) employing Queensland Health peer-workers. One stakeholder identified that a potential benefit of partnering with NGOs in service delivery is that NGOs can link CSS consumers to a wide range of community supports due to their network connections with other services. However, a challenge of having NGO employed peers (that the Queensland Health peer workers don't experience) is that these staff work for a separate organisation than the clinicians, and therefore have different escalation and reporting processes; distinct orientation, training and supervision requirements, and separate workforce policies and procedures. This can complicate working in the same space and requires careful management.

"They self-employ their peer workers through Queensland Health. I think that makes it somewhat easier because there's a level of expectation about what training they do, you can oversee things a little bit more, and they have the same guidelines and reporting processes...I think some of the challenges that we've had working with an NGO is, after hours, if an incident occurs, they have separate escalation processes to us...they have different policies and procedures that they have to follow."

Clinician, CSS

6.1.2 Referral pathways

There is some variability in the referral pathways into the CSS across sites. All sites accept referrals from the ED, ACT, community mental health teams, and self-referrals. In addition to this, five sites (Mackay, Metro North, Townsville, West Moreton, and Wide Bay) accept referrals from Queensland Ambulance Service Co-Responders (QAS CORE) whereby a qualified mental health professional along with a paramedic will outreach to a consumer in the community who is experiencing mental health distress and transport them to the CSS if deemed appropriate for the service. Five sites (Cairns, Metro North, Metro South, Townsville and Wide Bay) accept referrals from the inpatient mental health unit (and the Step-Up Step-Down program when available at the sites) and staff orient these consumers to the CSS close to their time of discharge as a support option they can engage with. These pathways have been well received by the sites that have implemented them and enabled the services to enhance their reach.

There are also some nuances around the self-referral pathway. Four of the seven sites (Metro North, Metro South, Townsville, and West Moreton) allow consumers to self-present to the CSS once they are known to the service (i.e., are repeat visitors) and can bypass the need for an eligibility assessment. To manage capacity within the space, Metro North and West Moreton require consumers to call beforehand. In contrast, Wide Bay, Mackay, and Cairns enable first time visitors to directly access the space, with the CSS clinician completing an eligibility assessment upon their arrival to the CSS. The benefit of allowing consumers to self-present is that they can completely bypass the need to go to ED, with many consumers speaking during the interviews about how they valued this aspect of the service.

Metro South utilise an Electronic Journey Board to visualise and manage referrals into and out of the CSS. This has provided a useful tool that assists in managing the capacity of the CSS, helps staff to plan for a consumer's arrival, and enhances the communication and workflow between the CSS and referring HHS teams. The functions of the Electronic Journey Board are highlighted in the case study below and the tool is recommended for other sites to implement to help manage referrals to and from the CSS.



Case study: Metro South | Electronic Journey Board

An Electronic Journey Board displays information about the status of CSS consumers, with functionality described below:

- Consumers are placed on the CSS Program Journey Board when they arrive at the CSS.
- Details of their presentation and the activities they do whilst in the space are recorded in the platform.
- Consumers who are expected to utilise the space as part of their transition or discharge plan from the inpatient unit are placed onto the CSS Program Expect Board by the Discharge Facilitator so CSS staff can anticipate their arrival. Similarly, community mental health team clinicians (e.g., from ACT) can refer a consumer who may be suitable for CSS and add them to the Expect Board.
- CSS clinicians can make referrals to other services and visualise these referrals on the board. For example, if a consumer meets criteria for acute care, then the CSS clinician can facilitate the referral to the ACT via the Journey Board.
- Entry and exit SUDS scores are recorded in the comments section of the CSS Program Journey Board.

6.1.3 Interventions, supports and activities provided

Consistent with state-wide Service Guidelines, the interventions and supports provided through the CSS are largely consistent across sites. However, provision of follow-up care does vary once a visitor has exited the CSS. Metro North will routinely complete a follow-up call with the consumer and/or carer the day after accessing the service to see if they would like to re-visit the CSS and confirm if there is anything they can do to support them further. In contrast, at the Mackay, West Moreton and Wide Bay CSS sites, this follow-up call will come from the Acute Care Team (and only in situations where this is clinically indicated). Those consumers and carers interviewed who received a follow-up call found this to be beneficial and therefore, other sites are encouraged to consider implementing this type of support.

“They generally give you a call the next day. They ask if you’d like to have a follow-up call, so it’s your choice whether you’d like to have one or not. It’s to see how things have gone at home after leaving the Safe Space, to see how you went with the safety plan. To check-in about whether you need to come in again and receive some more support again.” Consumer

The majority of CSS sites (Mackay, Metro North, Metro South, Townsville, Wide Bay, and West Moreton) offer a range of different mindfulness and distraction activities for individuals accessing the service, including colouring in, games, magazines, and music. These activities can help consumers relax into the CSS environment and act as a tool to build trust and rapport with the peer-workers prior to a discussion about their mental health. These sites also provide a range of fidget toys and sensory items, as well as self-help materials and printouts which consumers can then take home. Consumers spoke during interviews about the value of taking these materials home so they can continue to regulate their distress and practice the techniques learnt at the CSS. However, the Cairns CSS is unable to offer these kinds of activities and materials as the room they have been allocated within the hospital to deliver their service from is too small. As discussed further in Section 6.3.2, this highlights the need for services to be allocated an appropriate space from which to operate.



“They gave me a little gift bag with stuff to help with anxiety. It had some sensory stuff in it, so like a stress ball. It had some mentos for taste...it just had lots of sensory stuff to help with anxiety. I still have it to this day.” Consumer

“I made like little flashcards with affirmations, it was really nice and relaxing to go through affirmation cards they had and then write out the ones I liked. Then we laminated them and cut them out and put them on a little ring. So, I can just carry those around with me.” Consumer

The Cairns CSS is supporting a number of consumers who are presenting to the service with mental health concerns and are experiencing a co-occurring situational crisis of homelessness. This site has undertaken substantial work to develop supports that are appropriate to this group of consumers, as is outlined in the case study below.

Case study: Cairns | Supporting people experiencing homelessness

There is a large homeless population in Cairns. Consequently, the Cairns CSS has been providing support to a number of consumers who are experiencing homelessness. Staff reported that these individuals are typically open consumers of the mental health service who are also sleeping rough.

The Cairns CSS ethos is that people experiencing homelessness are in crisis and therefore should not be excluded from the CSS. Homeless services in Cairns are stretched and so the Cairns CSS is helping to meet this significant need in their region. Activities they have conducted to support this group include:

- The service developed informational materials that they distribute to consumers experiencing homelessness which provide a directory of the community support services available to them in the local area, such as shelters and food banks.
- The service offers consumers food and drink and provides a charging station to recharge their phone.
- The Cairns CSS have promoted their space with local homeless services.

Consumers reported during interviews that they valued how the Cairns CSS provides a place they can go to feel safe, accepted and cared for, and where they are ‘treated like a human’. This was in contrast to how they had experienced other services where they often felt stigmatised. It is evident that the CSS is providing an important service to the local homeless community who are also experiencing crisis and mental health challenges.

6.1.4 Data collection

There is considerable variability in the data collected by the individual sites. All of the sites, except Wide Bay and Metro South, have implemented the SUDS as the key outcome measure for the CSS, in line with the state-wide Service Guidelines. Each of the seven sites uses a different set of items to measure consumer satisfaction with the service, with none of the sites using the two recommended items from the Service Guidelines. West Moreton, Metro South, and Metro North are also collecting data on carer satisfaction, using a similar version of the survey that is administered to consumers. Furthermore, each site collects process data in addition to that which is recorded in CIMHA on varied indicators, such as interventions delivered, if carer was present, and time spent in CSS.

This variability in data collection poses challenges for evaluating the implementation and outcomes of the CSS at the state-wide level. Some further standardisation of measures collected should be considered, while balancing the need for sites to have flexibility in the data they collect which is beneficial to them at the local level. At a minimum, it would be useful if all sites implemented the SUDS and adopted the two recommended consumer satisfaction items outlined in the Service Guidelines. Process data on important indicators that enhance state-wide evaluation



capacity is also recommended, with the data collected by Mackay providing a good example of key indicators to be considered.

Case study: Mackay | Process data

Mackay is collecting process data on a range of indicators that are useful for understanding the implementation of the CSS, including:

- Referral source (self, MH CALL, ED, co-responder, ACT)
- Time spent in CSS (arrival time, departure time, total time)
- Activities and interventions delivered (sensory strategies, peer support, clinician support)
- Referrals made (ACT community, ED medical review, ED ACT Ax, IRSP, AODS, LLW, other, nil)
- Support person present (yes/ no)
- Main presenting concern (alcohol/ substance related, suicidal ideation, feeling lonely, anxiety, psychosocial issues, situational crisis, carer burnout)
- Exit destination (D/C home, ED – medical, ED- ACT)
- Person used CSS before (yes/ no)
- Encounter type (seen in CSS, ED in-reach, call taken)
- ED diversion (diverted ACT input, diverted ED, diverted ED + ACT)

6.2 Recent changes to Service Model

6.2.1 Expansion in operating hours

During the pilot phase, CSS sites typically operated 25 hours per week across four days. All CSS sites have subsequently expanded their operating hours (as at 1st July 2023), with the services operating 7-days per week on a 45- or 65- hour per week model (see Table 10).

Table 10 | Operating hours of the CSS sites.

CSS site	Pilot phase opening hours	Expanded opening hours
Cairns	Thurs to Mon: 3:00pm – 8:00pm Total: 25 hours/ week	Mon to Thurs: 12:00pm – 8:00pm Fri: 11:00am – 8:00pm Sat and Sun: 8:00am – 8:00pm Total: 64 hours/ week
Mackay	Mon to Fri: 5:00pm – 10:00pm Total: 25 hours/ week	Mon to Fri: 3:00pm – 10:00pm Sat and Sun: 3:00pm – 9:30pm Total: 48 hours/ week
Metro North	Thurs to Sun: 4:00pm – 9:30pm Total: 22 hours/ week	Mon to Sun: 2:00pm – 10:00pm Total: 56 hours/ week
Metro South	Thurs to Sun: 4:00pm – 10:00pm Total: 24 hours/ week	Mon to Fri: 12:00pm – 9:00pm Sat and Sun: 11:00am – 9:00pm Total: 65 hours/ week
Townsville	Wed to Fri: 2:00pm – 10:00pm Total: 24 hours/ week	Mon to Fri: 12:30pm – 9:30pm Sat and Sun: 11:30am – 9:00pm Total: 65 hours/ week



Wide Bay	Fri to Mon: 4:00pm – 9:00pm Total: 20 hours /week	Mon to Sun: 2:00pm – 9:00pm Total: 49 hours/ week
West Moreton	Sat to Mon: 4:00pm – 11:30pm Total: 22.5 hours / week	Mon to Sun 3:30pm – 10:00pm Total: 45.5 hours/ week

Overall, expanded operating hours have been well received by consumers, carers, and staff with numerous benefits observed. First, CSS staff reported that having expanded operating hours has increased their job satisfaction as they are able to work longer shifts and have days off in between. This, in turn, has improved the stability of the CSS workforce with reports of slower turnover of staff since the expansion to operating hours was implemented. Second, the expansion in opening hours has also facilitated an increase in referral numbers and enhanced service accessibility for consumers. Third, staff reported that the CSS being open every day of the week has made their opening hours clearer for the referring teams.

“Opening up those extra hours is just so much better, knowing on the weekend that I can go in there in the morning – like if I’ve had a bad night, I can go in there in the morning, that’s really comforting. I think the extended hours are great.”

Consumer

“It has also created a sense of stability as well for those people that were referring to us because I think some of those people out there were a little bit confused about when the space was open as well. Now that everybody knows the space is open 7 days a week, it has given them some security that if I do refer my clients there, I know it’s going to be open. And the people that work there now, that they actually feel valued, that the work that they are doing is meaningful and that there is a slower turnover of the staff in that space as well.” **Peer Team Leader, CSS**

However, West Moreton and Mackay experienced limitations in expanding their operating hours during the day on weekdays as these sites share their CSS room with other teams who occupy the space until the afternoon. Despite this barrier, these sites have been able to expand operating hours later into the evening and on the weekend.

6.2.2 Accepting referrals for youth

The state-wide Service Guidelines changed to allow CSS sites to accept referrals for 16- and 17-year-olds. The guidelines stipulate that this can occur if it is mutually agreed by the CYMHS, ACT, ED, and NGO provider teams. Wide Bay was the first site to accept referrals from this youth cohort, highlighted in the case study below. Recently, Mackay started to accept referrals from this group and the majority of other sites are still in the planning phase to implement this change. Metro South will not be expanding to accept referrals from 16-17 year olds as the Princess Alexandra Hospital doesn’t have a CYMHS service and any young person under 18 years old gets referred to the Queensland Children’s Hospital instead.



Case study: Wide Bay | Delivering services to youth aged 16-17 years

Wide Bay CSS began operating in February 2022 and started taking referrals for 16–17-year-olds soon after. Interviewed Staff reported that expanding the CSS to younger adults was beneficial, as it adds a greater diversity of people presenting to the space and normalises the experience of receiving support for mental ill-health. Staff also spoke of how accepting youth referrals has increased the accessibility of the CSS, as young people are able to access support services outside of school hours.

Through accepting referrals for youth, the Wide Bay CSS has been filling a gap for both adolescents who have a lengthy history of requiring support (including frequent ED use) and those who have just received a mental health diagnosis and present early in their journey.

6.3 Factors impacting implementation and sustainability of CSS

6.3.1 Staffing arrangements and capacity

To operate effectively, the CSS need to be able to recruit and retain staff with the right skills and experience. Interviewed Staff reported that the types of skills that make someone a good fit for the CSS include general counselling skills, good communication skills, ability to work well in a less structured environment, resilience and empathy. In addition to this, interviewees felt it was important that peer-workers have rich lived experience; and that clinicians have a good understanding and respect for peer-work.

