Discussion Paper: A National Safe Spaces Network

... the dream, the reality, the opportunity

Roses in the Ocean

stemming the tide of suicide

Introduction to this Discussion Paper

In 2019, Roses in the Ocean led a consortium of organisations in preparing and presenting a proposal to the Commonwealth government titled:

"Trialling a National Safe Spaces Network to reduce the risk of suicide"

The following Discussion Paper and accompanying Report: 'A Safe Spaces Narrative - emerging outsomes of Safe Space co-design', are offered as a way of updating and building on the contents of our original proposal to inform the next steps towards a National Safe Spaces Network.

Report: 'A Safe Spaces Narrative – emerging outcomes of Safe Spaces co-design'
(prepared by Beacon Strategies)

Much has been learned over the past three years through multiple Safe Space co-designs, unprecedented engagement with people with a lived experience of suicide and significant maturing of the lived experience of suicide movement.

People with a lived experience of suicide are encouraged by the respect being shown to them at a national level, and as a result are more confident to speak up and indeed dare to dream that they can in fact inform suicide prevention and system reform, including designing services that meet their needs.

Contents

... the dream

The story so far

In 2017, Roses in the Ocean was invited to provide investment priorities to the Federal Minister for Health and as a result outlined an extensive suite of non-clinical peer led services. At the ensuing Roundtable in November 2018 involving key sector and government representatives, consensus was formed for the development of a proposal for a 5-tiered National Safe Spaces Network tailored to different needs.

It was based on Wesley Mission Queensland's 3–tiered model for mental health Safe Spaces and extended the model with two additional tiers to cater for people experiencing emotional distress, suicidal thoughts and/or in suicidal crisis. Tiers 4 and 5 specifically focused on bringing a suicide prevention focus, based on the long-established Safe Haven Cafes and Maytree House respectively in the UK. Maytree House has been staffed for many years now entirely by previous guests of the service.

The expanded tiered approach comprises of existing infrastructure enhanced through training and peer workers for Tiers 1-3, and two new service options to create Tiers 4 & 5:

Tier 5 A non-clinical peer run residential safe house where people in crisis can stay for multiple days supported by suicide prevention peers with lived experience of suicide crisis/attempt (a new service option staffed with suicide prevention peer workers)

Tier 4 A non-clinical peer run safe alternative to emergency departments - 24/7 Safe Haven Cafes with suicide prevention focus, staffed by suicide prevention peers with lived experience of suicide crisis/attempt (a new service option staffed with suicide prevention peer workers)

Tier 3 A Safe Space to access psychosocial support and safety planning e.g. PHN commissioned services (primarily existing mental health services enhanced by peer workers)

Tier 2 A Safe Space to talk to someone and access a referral e.g. community centres/services/chemists that are already operational, with staff who are gatekeeper trained. (likely a multi-disciplinary team)

Tier 1 A safe 'refuge' to sit e.g. library, coffee shop, hairdresser, barber (community based non-clinical support)

The concept was also presented at the Suicide Prevention Summit convened by Minister Greg Hunt on December 3rd, 2018 and again at the final meeting of the year for the 5th Mental Health and Suicide Prevention Plan Implementation Committee on December 17th 2018, where the concept was once again supported in principle.

In February 2019, Roses in the Ocean in conjunction with Beyond Blue, Wesley Mission Qld, Australian Red Cross, Everymind and the Australian Institute for Suicide Research and Prevention subsequently submitted a proposal to Government, "Trialling a National Safe Spaces Network to reduce the risk of suicide", outlining a phased approach to the development of the National Safe Spaces Network.

The proposal supports all Tiers developing strong connections with each other as well as with local community, social and health services such that regardless of underlying factors contributing to a person's distress, they can be warmly connected to the next Tier and/or another local service of their choice if they so wish.

The dream is to have a national network of Safe Spaces offering a genuine addition and alternative to existing service models. The network will be flexible enough to allow for locally co-designed services to meet specific local needs, whilst meeting national standards to ensure fidelity to the values and principles of a pure Safe Space model.

The Phase 1 scoping activity outlined in the proposal was completed by KPMG alongside the Expert Advisory Group for the National Safe Spaces Network including broad national consultation in 2020. Phase 2 (development of Standards for the network) was recently identified as a funded initiative in the Federal Budget May 2021.

Since 2019, several states and territories have made investments into Safe Spaces, and Roses in the Ocean has been privileged to lead the co-design processes of over twenty of these. As with all aspects of suicide, suicide prevention and the lived experience of suicide movement, we continue to learn and wish to share our learnings with others.

... the reality

During this period of investment in policy development and innovation at a state level, Roses in the Ocean has designed and led over twenty Safe Space co-design processes across NSW and Queensland, and are currently working with five communities to establish their own community designed, managed and run Pop-up Safe Spaces.