“If you’ve got someone who is really structured in the way they work, they’re not the ideal person to work in that environment because it can be chaotic at times. You’ve got to be able to go with the flow. And you’ve got to be able to communicate with any person. Good communication skills are really, really important.” **Clinician, CSS**

“You need to be empathetic. And for the clinicians, truly acknowledging and being supportive that peer-work is its own discipline. We’ve had a few in the space that are very much not supportive of peers, but that’s only happened a few times. But I think the biggest thing is empathy and being able to listen.” **Peer Worker, CSS**

Recruiting the right clinician for the CSS was viewed as important by peer-workers, and necessary for ensuring that they feel safe working within the CSS and able to share their stories with consumers. In practice, this has been hit and miss. It is therefore recommended that peer-workers be involved in the recruitment of clinicians to ensure the clinician is the right fit for the team.

“It would be nice, because it’s a peer-led service, if we had input on the clinician recruitment. It just gets sprung on us, sort of thing. And it’s really important to keep our space safe, not just physically but psychologically. And that requires the right people working. Because at the end of the day we do share our own stories, so we need to be able to trust the clinicians to do that.”

Peer Worker, CSS

Sites reported several challenges associated with staffing the space. High rates of staff turnover were discussed during interviews; with temporary contracts, the need to work late nights, insufficient work hours available, and



burnout cited as key reasons responsible for this. At times, sites have had difficulties in staffing the CSS due to staff turnover and one reported reducing their operating hours temporarily as a result.

“With our space, I think it’s about 30 staff we’ve had turnover. I think the biggest thing is that it’s in the evening. You have got a lot of people that have children and can’t do the evenings. And if you’re fulltime you can only do 25 hours a week. People can’t afford to survive on that. Then you’ve got people that get affected by the work. Vicarious trauma, things like that. We’ve had people leave because they’ve become unwell.” **Peer Worker, CSS**

“Staff left because they got a permanent job. This is not permanent, it’s contract-based. It can be full-on. I can remember one day we had nine consumers that went through in seven hours. So it’s about job security. There’s no permanent role and some people, they’ve got a better opportunity.” **Clinician, CSS**

“Because of the changes in staffing, we had to close the Crisis Support Space a couple of days on different occasions as we didn’t have peer workers. Some people just left, and recently our clinician left as well. Now we are operating six days and Wednesday only three hours and Sunday we are closed.” **Clinician, CSS**

Some CSS staff discussed how CSS clinicians and team leaders were ‘spread thin’ in their roles, given the range of duties they have and scope of their portfolio which they need to manage. This was perceived as contributing to burnout. One strategy that was recommended to address this was hiring administrative staff to assist with the administrative functions of the CSS. This would free up more time for clinicians to focus on other duties that are more specific to their skillset and expertise. In addition, team leaders felt that the current staffing allocations for the CSS were insufficient and found it difficult to backfill positions when staff were sick or on annual leave. Consequently, they suggested having additional staffing within the service (such as an additional clinician on rotation).

The lack of permanent staffing was perceived by stakeholders as contributing to a lack of ownership over the CSS, and frequent changeover in clinical and leadership positions has led to challenges in implementing the service. Therefore, establishing permanency in roles could serve to enhance staff recruitment and retention as well as support effective service implementation.

“The project lead position was vacant for a few months. The clinical positions were never filled on a permanent basis. So it was very, very messy. And because of not having permanent staff attached to it, nobody had ownership of it.” **Team Leader, CSS**

6.3.2 CSS location and space allocation

All seven of the CSS sites included within this evaluation are located within hospital grounds, and most stakeholder groups reported that this location within the hospital was important. To staff and consumers, benefits of the hospital-based location included easy access to the CSS for those consumers who were referred via the ED and availability of appropriate support in the case a consumer needs to go back to the ED or needs an admission. The hospital location was also viewed as necessary by staff for achieving the outcome of avoiding ED presentation.

“One of the positives of being where it is, is that if anybody does become really unwell, you can get them back to the Emergency Department. All it takes is a phone call to us and we’ll either go and fetch them or they’ll bring them over if somebody does become unwell.” **Clinical Nurse Consultant, ED**



"I think there's value in terms of the ease of access to be able to get people here from the ED. Because I think a lot of people might have been challenged if they were here at the hospital and then they have to go somewhere else." **Clinical Nurse Consultant, ED**

"The hospital is the best place to put it. If you go to the Crisis support Space and it's worse and you need proper help, then they're at the hospital then. I think having it in the middle of town or something, would be a lot harder if someone hurts themselves to then call an ambulance, wait for the ambulance, you know." **Consumer**

"If the Crisis Support Space is there to avoid people going to the ED, then it really does need to be at a hospital close to ED." **NGO Manager**

However, some consumers felt that the hospital-based location can be triggering due to previous adverse experiences they have had with the mental health system. Consequently, staff and carers spoke about the value of having the CSS located in a place on hospital grounds where it felt sufficiently separate to the clinical hospital environment. The location of West Moreton's CSS in Jubilee House was cited as an example where this had been achieved.

"Because it's in Jubilee House, even though it's at the hospital, it's separate to the hospital. It's a totally different looking building, and it's got lovely gardens around it. But it's also good that it's on hospital grounds because of access to any emergency stuff that is there too. Even though my daughter didn't want to go into the hospital, she knew she was at the hospital, and even though she was at Emu Café she was still attached to the hospital if she really needed extra help. But she was still in a safe space. Even though the hospital was triggering for her, it was still right there, that safe bubble is still there." **Carer**

In contrast, the Cairns CSS is located in a space that has no windows and is next to the inpatient mental health wards. This location was reported as being triggering for some consumers, and staff cited that some consumers chose not to go into the space because of its location. Together, these findings highlight the need for CSS to be allocated an appropriate space within the hospital grounds to enable the service to be delivered in an environment that is consistent with the service model (i.e., feeling safe, home-like, warm, and welcoming).

"It's between the wards. That was a bit of a hassle because I don't really have fond memories of those wards, and you have to be right in the middle of it. It put me off and a few other people off that I'd spoken to as well. Even people that were in there. They couldn't quite 100 per cent relax, because they just kept thinking of the fact they were right beside the wards." **Consumer**

It was also evident from the evaluation that there would be benefits in having a community-based CSS location in addition to a hospital-based CSS, with several consumers, staff and stakeholders recommending this option. These interviewees felt that a community-based CSS would be more accessible for those consumers who find hospitals triggering and won't access the service if it's located there. Furthermore, it could act as a 'drop-in centre' and provide an option for offering consumers with ongoing support when they have a less acute presentation and are accessing the space for social connection or to prevent crisis. This was suggested as an option for those consumers who present frequently to the service and would then free up capacity for the hospital-based CSS to focus on groups of consumers who are experiencing an acute state of crisis.



“I think multiple locations in a region would be good. Having one location at the hospital is incredible, It’s the best location it could possibly be. But having a secondary location that’s not as closely affiliated with the hospital might make other folks more comfortable going there, because I know a lot people are scared of going to the hospital.” **Consumer**

In Metro North, there is both a hospital-based CSS and a number of community-based Safe Spaces in the region. The interactions between the two services and the benefits of having both of these services within the Metro North region are discussed in the case study below.

Case study: Metro North | Interaction between hospital and community-based crisis support care

Within the Metro North HHS region, there is both a hospital-based CSS located at The Prince Charles Hospital as well as four community-based Safe Spaces located in Caboolture, Redcliffe, Bardon, and Strathpine.

The two services have collaborated across several domains of service delivery, including:

- The lead clinician of the CSS was part of the advisory group involved in the establishment of the community-based Safe Spaces;
- The services refer consumers to each other; and
- The services have explored opportunities for job shares with staff shadowing shifts at the other service.

Staff felt that the presence of the community-based Safe Spaces has been beneficial in the Metro North region and has provided an appropriate long-term option for CSS staff to transition consumers from the CSS to ongoing support. The presence of both services enhanced consumers access to crisis support care, with consumers reporting they had accessed the community-based Safe Spaces when the hospital-based service was at capacity.

Other important considerations for the implementation of the CSS are the size and configuration of the CSS space, as this impacts the experience of privacy for visitors. Staff at several sites reported that the size of the space they operate in is small, which means that the privacy of consumers conversations can be compromised. Several consumers also reported that they felt their conversations could be overheard and were able to hear others’ conversations as well. To facilitate a sense of privacy within the CSS, sites reported using furniture, available outdoor areas, and music to create a sense of privacy for visitors. The establishment of private rooms within the CSS to facilitate private one-to-one conversations has been recommended by staff and consumers. In addition, several staff and consumers across sites felt that the CSS services need to be located within a larger space to enhance privacy for visitors and increase capacity to accommodate more guests.

“I can tell you straight away, one thing I don’t like about the place is that it’s too small and you can hear people’s conversations and you know that they can hear you. So you become inhibited and you don’t want to say anything.” **Consumer**

Other unique challenges were experienced by certain sites relating to their CSS space allocation. For example, Mackay and West Moreton share the space with other teams, which requires them to set-up and pack-down the CSS each day, therefore posing limitations upon when they can operate. Wide Bay was given a temporary building for service operation and there was uncertainty from staff about the future location once this arrangement had ended. These challenges highlight the importance of each CSS having their own dedicated, permanent space within the hospital and has been recommended by staff as an area for future improvement.



“It has been very frustrating for us working in a co-located area. It’s proved very difficult because we could only open for so many hours of an afternoon. We can’t even open at 4:30pm when we’re supposed to. I would suggest that everybody, if they can, has their own building because it is very hard to run the program in a shared space.” **Team Leader, CSS**

6.3.3 CSS procedures, processes and scope of practice

Clear procedures and processes that support the operations of the CSS help to ensure that the model is implemented with fidelity and assist with onboarding new CSS staff. In addition, documented procedures help referring teams to understand and follow the referral process, which in turn facilitates the receipt of appropriate referrals to the service and supports positive working relationships with these teams. One site reported that their lack of documented procedures was a key area for improvement and a lesson in which they hope new sites learn from, as it had led to miscommunication and arguments with the referring teams concerning the process for how potential consumers can be referred.

“I feel like having all the processes established from the beginning, and not just making them up as you go along. To be honest, we’re still in the process creation stage and we’ve been open for two years. Like with the referral pathways, what happens when ED want to refer someone, or when someone wants to self-refer? Having those clear guides set up from the beginning is number one. From there, it’s less messy and there’s less miscommunication, and there’s less arguments with other parts of the service as to how someone gets referred. Because it’s all written down, then it’s all really clear.”

Clinician, CSS

Furthermore, service implementation is enhanced when the scope of practice of peer-workers and clinicians is clearly defined and understood by CSS staff. This supports staff to operate within the boundaries of their role. Some peer-workers reported during interview that their scope of work is unclear at times and that having better clarity over their scope of practice would be helpful for them in their role.

“Clarifying the scope of practice. I think it’s really important to have the peer workers understand what their scope of practice is, and that there’s a lot of clarity around that. Not just for us, but also for clinical staff as well. I think it can get a little bit grey at times and I think it’s just good to have clarity around that, so that we can advocate for ourselves and also ensure that we’re staying within our boundaries and not working outside of scope.” **Peer Worker, CSS**

6.3.4 Staff training, supervision, and support

There is considerable variability in the training that CSS staff receive. In particular, for peer-workers where the training they receive is dependent on whether they are employed by an HHS or NGO; and which NGO they are employed by. Some sites provide and/or require no training that is specific to the peer-worker role, while others have peers undertake training in suicide interventions skills (e.g., Mental Health First Aid, Applied Suicide Intervention Skills Training) and the peer-work model. When provided, training in suicide intervention skills and the peer-work model was viewed by peers as pivotal in preparing them to work in the CSS environment. At other sites where this type of training was not provided, peer-workers felt that having this training would be beneficial. Some NGOs and HHSs also support their peer-workers to undertake a Certificate IV in Mental Health if this is something they are interested in doing, and was perceived by staff as a beneficial qualification to have.



In order for the CSS to function effectively and achieve good outcomes for consumers and carers, staff working within the CSS need to have appropriate training, supervision and support. Consumers, HHS staff and broader stakeholders felt that peer-workers would benefit from more training. Similarly, several peer workers identified areas in which they felt more training would be useful. In addition to having suicidal intervention skills and training in peer-work, suggestions included Dialectical Behaviour Therapy (DBT) and strategies for working with common but complex consumer presentations (e.g., borderline personality disorder, bipolar disorder). In addition, some staff felt that CSS clinicians would benefit from receiving training in the peer model. Given this feedback and the lack of consistency in the training offered to staff across sites, establishing some mandatory training requirements for each role within the CSS is recommended to ensure the safety and quality of service delivery.

“Really just give the peer workers a bit more training to help people. That would probably be all that I would change.”

Consumer

“I think the peer workers need better training. Personally, I would teach people dialectical behaviour therapy skills so they can help people manage and regulate their emote. I think other things that people should be trained in is in developing safety plans.” **Team Leader, Mental Health**

Regular supervision and debriefing sessions are important for CSS staff, as they provide the opportunity for ongoing training and development and are a platform for having discussions about strategies to use when working with particular consumers who have complex presentations. In addition, regular supervision and debriefing sessions were viewed as important for maintaining staff mental health, reducing burnout and enabling staff progression in their careers.

“I think one-on-one supervision is really important, not only for support and being able to talk about things that have happened at work and stuff like that, but also if we want to move forward in our role, in our career and maybe take on a more senior position or something like that.” **Peer Worker, CSS**

“The idea of practice supervision is that it’s a regular opportunity for our team to meet as a group with the practice supervisor who has pretty extensive experience working within the mental health sector. So they’re able to meet with that supervisor every month, and it’s essentially an opportunity to not only debrief about the experiences working in the space, but particularly for our peer workers is really centred around ensuring that we’re having those regular check-ins in terms of supporting our peer workers’ wellbeing, but also using it as an opportunity for further training and development. So if we happen to have a visitor who has accessed the space who may have presented in a complex manner, they can ask questions around how to best support that person.” **NGO Manager**

Structured supervision and mentoring sessions typically happen once or twice per month across sites. An early learning that was reported was around the need to factor in time for supervision (as well as team meetings and admin) during staff’s working hours at times when the CSS is not open to consumers. A few sites also reported that it is challenging to find time for these more formal supervision meetings due to limitations in the number of hours that people can work at the CSS, and difficulties in getting the whole team together at once when that they work on different days. Therefore, some sites were conducting supervision sessions outside of shift hours to enhance the likelihood that all staff can attend.



“When we initially opened, it was for consumers to access the entire time that staff were there, so that meant that there was no time for supervision for team meetings, for admin. Because as soon as it was open you could have a consumer in the space and it’s literally one room so there’s no room to do any sort of non-consuming facing work. We had to adjust our staffing times so that we were open for an hour before and after shifts without being open for consumers. That was a big learning.”

Team Leader, CSS

Informal supervision also occurs during shift, with senior peer workers providing support, training, and mentorship to more junior peers. Staff and stakeholders reported the need to ensure one senior peer worker is on shift for this purpose, however in practice this was difficult to achieve at times when only one senior peer worker was employed by the CSS. Therefore, hiring an additional senior peer-worker at each may assist with addressing this. In addition, some staff felt that the senior-peer worker role should be at the A05 (rather than A04) level to enhance supervision, mentoring, and support of peer-workers. Peer workers also felt that a daily debriefing was optimal, with some sites conducting informal debriefings at the end of each shift. It is recommended that daily debriefings are implemented more broadly. Furthermore, staff in Townsville spoke positively about their Practice Supervision Model, which is highlighted in the case study below.

Case study: Townsville | Practice Supervision Model

Townsville CSS has adopted a Practice Supervision Model which is available to selectability employed peer workers working within the CSS. The model promotes opportunities for individual and group options of supervision and is offered to allow the lived experience workforce to fully unpack and share their experiences where they feel most comfortable. This model comprises of the following elements:

- Daily informal debriefings conducted at the start and end of each day, led by the CSS clinician. In addition, the CSS clinician monitors peer workers’ engagement with consumers and monitors the notes they enter into CIMHA, then provides direct support when required.
- A monthly meeting for peer-workers and the selectability Practice Supervisor to reflect on the past month working in CSS, including any challenging or complex presentations that may have come through the space. Further training and development are also provided in these meetings.
- A monthly meeting with the ACT Team Leader, both CSS clinicians, selectability Team Leader, and two rotating peer-support worker representatives to discuss any outstanding tasks from previous meetings and further develop practice approaches. There is the opportunity for ad-hoc meetings to be arranged as required if any concerns impacting service operation require attention.

6.3.5 Relationships between stakeholders

6.3.5.1 CSS clinicians and peer-workers

The CSS works best when there is a positive working relationship between CSS clinicians and peer workers that is built on mutual respect and trust. Clinicians and peer workers then work together effectively as a team to support the consumers and carers who access the service. When there was a good working relationship between peer workers and clinicians, this was underpinned by clinicians having a good understanding of and respect for peer work and enabling the service to be peer-led as it is intended; and the peer workers understanding the role clinicians play in supporting them when needed.



“The relationships between peers and clinicians is paramount, because we have to trust them and they have to trust us to feel comfortable, to be able to share and to do those things, and ask those questions when we’re not sure as well. And we have to trust them and feel confident that the clinicians are making the right decision as well.” Peer Worker, CSS

“I think you need to have a really cohesive team, there needs to be trust and there needs to be collaboration amongst your team for it to be successful. Because we have more peer-workers than we do clinical staff and the governance falls on the clinical staff, they need to be able to trust that the peer workers are going to escalate any risk to them. Trust and transparency, I cannot stress that enough.” Peer Worker, CSS

“I think the relationship between peers and clinicians is quite positive. I think from what I’ve seen the peer workers are very good at what they do in terms of understanding the role of what the clinician is there for and the support that the clinician can offer if needed.” Clinician, CSS

“One of the clinicians has been really great and he’s very supportive of us peer workers and sits back and lets us take the lead.” Peer Worker, CSS

Staff also discussed the importance of the need for the personalities of CSS staff to fit well and felt that opportunities to build team cohesion outside of the workplace would be beneficial to enhancing workplace relationships.

“We were such a close-knit team and we just gelled and there were no issues and they respected us if we had our own thoughts or opinion. I think we’ve always said it’s really important who the actual clinician is, not just their knowledge and stuff but their personality as well. I just think having the right sort of personalities and team is needed and having the ability to team build outside of the space.” Peer Worker, CSS

6.3.5.2 CSS staff and referring teams

As previously discussed in Section 4.4.3 and Section 5.2, it is paramount that the CSS staff have a good working relationship with the ED and other referring teams (e.g., ACT). When good working relationships are present, this facilitates both the number and appropriateness of referrals to the CSS. It also helps to develop effective referral pathways that enable consumers to be rapidly triaged and consequently diverted from ED.

6.3.5.3 HHS and NGO

When NGOs are involved in delivering the CSS, strong working relationships between the NGO and HHS are a facilitator of implementation. Effective relationships were present when the HHS demonstrated commitment to an equal partnership between them and the NGO in delivering the CSS. Similarly, implementation of the CSS was enhanced when there were appropriate shared governance mechanisms in place between the HHS and NGO, regular meetings, and effective bi-directional communication pathways.

“In general, it’s a very positive relationship, very respectful, and it’s always been so. There’s that long-term relationship that exists between some of the senior leaders. I think there was a commitment from the word go to be a real partnership in the CSS. That was very apparent to me early on and there was this big effort in consulting with us. There’s this mutual good governance that flowed on and there’s mutual information going both ways. I think we’re all committed to working together for the benefit of the client group.” NGO Manager



In Cairns, there is evidence of a strong partnership between the HHS and the NGO, Mind, in delivering their CSS. Examples of the shared governance mechanisms and areas of ongoing collaboration between the HHS and Mind is highlighted below.

Case study: Cairns | Partnership with Mind in delivering the CSS

Cairns and Hinterland HHS and Mind have a strong partnership in implementing their local CSS. Key areas in which they collaborate include:

- CSS Operational Meetings (bi-monthly)
- CSS Governance Meetings (quarterly)
- Co-development and co-implementation of the CSS Model of Service and Guidelines
- Co-recruitment of CSS peer-workers and clinicians
- Co-delivery of 'CSS Roadshows' to the community sector
- Co-delivery of 'Service Huddles' to Queensland Mental Health teams

6.3.6 Funding

Having a sustainable, ongoing funding source is necessary for the sustainability of the CSS. Several interviewed staff and stakeholders expressed that cuts to operational funding would risk service sustainability. A few stakeholders felt that securing future funding for the CSS in future would rely on the ability to showcase service benefits for consumers and the mental health system. Another expressed that this is particularly important for the CSS because of concern that the CSS is an easy target for funding cuts as it does not bring in funding like traditional bed-based hospital services.

"I think funding in general would be one of the bigger risks. Because I mean, if they don't receive enough funding they won't have any Crisis Support Space. I would say that's one of the biggest challenges that they will face." **Clinician, ACT**

"In terms of the hospital perspective, because it's not a bed-based service or attracts funding in that way, it's an easy service to pick off. I guess if funding cuts start to happen that would be where services would traditionally look at first before they would look at inpatient services, for example. We need to just continually remind people about why this is a good thing, how consumers respond to this, what they get out of it. Because we'll never be able to compete with the big numbers or the bed-based funding that looks good on hospital reporting." **Team Leader, CSS**

6.4 Summary of findings

- The implementation of the CSS is relatively consistent across sites, however some variations were identified in the source of peer workforce employment; referral pathways; types of interventions, activities and supports offered and the data collected by sites.
- The evaluation identified several factors which underpin the successful implementation and sustainability of the CSS including sufficient workforce capacity; adequate staff training and supervision; appropriate CSS space allocation; quality relationships between stakeholders; clear procedures, policies and scope of practice; and sustainable funding source. Gaps and areas for improvement were identified across factors.



7. Effectiveness of CSS

Defining and evaluating effectiveness of the CSS

The effectiveness of the CSS explores the extent to which the CSS has achieved its intended outcomes for consumers, carers and the healthcare system. It also looks at the mechanisms and factors underpinning these outcomes to understand how and why the CSS works.

This section of the report answers the following key evaluation questions:

- Has the CSS reduced consumers' experience of psychological distress, and why/ why not?
- Has the CSS led to reduction in ED presentations, and why/ why not?
- Has the CSS led to a reduction in length of stay in ED for consumers, and why/ why not?
- Has the CSS led to a reduction in mental health admissions, and why/ why not?
- Has the CSS improved consumers' experience of crisis support care, and why/ why not?
- Has the CSS improved consumers' access to crisis support care, and why/ why not?
- What impacts has the CSS had for carers, how and why?

7.1 Impact on psychological distress

To explore whether the CSS may have impacted consumers' experience of psychological distress, analyses were undertaken which compared consumers' average (mean) scores on the Subjective Units of Distress Scale (SUDS) at the beginning (i.e., pre-) and end (i.e., post-) of their visit to the CSS. The data showed that consumers experienced an average reduction in their SUDS scores of 2.9 points at post-CSS. This reduction in SUDS scores was even greater when looking specifically at initial visits to the CSS, where an average reduction of 3.6 points on the SUDS was observed. As shown in Table 11, within-groups t-tests indicate that these reductions in SUDS scores are both statistically significant ($p < .001$) and equivalent to a large effect size (Cohen's $d = 1.30 - 1.66$).

Table 11 | Within-groups t-test of change in SUDS score from pre- to post- CSS visit.

Timepoint	Mean	St Dev	Estimated difference	95% CI	t-value	df	p-value	Cohen's d
All visits (n = 2,810 paired observations)								
Pre-CSS	6.10	2.28	-2.86	-2.79;-2.93	-77.99	2809	<0.001	1.30
Post-CSS	3.24	2.09						
Initial visits only (n =721 paired observations)								
Pre-CSS	6.84	2.18	-3.56	-3.40;-3.72	-43.29	720	<0.001	1.66
Post-CSS	3.27	2.11						

Note. This does not include data from Metro South or Wide Bay sites, as data on SUDS is not currently collected.



Figure 13 | Distribution of change in SUDS scores at post- CSS (inclusive of all visits to CSS).

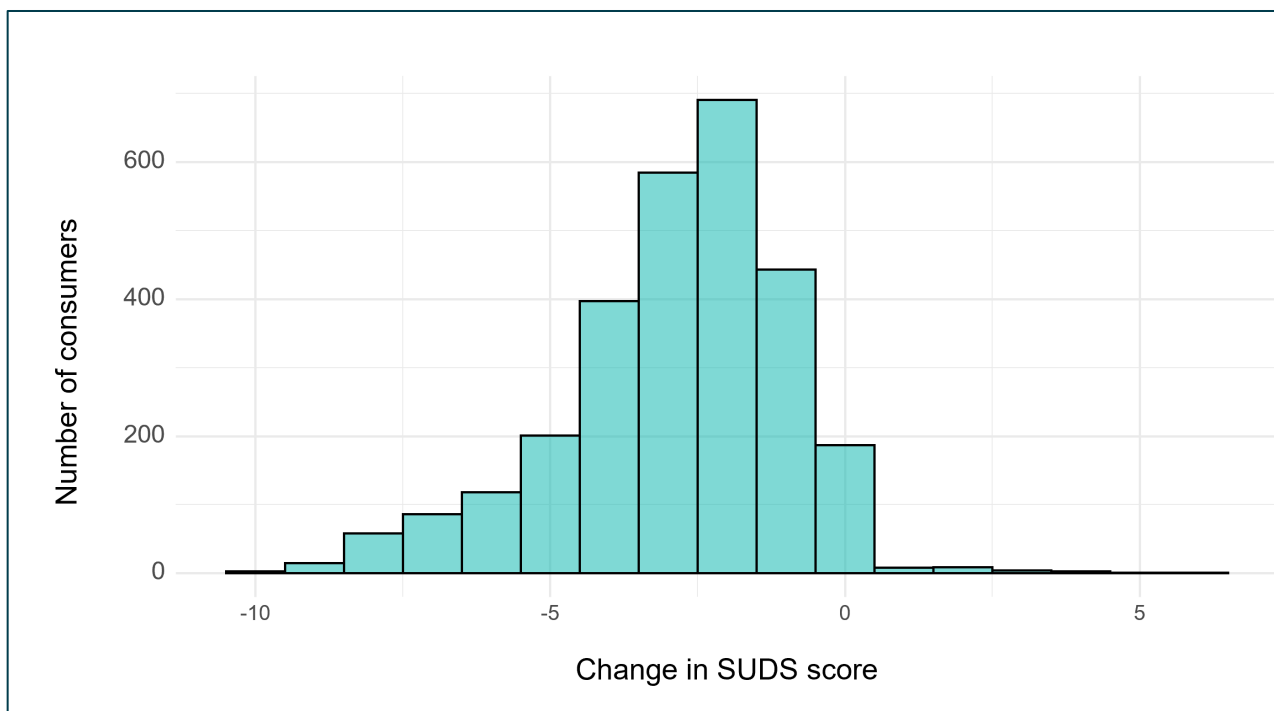
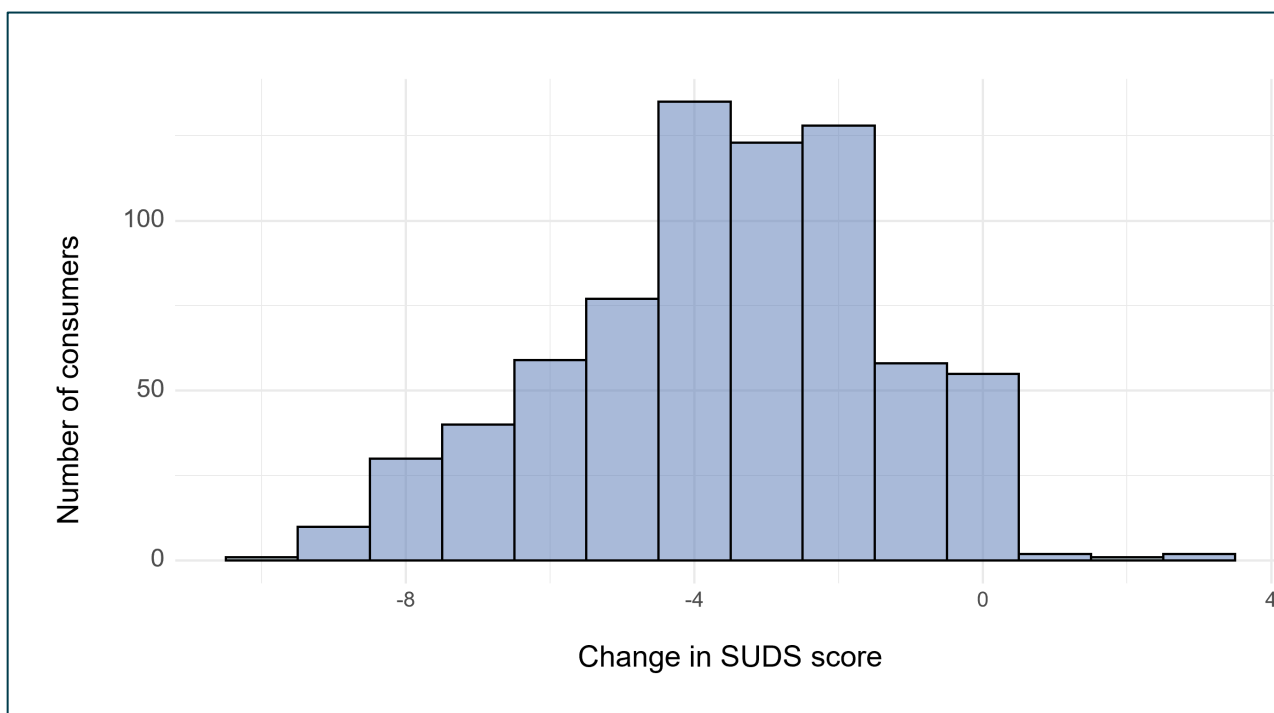