The co-design processes Roses in the Ocean has led are related to Tier 4 Safe Spaces, known in the UK as Safe Haven Cafes, though they are being given a range of names in Australia to date in the absence of a national standard at this point in time.

What people are sharing with us

Extensive detail of what people have shared throughout these 20+ Tier 4 Safe Space co-design processes is outlined in the Report: 'A Safe Spaces Narrative – emerging outcomes of Safe Spaces co-design', produced by Beacon Strategies, who were engaged to capture, collate and theme co-design outputs. The collation of all co-design outputs provides a clear picture of what community members and many health professionals are asking for, and highlights seven key components of a Tier 4 Safe Space to guide future co-designs.

Co-design outputs indicate that people with a lived experience of suicide are seeking a pure non-clinical model in a Tier 4 Safe Space. As most co-design processes to date have included health professionals and other service providers, it is interesting to note that the majority of these stakeholders are also advocating for a uniquely non-clinical alternative to emergency departments.

On the whole, the health professionals who have chosen to participate in co-design processes to date appear to either already be converts to an alternative non-clinical model based on the experiences of their own clients or have come to the process open to listening to people with lived experience of suicide, and in doing so, are supportive of the concept. There is strong support for suicide prevention peer workers to be well trained in both foundational and specialised peer worker curriculum and supported, with clear protocols to access and connect guests of the Safe Spaces to clinical care if the guest wishes.

Promising progress

It is exciting to see a handful of the Tier 4 Safe Spaces opening in Australia to date that truly represent what their local communities have asked for and are aligned to the intended model – a warm welcoming home, in a suburban street, where a person is greeted as a guest by a suicide prevention peer worker who has themselves experienced the pain of suicidal distress, crisis or attempt. A place where their rights are honoured, their self-determination respected, and their privacy protected. A place where experienced, well trained suicide prevention peer workers are comfortable holding space with them and walking alongside them as they collectively determine the next best steps to support. A place where they know they are welcome to return to whenever and as often as they want to.

Concerns

However, despite the clear congruence between people with lived experience of suicide and health professionals in their collective desire to see a genuine alternative to what is currently available to people experiencing suicidal thoughts and/or crisis, the reality of what has happened after many Tier 4 Safe Space co-design processes raises concerns.

In many cases, the service model that is ultimately implemented is not honouring the co-design outputs, resulting in a service that is different to what was requested by the people who wish to use the service. Some service providers are choosing which components of co-design outputs suit them to implement.

> There appears to be confusion over the model that is actually being co-designed. The reality is that many of the 'Safe Spaces' being opened are in fact aligned with a Tier 3 service (primarily operated by mental health services or government mental health agencies) with the enhancement of peer workers, though in many circumstances there are only mental health peer workers being recruited instead of a combination of mental health and suicide prevention peer workers.

The resulting services, being promoted as Tier 4 Safe Spaces, are missing the mark and range from disappointing to alarming. Examples include:

- Safe Spaces located inside hospitals next to Emergency Department
- Safe Spaces requiring triage through Emergency Department before access
- a Safe Space surrounded by a wire fence and a locked gate
- discussion of security guards to be posted at Safe Space entrances
- Safe Spaces with peer workers with NO lived experience of suicide, or
- people with a lived experience of suicide working as a Suicide Prevention Peer Worker without being provided specialised, contextualized training specific to this unique

combination of experience and provision of support in suicide context

- lack of allocated hours within the peer workers weekly duties to accommodate debriefing and review of complex interactions with guests
- Safe Spaces set up within existing mental health services
- high level of fatigue and burn out experienced by peer workers, highlighting the lack of suicide prevention peer workers with even a basic level of training and experience
- Safe Spaces enforcing the use of assessment tools such as the Subjective Units of Distress Scale despite co-design outputs stipulating no assessments
- Safe Spaces insisting on the collection of extensive personal data

> Of course, improving existing services and the emergency department itself by introducing a peer enhanced model is excellent and a positive step in delivering a far better experience for the people who choose to attend those services. It is however, damaging to the National Safe Spaces Network concept to endeavour to generically call these places Safe Spaces or Safe Havens when they are not aligned with the intended pure model for Tier 4 or Tier 5 Safe Spaces.

Challenges

In the co-design of genuine Safe Spaces, several substantial challenges have become apparent.