Figure 14 | Distribution of change in SUDS scores at post-CSS (inclusive of initial visits to CSS).



Consumers also spoke during interviews about the positive impact that the CSS had on their experience of psychological distress. Several reported feeling calmer and safer as a result of visiting the CSS and were able to leave in a more positive and clear mental state.



“Each time that I’ve been there, I was always a lot calmer on the way out and feeling a lot safer on the way out.” Consumer

“You tend to leave in a better head space, a bit more happy, a bit more clearer. You do always leave on a sort of positive note.”

Consumer

“They’ve been quite helpful in reducing my distress levels and giving me an option that I feel I have that I can go to.” Consumer

This reduction in psychological distress was attributed to the CSS environment, which was perceived as calming, warm, relaxing, safe, and welcoming. In addition, the use of the sensory items (e.g., massage chair) and mindfulness activities (e.g., colouring in), as well as ‘talk therapy’ with peer-workers helped to de-escalate consumers’ experience of distress.

“I think just like the low stimulating environment, like with soft lighting and comfortable chairs and like sensory things. I think that really helped de-escalate my emotions.” Consumer

“I think just the feeling of safety and security. The chairs were comfortable. That always helps. They have a beanbag with weight things that make you feel more relaxed.” Consumer

“Some days I am really strung out and that’s when I need to get this shit out of my head. I don’t know what to do here. Or I need some guidance. Some days I will go to a five, and I feel agitated and on edge. Nine times out of 10, I’ll come out a one or a zero. Some days a two-minute conversation – that’s all it took. Then I just go in the massage chair. It’s a safe head space for me. No matter what’s going on outside, I can actually switch all that off.” Consumer

Together, these findings provide good evidence that the CSS is effective at helping consumers to reduce their psychological distress. However, it cannot be determined if the change in psychological distress as indicated by the reduction in SUDS score is clinically significant given the absence of literature regarding the psychometric and clinical properties of the 11-point scale used by the CSS.³

Another impact, linked to psychological distress, that emerged through the interviews was that the CSS is helping consumers to reduce their experience of suicidal ideation and engagement in self-harm behaviours.

“I haven’t self-harmed or had a suicide attempt since I started going there. I was attempting suicide and in the ED after attempts and self-harm events once or twice a month, so it was quite regularly. Since I was introduced to this service, I haven’t.” Consumer

³ Only one previous study has reported on the clinical significance of change in SUDS scores. McGlade and colleagues (2023) examined exposure treatment for social anxiety disorder with adult participants who reported their level of distress before and after treatment using the SUDS scale with a 0-100 scaling. The research found participants reported a significant reduction in distress of 33.2 points on the SUDS, which the authors interpreted to be clinically significant. However, given the lack of literature on the psychometric properties of the SUDS scale it is unknown whether clinically significant results on the 101-point scale can be generalised to the 11-point scale used by the CSS.



7.2 Impact on ED presentations

To explore whether the CSS may have contributed to ED diversions, quantitative analyses was undertaken which compared the average (mean) number of ED presentations (with a primary diagnosis code indicative of mental illness, self-harm and/ suicidality) that consumers had in the 6-month period prior to and after their initial visit to the CSS. Within-groups t-tests were undertaken to examine this change in the entire sample of CSS consumers as well as for those individuals with at least one ED presentation in the 6-months prior to their initial visit to the CSS (see Table 12). These analyses found that the entire cohort of consumers demonstrated no change (mean difference = -0.01 visits) in the number of ED presentations in the 6-months following their initial visit to the CSS. However, a statistically significant, small-sized reduction, was found in ED presentations (mean difference = -0.35 visits) for those consumers with a prior history of presenting to the ED.

Table 12 | Within-groups t-test of change in number of ED presentations from 6-months pre- to post-initial CSS visit.

Timepoint	Mean	St Dev	Estimated difference	95% CI	t-value	df	p-value	Cohen's d
All consumers (n = 1,279 paired observations)								
6-months pre CSS	0.84	2.13	-0.01	-0.09; 0.07	-0.24	1278	0.810	0.004
6-months post CSS	0.83	2.34						
Consumers with at least one ED presentation in 6-months prior to initial CSS visit (n = 499)								
6-months pre CSS	2.58	4.10	-0.35	-0.65; -0.05	-2.31	498	0.021	0.08
6-months post CSS	2.23	4.89						

The qualitative data provided additional insights into the potential impacts of the CSS on ED presentations. Indeed, several staff who were interviewed reported that ED presentations had reduced as a result of the CSS. This was typically viewed as being specific to certain individuals who previously presented to the ED on numerous occasions but now present to the CSS frequently instead; and for those who would present to the ED frequently but didn't need the type of care provided by the ED.

"I think the ED is busier than it ever has been. But for certain presentations, I say it has reduced. For people that would come and want to see the doctors but didn't really need to, I think some of that has reduced. The soft presentations, if we call them that, that just needed a friendly face and encouragement and some reassurance. I think again those type of clients have gone down to the crisis space." **Social Worker, ED**

"We know who our regular presenters were and before they were regular presenters to the Crisis Support Space, they were regular presenters to the ED. But they were not getting the same level of service in the ED that they get in the Crisis Support Space. Arguably they might present more now to the Crisis Support Space than they did to emergency." **CSS Project Manager**



"We have one consumer in particular who would be in the ED weekly with chronic suicidality. Since engaging with our service, she's not had an ED presentation." Peer Worker, CSS

Consumers interviewed reported that in most cases, they would choose to go to the CSS rather than going to the ED. The reasons for this are described in more detail in Section 7.5.2. However, they also reported situations in which their mental health has deteriorated to the point where they know that they need the type of medical care and support that is provided through the ED, and would therefore present to the ED instead of CSS in those instances.

"I have enough insight into my illness now, and so does my dad and my family, that we tend to know what I need and I was past the point in the manic episode where my thought processes were so far gone that I needed an admission. So I needed to go straight to ED. The Crisis Support Space itself wouldn't have been enough to keep me out of the manic state that I was in. That's why, because my level of acuity was to the point that just going to the Space wouldn't have helped. I mean it would have helped alleviate my emotional distress, but I needed medical intervention." Consumer

Staff also reported that there are times in which consumers have been unable to access the CSS when they needed to because the service has been at capacity or closed, meaning that they had to present to the ED instead. Consequently, several consumers and staff recommended an expansion in service operating hours and capacity.

"We only have a very small space to work from, and it is going to get to the point soon where we're going to need a bigger space and more staff. Because we don't want to get to the point where we're turning too many people away. We have had an incident recently where a consumer rang up and was told that we were too busy and she ended up calling the ambulance and presenting to ED, which isn't what we want." Peer Worker, CSS

"I've been to the ED a couple of times since going to the CSS the first time. But only when it wasn't open. Like when those gates were closed and the CSS was locked, I went to the ED. But I wouldn't go to the ED if the CSS was open." Consumer

Because of the nature of ED clinical governance ED, it can be challenging to divert consumers from the ED to the CSS when they come in on an Emergency Examination Authority (EEA). ED diversions are often made possible through self-referrals where once a consumer has been assessed for the CSS on their first visit (such as through the ED or ACT) they are able to re-present without needing to go through ED. Similarly, ED diversions are made possible via alternative HHS pathways (e.g., MH CALL, co-responder) whereby consumers are assessed as being suitable for the CSS and able to bypass going to the ED. Therefore, the availability of referral pathways that operate outside of the ED are key to ED diversion.

"It probably hasn't helped with ED avoidance greatly because a good amount of people accessing ED care in mental health crisis come with police or ambulance after an emergency authority. Because of the nature of that involuntary assessment, they're required to go directly through the ED." Team Leader, ACT

"I think initially the model was arranged in a way that people had to present to ED to access Safe Space, but that doesn't really support what you're trying to do with Safe Space in terms of offering an alternative. Through trust building in the service, now the two ACT clinicians are comfortable with take a call through MH CALL, triaging that and then liaising with Safe Space to see



if the person could go direct to Safe Space rather than having to present to ED and have a full assessment first. That's a really good change to the model and obviously it saves people that journey of having to go and wait in ED.” Team Leader, CSS

Overall, it is challenging to assess the impact of the CSS on ED diversion due to an absence of available data on this outcome. The present evaluation was able to utilise data on the number of ED presentations that consumers had pre- and post- their initial visit to CSS to draw inferences about the potential impacts of the service on ED diversion. However, this approach is limited in that it cannot be ascertained how many of these ED presentations may have been appropriate for the CSS and therefore potentially avoided compared to those which clinically required a visit to the ED. Some sites, like Mackay have started to collect data on ED diversion which is entered on a case-by-case basis as the consumer arrives at the CSS based on information gathered on their journey into the CSS. It is recommended that this be implemented more broadly across sites to enhance the capacity of future evaluations to assess the impact of the CSS on ED diversion.

7.3 Impact on ED length of stay

To explore whether the CSS may have contributed to a reduction in length of stay in ED for consumers with a mental health presentation, an analysis was undertaken to compare the average length of stay for those times in which the CSS was closed compared to those times in which the CSS was open. This analysis found that during the times in which the CSS was open, the average length of stay in ED for consumers with a mental health presentation was 24 minutes shorter than those times in which the CSS was closed. As shown in Table 13, a Welch two-samples t-test found that this reduction in ED length of stay was statistically significant ($p < .001$). This finding suggests that the implementation of the CSS may be helping to reduce ED length of stay for consumers with a mental health presentation.⁴ This is particularly promising given that the CSS are designed to be open during the hours in which ED are busiest.

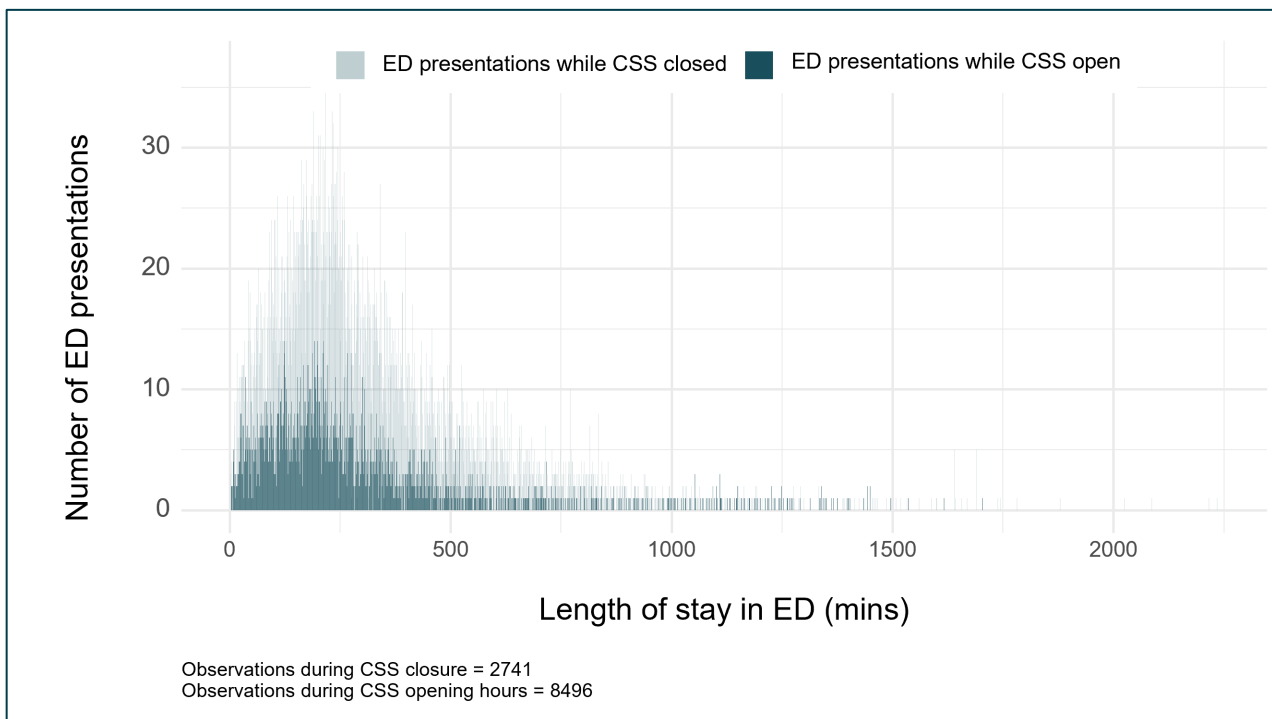
Table 13 | Independent samples t-test of difference in ED length of stay for times in which the CSS was opened vs. closed.

Group	Mean	St Dev	Estimated difference	95% CI	t-value	df	p-value	Hedge's g
CSS closed	316 mins	236 mins	-24 mins	13 mins; 34 mins	4.323	4406	<.001	0.10
CSS open	292 mins	252 mins						

⁴ Due to a lack of available data from an appropriate control group, the findings from this evaluation can only suggest that the CSS has helped to reduce ED length of stay. Causation cannot be inferred based on the adopted research design and alternative explanations for these positive results cannot be entirely ruled out based on the available data (e.g., that there were less presentations to ED overall during the times in which CSS was open, or that another program that has been implemented at HHSs was responsible for this reduction in length of stay).



Figure 15 | Distribution of ED length of stay when CSS opened vs. closed.



While the precise mechanism of action is unclear from the data available to this evaluation, it is hypothesized that the CSS helps to reduce ED length of stay through implementing referral pathways that enable consumers to be rapidly assessed, triaged, and then referred to the CSS (as opposed to waiting for hours in the ED to be medically cleared). The extent to which the latter occurs in practice varies. For example, Cairns has achieved success with implementing a rapid referral pathway within ED whereby a Clinical Nurse Consultant will triage individuals presenting with a mental health issue within the 10-minutes of arrival to ED. If they are appropriate for the CSS then they can be referred there, as opposed to waiting in the ED for a full medical assessment. Other sites have experienced challenges in achieving this due to concerns from ED staff around clinical governance and risk, and a reluctance from relevant leadership in signing off on processes that would enable this to occur. As discussed in Section 6.3.5.2, this highlights the need for buy-in and support for the CSS from the ED and broader HHS staff as well as the development of strong working relationships with the referring teams.

7.4 Impact on inpatient admissions

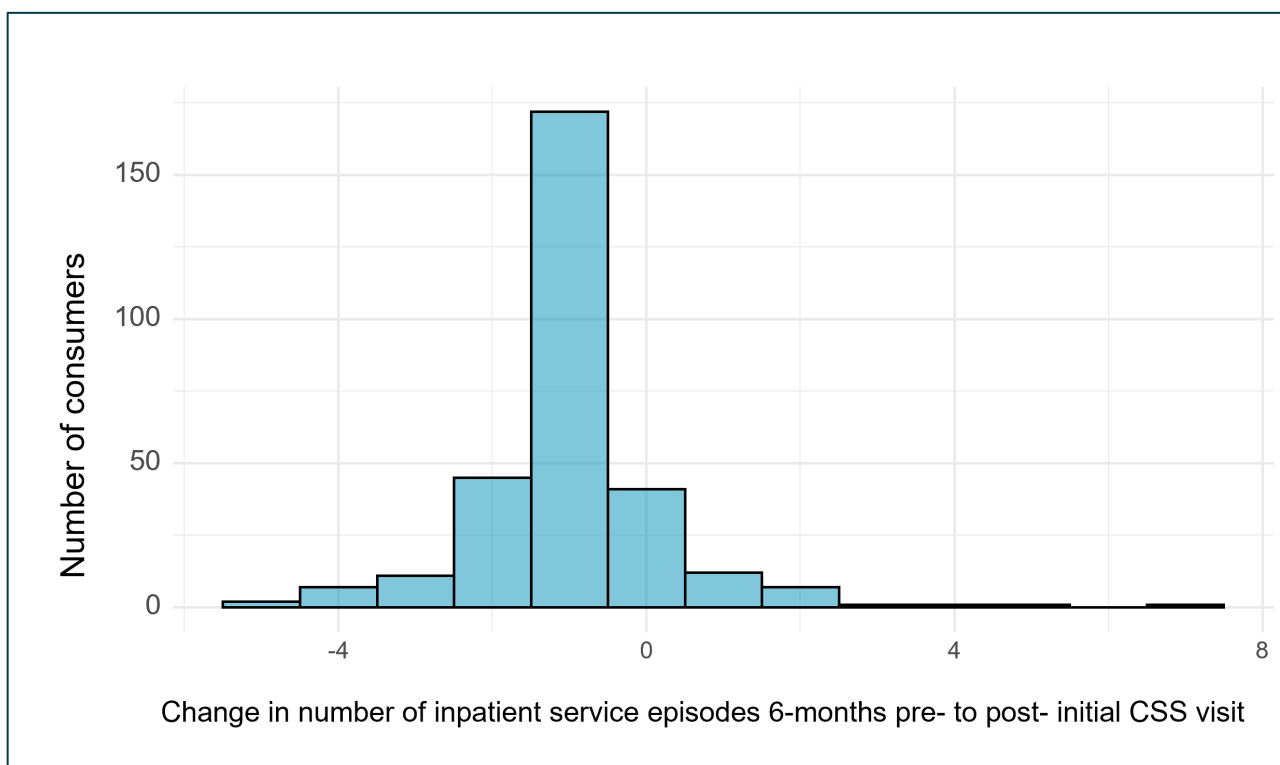
An analysis of change in the average (mean) number of acute inpatient service episodes in the 6-month period prior to and after a consumer's first visit to the CSS was undertaken to explore whether the CSS may have helped to prevent inpatient admissions for consumers. Within-groups t-tests were undertaken to examine this change in the entire sample of CSS consumers as well as for those individuals with at least one inpatient admission in the 6-months prior to their initial visit to the CSS (see Table 14). No change was observed when considering all consumers who presented to the CSS, however this is not surprising given that most consumers (56%) had no recent admissions. Importantly, when looking at those consumers who had at least one inpatient admission in the 6-month period prior to their initial visit to CSS, the data showed an average reduction of approximately 1 service episode (mean difference = -0.96) at post-CSS that was both statistically significant ($p < .001$) and equivalent to a large effect size (Cohen's $d = 0.85$).



Table 14 | Within-groups t-test of change in acute inpatient service episodes in the 6-months pre- and post- initial CSS visit.

Timepoint	Mean	St Dev	Estimated difference	95% CI	t-value	df	p-value	Cohen's d
All consumers (n = 529)								
6-months pre CSS	0.90	1.09	-0.09	-0.21; 0.34	-1.413	528	0.158	0.08
6-months post CSS	0.81	1.04						
Consumers with at least one inpatient admission in 6-months prior to initial CSS visit (n = 301)								
6-months pre CSS	1.58	1.02	-0.96	-1.10; -0.81	-13.172	300	<.001	0.85
6-months post CSS	0.62	1.22						

Figure 16 | Distribution of change in acute inpatient service episodes (inclusive of consumers with at least one inpatient admission in 6-months prior to initial CSS visit).



Consistent with the quantitative data, the interviews also provided evidence that the CSS is helping to prevent inpatient admissions. Indeed, several consumers reported that the CSS was preventing them from being admitted and CSS staff believed that the service had helped to avoid inpatient admissions. Interviewees explained that this was achieved through assisting consumers to de-escalate, teaching them skills to manage their mental health, and



through developing safety plans. Together, these findings suggest that the CSS may be effective at preventing inpatient admissions for those consumers who had recently been engaged with acute inpatient mental health services.⁵

“It’s been a great support, yeah. What I’ve got out of it, it’s helped me keep out of hospital I’d imagine. That’s the main thing I think. So yeah, it’s definitely effective in that sense.” **Consumer**

“They keep me out of an admission quite regularly, so normally if they weren’t there and if I’m not able to go there, then it would probably be ED and an admission. Generally though, I can go there and they’re able to bring my stress levels down or formulate a safety plan with me. Then my stress levels have decreased by the time that I’ve left and I’m not actively thinking about suicide and I’m able to just continue managing problems that come up and my symptoms, until it gets a little bit worse gain, then I’m able to re-present. It means I don’t have to go to ED, and I don’t need an admission and all the hassle that brings.” **Consumer**

“They’re not having as many admissions to the Mental Health Inpatient Unit. Because when they’re starting to have the crisis, they know they’re having a crisis, you can de-escalate them. One of our biggest things is de-escalation. They come in high stressed in a crisis saying, ‘I need to be admitted to the Unit.’ Then we’re like, ‘Okay, let’s sit down and unpack this. Why do you think you need to be admitted to the Unit? What’s going on?’ I think our service does stop Mental Health Inpatient Unit admissions.” **Peer Worker, CSS**

7.5 Impact on consumer experience with crisis support care

7.5.1 Consumer satisfaction with CSS

Given the extensive variability in the nature of the items used by sites to measure consumer satisfaction with the CSS, and the lack of data collection on carer satisfaction by most sites, the present evaluation was unable to undertake a quantitative assessment of consumer and carer satisfaction with the CSS. Therefore, the semi-structured interviews provided several insights into this evaluation question.

Evidence obtained from the interviews indicates that most consumers were largely satisfied with their experience of the CSS. Most spoke very positively about the service, felt that it met (or even exceeded) their needs and expectations, and several expressed that it was the best experience they had had with a mental health service.

“I could not imagine a better support than what we received that day, and its possibly one of the best examples of mental health support I’ve actually see in my life first person. How quick it was and how immediate and compassionate it was. They just attended to my needs so effectively. I could continue talking about which needs they attended to, but at the end of the day, the best statement to make is they attended to all of my needs successfully and that helped me for months in my life already.” **Consumer**

⁵ The lack of data from an appropriate control group prevents conclusions regarding causality from being made. Therefore, the mixed-methods evidence obtained through this evaluation can only suggest that the CSS has helped to prevent inpatient admissions. Alternative explanations for this finding are unable to be ruled out based on the available data (e.g., that engagement with another mental health service that a participant was engaged with concurrent to the CSS was responsible for the reduction in inpatient admissions).



"I'm very satisfied. Every time I've been in there it was very helpful. In the time that I have been trying to get help for my mental health, the Crisis Space has been like far and above anything else I've ever used before." **Consumer**

Consumers spoke about several aspects of the CSS which underpinned their satisfaction with the service. The majority of consumers and carers spoke very positively about their interactions with the CSS staff, reporting how they found them to be friendly, warm, welcoming, non-judgemental and easy to talk to, which in turn made them feel safe and comfortable. Linked to this, consumers valued how staff did not stigmatise them for having a mental illness and instead treated them with kindness, respect and validated their experience. Consumers also valued how staff remembered them and their story and made them feel truly heard. Together, these behaviours exhibited by staff helped to build rapport and trust between them and the consumer.

"I think the best part was how inviting the staff were and how comfortable they made you feel. You don't feel judged, it just feels very safe." **Consumer**

"I like the warm welcome, and just how everyone's really friendly in there." **Consumer**

"The fact that I actually felt like that they were actually listening. Because say we go in there after this interview, they'll remember the last thing we spoke about it and they'll remember your names." **Consumer**

"Everyone was very welcoming, very understanding. And so they built up a good rapport with me." **Consumer**

Many consumers highly valued speaking and connecting to the peer-workers with lived experience, who were able to understand and empathise with what they were going through and provide helpful advice on how to manage their mental health that drew upon the peer worker's personal recovery journey.

What I like about it is the peer workers are all going through some type of mental health issue themselves. I like the fact that the peer workers have some understanding of the journey I'm going through and whatever else the people that use the service are going through, because they're going through their own mental health issues themselves. They get where you're coming from and give you little bits and pieces to try, just to help you get by. Like tools they've used that may work for you." **Consumer**

It was important to consumers that they had control over their visit to the CSS, in that they were able to leave the CSS when they felt ready and safe to do so, and could self-direct the nature of the supports they received. Similarly, they valued how the peer-workers waited until they were ready to talk and did not place pressure on them to share anything they were not ready or willing to discuss.

"In the crisis support centre there is no time limit. You're welcome to stay as long as you like or as long as you need or as long as the opening hours." **Consumer**

"They come and sit with you if you want or they leave you alone if you want. It's very – you're in charge. They don't try and control you or tell you that you should feel something." **Consumer**



7.5.2 Comparison of CSS experience to ED

Overall, the evidence supports that the presence of the CSS within the hospital grounds improves consumers' experience with crisis support care. Consumers who were interviewed often reported having had adverse experiences with the ED, describing instances where they had to wait a long time to be seen and received inadequate support that was actually detrimental to their mental health at times. In addition, the ED environment was often described as distressing as it was crowded, noisy, and had bright lights.

In contrast, consumers and carers were able to access the CSS without a long wait time and felt that the CSS offers a more calming and safer environment where they are treated *"like a human not a number"*. They also reported that in most cases, the CSS was more effective than the ED in helping them to manage their crisis because the type of care provided (e.g., talk therapy with peer-workers who have lived experience) is more appropriate for their needs.

"I think that going to a space like the CSS is much better than going to the ED because you present to ED and they're so busy. Generally, the ED staff don't like having mental health patients present, so generally you don't get the nicest treatment. They can be rude to you, not understanding, they don't really get it. Frequently I present to ED at 8:00pm and then I'd sit on a chair in the waiting room without food, unable to sleep, distressed, just alone essentially until 4:00am when a clinician would come to see me. That just makes everything worse. Whereas going to the Crisis Support Space you have someone to talk to almost immediately. They usually have a calm, welcoming environment where you just feel safe, compared to the ED noises and business and the lights. Some of them I've been to have food, make a cup of tea and you're able to actually speak to someone a lot quicker. I find them much better than ED." **Consumer**

"The ED is overcrowded, it's noisy, it's boring, it's hell. But with the Crisis Support Space, you'll walk in there and it's just very chilled and relaxed. Everything's calm, quiet, peaceful, not overcrowded. Definitely a different space. In the ED you're treated as a number versus a person. Mental health patients don't always get the best assistance in medical. But with the Crisis Support Space, you're treated as a person, you're treated like a human being, which helps." **Carer**

7.6 Impact on consumer access to crisis support care

It is evident from the interview data that CSS presence across Queensland has helped to enhance consumers' access to crisis support care. Indeed, several consumers interviewed reported that prior to the CSS opening there was nowhere for them to get help when they were experiencing a mental health crisis. Similarly, many reported that if the CSS was not available or open then they would have nowhere else to go for support. Therefore, the CSS is meeting a significant gap in the mental health service system, as there are a lack of out-of-hours crisis support options available other than presenting to the ED.

"It's not the first time I've had a crisis, but it's the first time in my life that I've had somewhere to go." **Consumer**

"If they didn't exist, I'd have nowhere to go. I'd be struggling. I'd be struggling 100 percent. I hope they never get rid of them."
Consumer

The accessibility of the CSS is an important feature of the service to consumers and carers. They valued and found comfort in the fact that they know they can re-present to the CSS when they need to, and can receive care that is



not only appropriate to their needs, but is also free and does not involve a lengthy wait time. These factors also underpinned satisfaction with the service.

“It’s just been a really important one for me, of having somewhere that I can go back to if I’m really struggling. I know that I’m not going to have to have this huge wait time of like weeks or months to be able to see someone.” **Consumer**

“As you know, therapy can be very expensive. This is a good, free service. It’s good in the sense that’s a free service if someone can’t afford therapy. Because I’m sure there’s many out there who are suffering from depression, who can’t afford to go see a therapist to get help. The fact that something like this exists is more than good. I can’t speak highly enough of it.”
Consumer

However, at times consumers reported that they were unable to access the CSS when they needed to due to the service not being open or at capacity. When this occurred, it contributed to a negative experience with the service for consumers. As a result, several staff, consumers, and carers have recommended that the CSS increases its opening hours and service capacity.

“One time we called up about going there and they told us to hold off for a while. Because they had too many people in the space, and they couldn’t take another person. That’s the only downfall for it that I could see. Because I know that it is going to get busier as more and more people know about the space. They need to put on more staff or whatever so that it becomes more usable for everybody that needs to go there.” **Carer**

To facilitate consumer access to the CSS it is also important that there is clear signage directing visitors to the CSS location. At some sites, consumers reported that the location of the CSS was difficult for them to find due to a lack of signage and available directions. In fact, one consumer mentioned that the first time they had tried to visit the service they were unable to find it. In addition to having clear signage and directions, peer-workers at several sites meet with consumers at the ED or reception to take them to the CSS. This both eases stress with navigation and provides a warm way of introducing new consumers to the service.

7.7 Impacts for carers

The carers interviewed through this evaluation consistently reported that the CSS provides a place where they can unwind and feel safe. They reported a great sense of relief knowing that there was support for them available at the CSS, as well as relief in knowing that their loved one had somewhere to go to receive help while in crisis. Carers also discussed the toll that caring for a loved one experiencing mental health concerns had on their own wellbeing, and that through receiving emotional and informational support from the CSS staff when visiting the service, this helped them to de-stress and manage their own mental health. In addition, being able to access the CSS helped carers feel less alone and validated their experiences through being able to talk to peer-workers who understood and could relate to what they were going through. CSS staff also spoke about the importance of providing carers with psychosocial education around carer fatigue, stress, and burnout and referring them to community resources and supports that meet their needs.

“The only downtime that I had was when we went to the Crisis Support Space. I could just make a cup of tea and just sit down. Especially at the start, it was really good for me to get out what I was going through too. One of the support workers there, she



was in a similar situation. So she was very understanding of what I was going through, and we were able to have a bit of a connection and laugh.” Carer

“It gives me somewhere, I guess you could say, a respite as well, so it reduces my stress and anxiety. Living with someone that’s suicidal, anxious, crying, very depressed, it takes its toll on me as well. So by going there I can chill out as well. It helps support people as well, definitely.” Carer

7.8 Summary of findings

- The CSS is effective at reducing consumers’ psychological distress, with consumers experiencing a statistically significant and large reduction in their SUDS scores (average change = -2.86 points) from pre- to post their visit to the CSS.
- There is emerging evidence that the CSS may be helping to reduce the number of mental health presentations to the ED for those consumers with a history of presenting to ED. A small, but statistically significant, reduction was observed in the number of times these consumers presented to the ED with a primary diagnosis of mental illness, suicidality and/or self-harm (average change of -0.35 visits) in the 6-month period following their initial visit to the CSS when compared to the 6-month period prior.
- Findings suggest that the CSS may be helping to reduce ED wait times, with the average length of stay in ED for consumers with a mental health presentation being statistically significantly shorter (average difference = -24 minutes) during times in which the CSS was open compared to times when its closed.
- The CSS may be helping to prevent inpatient admissions; those consumers with a history of inpatient admissions had a statistically significant and large reduction in their number of inpatient admission (average change = -1 acute service episode) in the 6-month period following their first visit to the CSS in comparison to the 6-month period prior.
- Interviews with consumers and carers showed that the CSS has enhanced their experience of crisis support care, with the majority highly satisfied with their experience of the service. Furthermore, consumers and carers consistently felt that the CSS provides a more appropriate option for crisis support than the ED.
- There is emerging evidence from the interview findings that suggest that the CSS has enhanced consumers’ access to crisis support care and is meeting a core gap in out-of-hours crisis support care.
- The interviews undertaken with carers indicate that the CSS provides valued support for carers, which helps them to maintain their own mental health and wellbeing while caring for a loved one experiencing mental health concerns.
- Interviews suggest that there are several ‘key ingredients’ underpinning the effectiveness of the CSS, including the warm and welcoming CSS environment, talking to peer-workers with lived experience, the interventions and supports provided (e.g., safety planning, distraction techniques), the person-centred



approach to care, the referral pathways into the service, and the service’s visitor capacity and opening hours. Mapping of these ‘key ingredients’ against outcomes is provided in Table 15.

Table 15 | Mapping of ‘key ingredients’ against the CSS outcomes through which they impact change.

	CSS environment	Peer-workers	Interventions / supports	Person-centred approach	Referral pathways	Visitor capacity	Opening hours
Reduced psychological distress	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
Reduced ED presentations					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Reduced ED wait times					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Reduced inpatient admissions			<input checked="" type="checkbox"/>				
Enhanced experience of crisis support care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>			
Enhanced access to crisis support care						<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Enhanced carer wellbeing		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				



8. Maintenance of CSS

Defining and evaluating maintenance of the CSS

At the consumer and carer level, maintenance of the CSS explores the extent to which the CSS has achieved a sustainable impact on individuals who have accessed the service.

This section of the report answers the following key evaluation questions:

- To what extent did consumers and carers develop knowledge and skills during their time at the CSS, and have they used these knowledge and skills since?

8.1 Impact on consumers' and carers' knowledge and skills

There was evidence obtained through the semi-structured interviews that the CSS is helping consumers to develop knowledge and skills that they use to self-manage their mental health and help prevent them from escalating to the point in which they are experiencing crisis. Indeed, several consumers reported that they had learnt to identify their personal triggers and were taught techniques by the peer-workers to help them de-escalate and distract themselves when experiencing heightened feelings of distress. Consumers found these techniques helpful and reported using them in their daily life to self-manage their mental health.

“Even just the techniques that they’ve helped me with, to combat that sort of stuff. I use it all the time. If I feel like I’m having a panic attack or anything like that, go have a cold shower or try and distract yourself. Like read something. Lots of sensory stuff too – put a scented candle on or something, just to activate your mind a bit more – a lot of the stuff they told me helps.”

Consumer

“Like I’ve cut back a lot on my anti-anxiety medications and stuff because they helped me to learn to deal with it a bit healthier. Now there’s just a whole heap of those weird toys all over the place. It’s just this silly little worm – but it’s like if you need to, it’s a sensory thing. And there’s heaps of other fidgets all over the place. But yeah, it was nice to learn different ways. To learn things that I can use to help bring down my anxiety or help focus on something. Like I’d never known my triggers for mania, and I’ve learnt a lot about that since going to the Crisis Space.” **Consumer**

In addition, several carers discussed that they too learnt techniques at the CSS which they then used to support a loved one experiencing mental health crisis. Some carers had also increased their knowledge of the mental health supports available to them in their role as a support person.

“She talked through some different techniques and tricks that no one had ever showed us before for anxiety. Even those Sour Worms and things. How sometimes, physical sensations in your body can disrupt those thought patterns. There were some practical things we picked up that we added to our toolkit. Like I always keep Sour Worms in the house and it can help disrupt that pattern if she’s starting to get wound up.” **Carer**



“In terms of my education on the support that’s available to me as a carer, and in the support that’s available to me as somebody who may experience crises, my education has increased tenfold of the available resources to me. [The CSS] is functioning very, very well as a hub of information.” Carer

8.2 Summary of findings

- The CSS helps consumers to develop knowledge and skills that they then use to manage their mental health and which help to prevent them from escalating to the point in which they are experiencing crisis. In addition, carers learnt techniques at the CSS which they then used to support a loved one experiencing mental health crisis.



9. Recommendations

Drawing upon the findings of this evaluation, QCMHR proposes 14 recommendations to enhance the future delivery and sustainability of the CSS across Queensland. These recommendations serve to address gaps, challenges and areas of opportunity identified through the evaluation. These recommendations are provided in Table 16, along with the rationale for proposing them and the suggested party with lead responsibility for implementation.

Table 16 | Detailed recommendations for the future enhancement of the CSS in Queensland.

Recommendation	Rationale	Lead responsibility
1. Provide ongoing and regular education about the CSS to referring staff.	Referrers (e.g., ED clinicians, co-responders, community mental health staff) having a sound awareness and understanding of the CSS underpins both the number and appropriateness of referrals received by the CSS, which then impacts the reach of the service. Promoting the CSS and providing education to potential referrers about the service (including what the service offers, what its opening hours are, who is eligible for a referral, and how to refer to the service) is needed to ensure a steady flow of referrals to the CSS. CSS staff reported that this been challenging to achieve due to the vast number of different staff working across referring teams. Therefore, promotional and educational activities with referring teams need to occur on a regular basis in order to be most effective. Further, it is recommended that sites develop local stakeholder engagement plans to support them in undertaking these promotional and educational activities with referring staff.	CSS Service Providers
2. Continue to build positive working relationships with referring teams.	It is important that CSS staff have a good working relationship with the ED and other teams which refer consumers to the service. The evaluation found that when good working relationships were present, this was associated with greater buy-in and support from the referring teams, which in turn, facilitated the number and appropriateness of referrals to the CSS. Therefore, sites should continue to invest effort and time into developing and maintaining positive working relationships with referring teams.	CSS Service Providers
3. Explore opportunities to further expand the operating hours of the CSS.	The evaluation found that the operating hours of the CSS influence the reach and effectiveness of the service. The recent expansion in operating hours was well received by all groups of stakeholders and has served to enhance the number of presentations to the service and the overall accessibility of the CSS for consumers. A consistent	MHAOD Branch



Recommendation	Rationale	Lead responsibility
	<p>recommendation that emerged from consumers, carers and staff was around the need to further expand the operating hours. They stressed that <i>'crisis doesn't happen on a timeline'</i> and ideally the service would be available 24 hours a day/ 7 days per week.</p> <p>It is recommended that opportunities to further expand the operating hours of CSS are considered, including exploration of the feasibility of expanding the service to 24 hours a day/ 7-days per week.</p>	
<p>4. Identify and implement local strategies for increasing presentations to the CSS from under-represented groups of consumers.</p>	<p>The evaluation identified that males, Aboriginal and Torres Strait Islander people and individuals from CALD communities were under-represented in the consumer cohort (relative to the eligible ED population) and therefore are groups that are less likely to be reached by the CSS.</p> <p>Further research (to be undertaken at the local level) is suggested to identify the reasons why these groups are under-represented, including understanding if they are less likely to be referred to the CSS and/or are less likely to uptake a referral (and if so, why). Potential barriers to accessing care for these groups should be explored, in addition to the cultural appropriateness of the spaces. The findings from this work can then support the identification and implementation of local strategies to enhance the number of referrals and presentations to the CSS from males, Aboriginal and Torres Strait Islander people and individuals from CALD communities.</p>	<p>CSS Service Providers</p>
<p>5. Develop appropriate support pathways to accommodate the needs of 'repeat presenters' to the CSS.</p>	<p>The evaluation found that there is a small group of consumers who are accessing the CSS very frequently and therefore a large proportion of service delivery is to being utilised by these 'repeat presenters'. At present, frequent visitors to the CSS are not explicitly accommodated within the model of service although sites have started to develop local strategies to support this group of consumers. It is important to ensure that the needs of frequent visitors to the CSS are met through the service. Therefore, appropriate support pathways should be developed and formalised, as well as written into the model of care for the CSS. The data obtained through this evaluation suggests that this should incorporate referrals for repeat visitors to more appropriate services that can support them long-term.</p>	<p>CSS Service Providers</p>



Recommendation	Rationale	Lead responsibility
<p>6. Explore opportunities to increase the number of guests the CSS can host at a time during opening hours.</p>	<p>The evaluation found that visitor capacity of the CSS (i.e., the number of consumers the CSS can see at a given time during its opening hours) impacts its reach and effectiveness. Consumers and staff reported that at times, consumers were unable to access the service when they needed to as it was at capacity. As awareness of the service increases and the CSS continue to become more established and embedded within their local mental health service networks, the demand for the CSS will increase. Therefore, it is recommended that opportunities to further expand the visitor capacity of the CSS are considered – such as through increasing the size of the spaces in which the CSS are situated and rostering on more staff.</p>	<p>MHAOD Branch</p>
<p>7. Ensure the physical spaces allocated to CSS sites are fit-for-purpose.</p>	<p>For the CSS to be effective, the services need to be allocated an appropriate space within the hospital grounds which enables the service to be delivered in an environment that is consistent with the service model (i.e., feeling safe, home-like, warm, and welcoming). However, some sites have been allocated spaces within the HHS to set-up the CSS that are not considered ideal (e.g., are very small, have no windows). Others have had to share their space with other services, which poses limitations on the hours during which they can operate. In addition, consumers and staff frequently commented on the small size of the CSS which impacts privacy for consumers and limits service capacity in terms of the number of guests it can accommodate at a time. Therefore, a common recommendation that emerged across the different stakeholder groups interviewed was around enhancing the space that the CSS have been allocated and ensuring that these are fit-for-purpose.</p>	<p>MHAOD Branch</p>
<p>8. Review current staffing arrangements to identify workforce barriers, enablers and solutions.</p>	<p>Adequate staffing is vital for successful implementation of the CSS; however staff and stakeholders reported several issues with the current staffing arrangements. For example: intense workloads for CSS team leaders and clinicians have meant these staff are ‘spread thin’ and over-burdened by administrative tasks; having only one senior peer-worker on staff makes it difficult to ensure that a senior peer worker is always on shift to provide appropriate supervision; and the current level of staffing for clinicians makes it difficult to cover sick and holiday leave.</p>	<p>HHSs and CSS Service Providers</p>



Recommendation	Rationale	Lead responsibility
	<p>The capacity of the CSS to recruit and retain staff with the right skills and experience was identified in the evaluation as being crucial to the service’s implementation. However, sites have encountered considerable difficulty with retaining staff and this has been, in part, underpinned by the lack of permanent contracts on offer.</p> <p>In light of these issues, it is recommended that a review is undertaken of the current staffing arrangements, with a view to determine if current staffing is consistent with the state-wide model. In addition, a broader workforce review should be considered to identify the barriers and enablers of a sustainable CSS workforce and to inform implementation of appropriate solutions.</p>	
<p>9. Develop and implement a set of standards outlining minimum training requirements for CSS staff to ensure a capable workforce.</p>	<p>Appropriate staff training ensures the safety and quality of service delivery. There is considerable variability between sites in the training provided to and required by peer-workers. Staff and stakeholders strongly recommended the need for peer-workers and clinicians to have more training in domains that are specific to the requirements of working within the CSS.</p> <p>It is recommended that a set of consistent, relevant training requirements for peer-workers and clinicians are established for the CSS that meet the needs of both staff and consumers. Suggestions include training in the peer-work model and suicide intervention skills for all CSS staff at a minimum.</p>	<p>MHAOD Branch</p>
<p>10. Clearly define the scope of practice for the CSS workforce.</p>	<p>The evaluation found that service implementation is enhanced when peer-workers’ and clinicians’ scope of practice is clearly defined and understood by CSS staff, which then helps these staff to operate within the boundaries of their role. Staff reported that their scope of work is unclear at times and that having better clarity over their scope of practice would be helpful.</p> <p>It is recommended that the scopes of practice for each of the roles within the CSS are clearly defined, documented, and communicated to the CSS workforce.</p>	<p>CSS Service Providers</p>
<p>11. Develop and implement supervision models in line with best practice.</p>	<p>Supervision and debriefings are important for ongoing training and development, maintaining staff mental health, reducing burnout, and enabling staff progression in their careers. There is considerable variability in the extent to which supervision and debriefings are available to staff</p>	<p>CSS Service Providers</p>



Recommendation	Rationale	Lead responsibility
	<p>across sites. It is recommended that supervision models are developed and implemented, consistent with best practice. This should include access to regular, individual supervision and daily debriefings.</p>	
<p>12. Establish and implement a standardised set of data indicators across CSS sites to enhance state-wide evaluation and monitoring capabilities.</p>	<p>The current evaluation encountered several challenges in evaluating the CSS at the state-wide level due to considerable variability in the process and outcome data collected by sites. In addition, data was unavailable on several indicators that are important to assess meaning that certain evaluation questions that were initially proposed were unable to be answered.</p> <p>It is recommended that a set of standardised measures are established across all CSS sites to enhance state-wide evaluation and monitoring capacity, with routine quantitative data collected on the following indicators (which is in addition to the data which is already routinely entered in CIMHA):</p> <ul style="list-style-type: none"> • Process data on referrals to CSS, including: <ul style="list-style-type: none"> ○ Characteristics of referred individuals ○ Reasons for non-uptake of referrals ○ Referral source • Process data on visits to the CSS, including: <ul style="list-style-type: none"> ○ Consumer’s reason for presenting to CSS ○ If consumer is a repeat presenter ○ If consumer presented with a support person ○ Types of interventions and supports delivered during visit ○ Amount of time spent in CSS ○ If referrals were made and to where ○ Where consumer went to after visit • Outcome data from visits to CSS, including: <ul style="list-style-type: none"> ○ Number of ED presentations diverted ○ Number of inpatient admissions avoided ○ Consumer and carer satisfaction with service experience ○ Change in psychological distress from CSS entry to exit 	<p>MHAOD Branch, HHSs and CSS Service Providers</p>



Recommendation	Rationale	Lead responsibility
	<p>These indicators should then be embedded within the CSS Dashboard to facilitate routine monitoring of service performance and inform regular continuous improvement activities. A program logic to support ongoing monitoring and evaluation of the CSS was developed through this evaluation and is provided in Appendix D.</p>	
<p>13. Commission an economic evaluation of the state-wide CSS to understand its cost-effectiveness and cost-utility.</p>	<p>Undertaking an economic evaluation of the state-wide CSS will greatly assist the MHAOD Branch with future decision-making regarding the service. At present, data is not routinely collected on indicators that are needed to conduct an economic evaluation (e.g., number of ED presentations avoided as a result of the CSS) and therefore this could not be undertaken through the present evaluation.</p> <p>It is recommended that the Branch commissions an appropriate service provider with expertise in health economics to undertake an economic evaluation of the CSS to understand its cost-effectiveness and cost-utility within the broader mental health system. Prior to this evaluation being conducted, this service provider will need to provide guidance to the Branch on the types of data that have to be collected at the state-wide level to enable a robust economic evaluation of the CSS to be undertaken. The Branch will then need to establish mechanisms for routinely collecting this data across Queensland.</p>	<p>MHAOD Branch</p>
<p>14. Undertake further service experience research using a representative sample of consumers and carers.</p>	<p>A key aim of the CSS is to improve the consumer and carer experience of crisis care, with the present research finding evidence that the service is achieving this aim. Despite the research team's best efforts to recruit a broad and representative range of visitor views, there are limitations to the generalisability of the service experience results given the characteristics of the sample of CSS visitors who were interviewed through this evaluation. For example, all but one of the consumers who were interviewed were repeat presenters to the CSS, although the majority of consumers who present to the CSS do so only once.</p> <p>Additional qualitative research should be undertaken to further understand consumer and carers' experience with the CSS, utilising a representative sample of service visitors. This sample needs to be inclusive of those consumers who present to the CSS on only one occasion and consider the voices of those who are referred but choose not to uptake the service. This particular piece of</p>	<p>MHAOD Branch</p>



Recommendation	Rationale	Lead responsibility
	work would benefit from being led by lived-experience researchers.	



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Appendix A: Review of global and national models of Crisis Support Spaces

There are a number of CSS models (similar to Queensland Health's CSS) which have been established in both Australia and overseas to provide person-centred support to people experiencing mental health crisis as an alternative to presenting to an ED. As part of this evaluation, a rapid literature review was undertaken of the peer-reviewed and grey literature to identify existing research studies and evaluations which have been conducted to assess the effectiveness of CSS models of care.

This section of the report presents:

- A brief description of the key features of CSS models which have been established in Australia and overseas;
- A summary of key findings regarding the outcomes of CSS models for individuals accessing the service and the mental health system; and
- A critical reflection on the methodologies utilised by past research studies and evaluations.

Safe Haven Café, Aldershot UK

In 2011, the UK charity organisation Mind commissioned an independent inquiry into acute crisis mental health services where they interviewed people with lived experience of receiving acute mental health care. People who had experienced a mental health crisis and sought services stated they would prefer to be treated in a more welcoming and respectful environment away from the EDs, as an alternative to the current medicalised model. It was also emphasized that many individuals preferred to receive support from peer workers, who are people that also have a lived experience of mental health crises and are employed in mental health services on this basis to provide emotional and social support for others experiencing mental crises (Mind, 2011). As a result of this work, the Safe Haven Café model was developed (Surrey and Borders Partnership Foundation NHS Trust, 2014).

The Safe Haven Café was established as a person-centred alternative to EDs for adults who are experiencing or are at risk of mental health crises. The service was launched in 2014 and it provides an evening drop-in service for anyone experiencing a mental health crisis or their carer. It is staffed by peer workers who provide one-to-one support and assistance with coping strategies, and mental health clinicians who provide initial triage, referrals and clinical support if required.

An evaluation of the Safe Haven Café was undertaken from 2016-2017 to provide an in-depth exploration of the impacts of the café on the consumer experience and healthcare utilisation. Service user feedback provided important insights into how the service is being used and the impacts of the service for visitors. This data showed that the most common reason for visitors attending the Safe Haven Café was to prevent themselves from escalating into crisis (56%), while 23% attended for social reasons, and 13% presented during crisis. Most visitors reported that the service prevented them from being in crisis (85%), helped them to manage a difficult time (89%), provided a safe place for them to go (94%) and better equipped them to manage their mental health crisis (90%). They were



also satisfied with their experience of the service (98%) and felt that they were treated with dignity, respect, warmth and compassion (97%) by service staff. Furthermore, 27% of visitors would have attended the ED if they hadn't been able to access the Safe Haven Café (Griffiths and Gale, 2017).

There were also three key findings relating to the system-level impacts of the service. Firstly, the evaluation found an average reduction of 48% in the number of times that service users attended the ED at 12-months following their first visit to the Safe Haven Café, when compared to the 3-months prior to their first attendance. Secondly, there was an average reduction of 16% in the number of admissions to acute inpatient psychiatric beds at 38-months following the service's launch in comparison to the 12-months prior to the service opening. Thirdly, there was an average reduction of 23% in the number of mental health related calls to police that resulted in police deployment in 2016-2017 compared to the year prior to the service opening (Griffiths & Gale, 2017).

St Vincent's Safe Haven Café, Melbourne Australia

The Safe Haven Café model was first introduced in Australia in 2018 at St Vincent's Hospital in Melbourne, Victoria, following the original Aldershot model of a person-centred alternative to EDs for mental health crises. Like Aldershot, the service operates as an after-hours drop-in centre that is staffed by mental health clinicians and peer workers, and is designed to provide a safe, supportive and welcoming space for people experiencing mental health crises. Furthermore, it offers one-to-one support to facilitate the development of self-management skills to improve mental health, and information on support options available (PWC, 2018).

An evaluation of the service undertaken by PWC in the same year suggested that the service reduced mental health presentations at the ED by 12%. As a result, this delivered estimated cost savings of more than \$33,000 per annum. Visitors to the café consistently reported positive experiences with the services and commonly described how they felt "welcome", "safe", "warm" and "comfortable" when accessing the café (PWC, 2018).

The Living Room, Illinois USA

The Living Room opened in Illinois in 2011, as a community-based alternative to EDs for people experiencing mental health crisis. Similar to the Safe Haven Cafés, The Living Room operates out-of-hours and is staffed by mental health clinicians and peer workers (Shattell et al., 2014). The service philosophy embraces the Recovery Model, with a focus on autonomy, respect, hope, empowerment, and social inclusion. Common interventions administered at The Living Room include assistance with developing coping skills, providing resources and referrals, problem-solving and de-escalation strategies, and social support (Heyland et al., 2013).

An initial evaluation of The Living Room conducted on service operations in its first year estimated that use of the service led to a 93% deflection rate from EDs, representing savings of approximately \$550,000 to the state health system (Heyland et al., 2013). A follow-up evaluation conducted in 2015 found that guests experienced a reduction in psychological distress from pre- to post- accessing the service, with an average reduction in Subjective Units of Distress Scale (SUDS) scores of 2.10 points. As a result, 94% of visitors did not require use of the ED within 30-days of accessing the service. The evaluation also found that talking with someone about the problem and using problem solving skills, learning coping skills, reassurance of knowing the service was there if needed and resources and referrals provided by staff were the most helpful aspects of the service (Heyland & Johnson, 2017).



Community Crisis Intervention Service, Northern Ireland UK

The Community Crisis Intervention Service opened in Northern Ireland in 2019, offering an alternative service to the ED for individuals who found themselves in a state of suicidal crisis. The service is delivered in a non-clinical environment by peer workers and clinicians; and provides an initial brief assessment and triage, de-escalation interventions, stabilisation through identification of further supports to address underlying concerns, and onward signposting to sources of support. Individuals can self-refer to the service by phoning the service themselves or be referred via community services (Ennis & Walker, 2022).

An evaluation of the Community Crisis Intervention Service was undertaken at the end of the first year with data collected via semi-structured interviews with five consumers. These consumers considered their experiences with the Community Crisis Intervention Service to be more appropriate and positive than the ED. They valued that the service was delivered in a warm and non-medical environment, which contrasted with adverse experiences they had previously encountered at the ED. The intervention was perceived as helping them to develop adaptive coping methods to manage future mental health crises and were successful in de-escalating their presenting state of crisis. Consumers were overall very satisfied with the service they received and described how they felt comfortable to seek help through the Community Crisis Intervention Service in the future if needed to prevent a mental health crisis from escalating to the point where they would need hospital care (Ennis & Walker, 2022).

Dial House, Leeds UK

The Leeds Survivor-Led Crisis Service was set up in 1999 by a group of consumers, who had campaigned for five years to develop the service, which became known as Dial House. The service was set up to be a place of sanctuary as an alternative to EDs for people experiencing mental health crises. Similar to the other services described, Dial House is an evening drop-in service where people in a mental health crisis can relax in a home-like environment and receive one-to-one support from peer workers to de-escalate their immediate crisis and develop skills to manage on-going crises (Leeds Survivor-Led Crisis Service, n.d.).

A service evaluation was completed in 2011 drawing on stakeholder interviews with Dial House visitors, carers, and staff. The authors reported that consumers found Dial House to be a place of sanctuary and a safe environment where they could relax and escape from the pressures that cause them to feel in crisis. The service was found to contribute to ED deflection as 75% of consumers reported they would have presented to ED if they were unable to access Dial House. Furthermore, a social return on investment analysis was conducted and estimated that the social value generated by Dial House was £5.17 for every £1 invested in the service (Bagley, 2012).

Safe Spaces, Brisbane Australia

Brisbane North PHN has established four Safe Spaces in the Brisbane region to provide a warm, welcoming, supportive and non-clinical environment for people experiencing psychological distress. These Safe Spaces are peer-led, operate on an after-hours basis, and are intended to provide an appropriate alternative to presenting to the ED. Peer-workers support Safe Spaces visitors to de-escalate their distress, assist with safety planning, and offer warm referrals to other services as required (Nous Group, 2023).

An evaluation of the Safe Spaces is underway by Nous Group and a progress report has been released in 2023 with some early findings. The evaluation found that most visitors (86%) to the Safe Spaces have experienced an



improvement in their psychological distress levels. In addition, the evaluation estimated that 176 ED-related admissions have been avoided through allowing guests to revisit the Safe Spaces (Nous Group, 2023).

Reflection on methodologies

When considering the findings of existing studies and evaluations which have assessed the effectiveness of CSS models of care, it is important to be mindful of the quality of the research methodologies employed. This is because the methodological quality of this research impacts the extent to which there can be confidence in the accuracy of the findings and conclusions drawn. Our team undertook a recent scoping review that examined the existing CSS literature (Postorivo et al., 2024) and assessed the quality of this body of research. We concluded that the quality of the literature available on the CSS model of care is currently limited, with most previous studies and evaluations identified in our review being graded as poor quality. The reasons for this include:

- Consistently limited reporting on the methodologies used, and at times inappropriate use of statistical tests and qualitative analytical techniques to draw inferences and conclusions.
- Issues with qualitative methods, including very small and/or unrepresentative samples of participants, and a tendency to use free-text surveys (as opposed to in-depth interviews) to answer qualitative research questions.
- Issues with quantitative methods, particularly the use of subjective, self-report data from consumers to draw conclusions regarding the impacts on ED diversion (as opposed to analysing objective administrative data on actual ED attendance). Additionally, studies often relied on questions which asked about a consumer's behavioural intentions (e.g., "Would you have gone to the ED if the CSS was not open?").

It is evident that there is a need for further, high quality research on the effectiveness of CSS models of care to strengthen the current evidence-base and confirm the findings of existing studies.

Summary of findings

- There is a growing body of evidence from previous evaluations and research undertaken to date that support the appropriateness and effectiveness of the CSS model as an alternative to the ED for individuals experiencing mental health crisis.
- For consumers, previous studies consistently found that attendees at CSS were highly satisfied with their experiences of the service and found them to be a safer and better experience than presenting to ED. In addition, CSS helped visitors to reduce their psychological distress and to develop coping skills.
- For the system, several studies showed that CSS helped to reduce mental health presentations to ED, admissions to acute inpatient care, and led to cost- savings.
- Issues with the methodologies utilised by previous studies mean there is a need for further high-quality research on the effectiveness of the CSS model.



Appendix B: Steering Group Membership

Member	Role	Position	Organisation
Dr Zoe Rutherford	Co-chair	Co-ordinating Principal Investigator	QCMHR
Dr Zoe Papinczak	Co-chair	Senior Research Officer	QCMHR
Danielle Postorivo	Member	PhD Student and Research Officer	QCMHR
Hannah Pocock	Member	Research Officer	QCMHR
Jacqui Vaevaemaki	Member	Principal Project Officer	MHAOD Branch
Christos Papadopoulos	Member	Lived Experience Representative (Carer)	Health Consumers Queensland
Amanda Guilfoyle	Member	Lived Experience Representative (Carer)	Health Consumers Queensland
Zac Chu	Member	Lived Experience Representative (Consumer)	Health Consumers Queensland
Nathan Sutherland	Member	Lived Experience Representative (Consumer)	Health Consumers Queensland
Elizabeth Bayliss	Member	Principal Project Officer, Clinical Systems, Collections and Performance Unit	MHAOD Branch
Alyse Trueman	Member	Manager, Analysis and Accountability Team, Clinical Excellence Queensland	MHAOD Branch
Carey Thompson	Member	Senior Peer Coordinator	The Oasis, Wide Bay HHS
Sam Walker	Member	Advanced Peer Worker	The Space, Metro North HHS
Alice Huntly	Member	Clinical Nurse Consultant	The Oasis, Wide Bay HHS
Cassandra Rooney	Member	Clinical Nurse Consultant, Emergency Department	Princess Alexandra Hospital, Metro South HHS
Patricia Shirkie	Member	Team Leader	Wadda Mooli, Townsville HHS
Tenielle Arama	Member	Clinical Lead	The Space, Metro North HHS



Ajay Sharma	Member	Senior Social Worker	The Space, Metro North HHS
Sonia Condon	Member	Principal Advisor, Mental Health Information	West Moreton Digital Health, West Moreton HHS
Christian Strang	Member	Senior Social Worker, Integrated Mental Health	Mackay HHS
Kirsty Rimmer	Member	Team Leader	Princess Alexandra Hospital, Metro South HHS
Kristie Bull	Member	NGO Team Leader	Mind Australia, Mackay HHS



Appendix C: Reach population estimate criteria

The following criteria were used to identify those individuals within the EDC dataset that may have been potentially eligible for a referral for the CSS. The EDC dataset provided to the evaluation team for this research contained data from all individuals aged 16+ years who accessed an ED in an HHS where a CSS is located, with a primary or secondary diagnosis of mental illness, self-harm and/or suicidality (based on ICD-10 codes) between 01/07/2019 and 31/10/2023. While the information available within the EDC does not provide the type of information needed to determine if an individual was definitely eligible for a referral to the CSS, it did provide information that enabled those individuals who definitely would NOT have been eligible for a referral to be excluded.

Table 17 | Parameters used to determine the population of individuals presenting to ED who may have potentially been eligible for referral to CSS.

EDC Variable	Criteria
Presentation date	Exclude ED presentations prior to the CSS opening date: <ul style="list-style-type: none">• Cairns Hospital- before 01/02/2021• Mackay Base Hospital – before 01/12/2020• The Prince Charles Hospital – before 01/01/2021• The Princess Alexandra Hospital – before 01/04/2021• Townsville University Hospital – before 01/06/2022• Hervey Bay Hospital – before 11/02/2022• Ipswich Hospital – before 01/09/2021
Age	Exclude ED presentations with an age of 16-17 years for all sites except Hervey Bay Hospital.
Triage category	Exclude ED presentations with the following triage categories: <ul style="list-style-type: none">• Resuscitation: immediate (within seconds)• Emergency: within 10-minutes• Urgent: within 30-minutes
Departure status	Exclude ED presentations with the following departure status categories: <ul style="list-style-type: none">• Admitted• Admitted to Hospital in the Home Service• Admitted to Short Stay Unit• Admitted to Observation Ward• Died in the ED• Hospital in the Home patient transferred to ward• Transferred to another hospital



Primary and/or
additional diagnosis
code

Exclude ED presentations with the following ICD-10 codes:

- F01 - Vascular dementia (all sub-categories)
- F02 – Dementia in other diseases classified elsewhere (all sub-categories)
- F03 – Unspecified dementia (all sub-categories)
- F04 – Amnestic disorder due to known physiological condition (all sub-categories)
- F05 – Delirium due to known physiological condition (all sub-categories)
- F10-19 – mental and behavioural disorders due to psychoactive substance use (when .0 is included [indicating acute intoxication] or .4 is included [indicating withdrawal state with delirium])



Appendix D: Program Logic Model

A program logic model was developed for the state-wide CSS, articulating how the CSS is intended to work. It provides a visual representation of the relationships between the program's inputs, activities, outputs, and expected outcomes. An overview of the key components of program logic models are summarised in Table 18.

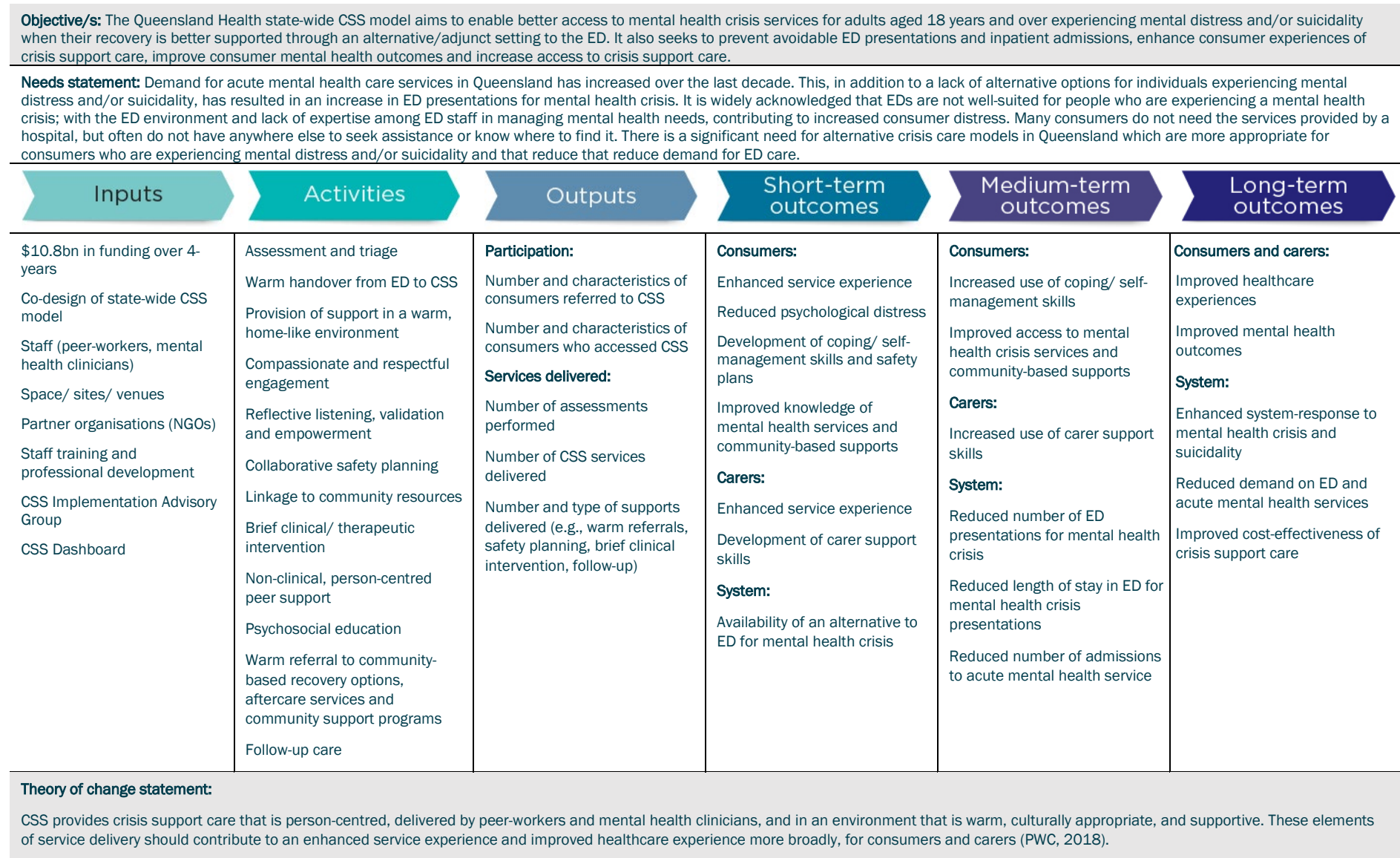
Table 18 | Definitions of program logic model elements.

Model Element	Definition
Objectives	Identifies what you want to achieve through service delivery.
Needs statement	Provides information about why a service is needed, and the problem or need that the program will address.
Inputs	The resources that have been deployed to establish and implement a service (e.g., staff, funding, spaces).
Activities	The specific actions, interventions and processes that are delivered through the service.
Outputs	Measures of who receives the services and what services and activities have been delivered. These outputs are needed to achieve the short-term outcomes.
Short-term outcomes	The changes that you would expect to see at the completion of the service.
Medium-term outcomes	The changes you would expect to follow on from the short-term outcomes.
Long-term outcomes	The long-term outcomes you would expect to follow on from the medium-term outcomes and which should resolve the issue identified in your needs statement.
Theory of change	Explains how and why the activities in the program logic model will lead to the intended service outcomes, drawing upon published research evidence about what works and how it is expected to contribute to intended outcomes.

The program logic model for the state-wide CSS is provided in Figure 17. This was developed following a literature review of previous evaluations of crisis support models of care, a document review of the CSS service guidelines, and drawing upon the findings of the present evaluation.



Figure 17 | Program logic model for Queensland's state-wide Crisis Support Space model.





CSS offers a range of crisis supports, including safety planning, peer-support, psychosocial education, warm referral to mental health services and brief therapeutic interventions; which should in turn lead to reduced psychological distress, the development and use of coping and self-management skills, and improved knowledge of and access to mental health services for consumers (Heyland & Johnson, 2017; NHS, 2014). In addition, the provision of support and advice to carers should help carers to develop skills which they can then use to support their loved one experiencing mental distress. Together, this should lead to improved mental health outcomes for consumers.

CSS assesses and triages consumers presenting at ED with mental distress and/or suicidality, and refers those who do not require the level of care available through ED to CSS. Once referred, consumers are able to re-visit CSS as needed. Therefore, through providing an alternative service option to ED for individuals experiencing mental health crisis, CSS should reduce the number of ED presentations for mental health crisis (PWC, 2018) and reduce the number of admissions to acute mental health services (NHS, 2014). This should in turn, reduce demand on ED and acute mental health services; improve the cost-effectiveness of crisis support care and enhance the health system's response to mental health crisis and suicidality.