1. Funding has typically been funneled through the hospital and health systems, local health districts or Primary Health Networks, resulting in co-design processes being constrained by clinical decision-makers and staff who are deeply entrenched in the biomedical model and are intrinsically risk averse and resistant to non-clinical models of care.
2. There is a genuine lack of understanding of the pure Tier 4 & 5 Safe Space model concept and acceptance of how it has evolved even further through multiple co-design processes with people with lived experience of suicide, highlighting their strong desire for a peer only model.
3. Unrealistically tight timeframes that limit the capacity to build relationships with people with lived experience of suicide who have understandably low levels of institutional trust whose insights are central to service improvement. Limited timeframes also reduce the opportunity for deep community engagement required.
4. Inability by some traditional experts to appreciate the purpose of involving people with lived experience of suicide (with a diverse range of underlying factors that contribute to their suicidality) in a meaningful way and so the process can become a 'box ticking' exercise.
5. Inappropriate and unnecessary parameters being imposed on the service model that pre-determine it before the co-design process has even started and squash the 'blue sky' thinking that is vital to co-design.
6. A desire by funders and health professionals to create a multi-disciplinary service (more Tier 3), instead of embracing the opportunity to create and provide a genuine alternative to what already exists (Tier 4 & 5), and what is being asked for.
7. A failure to recognise that a large cohort of community members do not wish to access and do not trust existing mental health service providers, and in contracting them to deliver Tier 4 Safe Spaces, they are imposing their power over the process and the people who are needing a new style of service. Trust is lost before the process begins.
8. Some co-design stakeholders are so deeply impacted and institutionalised by the system, they find it difficult to dare to dream, or simply have learned not to. When reminded that a Tier 4 Safe Space is a genuine non-clinical alternative, and that the purpose of co-design is to design a service that will meet the needs of the person as determined by the person, stakeholders start speaking the truth about how they actually want their needs met.

... the opportunity

Staying true to the concept

We have an opportunity to re-focus the commitment to the pure concept of a Safe Space

The National Safe Spaces Network was proposed and supported through the national Phase 1 Scoping conducted by KPMG, on the basis that the issue was that Emergency Departments are not suitable for supporting people in suicidal crisis and that Australian's wanted non-clinical alternatives staffed wholly by well trained and supported Suicide Prevention Peer Workers with their own lived experience of suicidal crisis and/or attempt.

The concept of Tier 4 & 5 Safe Spaces was never about creating another multidisciplinary service or finding another service in which clinicians can operate from. It is about designing something different that will appeal to many in the community who do not wish to engage in what is currently available.

We must remember that almost half the people who die by suicide do not have a mental illness and the majority of the 65000+ suicide attempts made every year are unknown to the health system. A large proportion of people are choosing not to engage with help offered through the current health system and mental health services. We must offer them a genuine alternative, not a slightly re-badged version of what already exists.

The majority of Safe Space co-designs that have occurred to date in Australia have been packaged as developing a Tier 4 Safe Space and yet have not been allowed to honour the pure concept proposed. Sadly, the actual outputs from co-design processes are often not being honoured in their entirety due to funder demands for a clinical component to the service, limited appetite for opening hours at times expressed as needed by people with lived experience of suicide, and a genuine understanding and appreciation of the unique skill set and lived experience required for the suicide prevention peer workforce.

If we are to offer a genuine alternative to what is currently available for people through the Emergency Department and other traditional clinical services, it is imperative that there is a genuine understanding of, and commitment to, the full Tiered model of national Safe Spaces Network including the pure Tier 4 & 5 Safe Space models of non-clinical, suicide prevention peer-led services. In doing so, we will demonstrate that the voice and opinion of people with a lived experience of suicide has been acknowledged and their opinion has been valued and acted upon as part of the solution.

Key components of a Safe Space

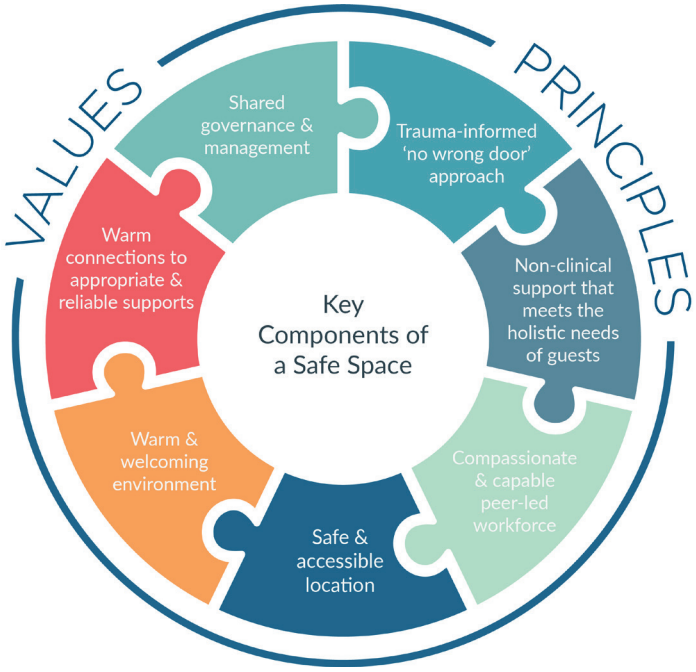
To support existing and future Tier 4 Safe Spaces to be aligned with what people with lived experience of suicide are asking for, Roses in the Ocean has identified the key components of a non-clinical Safe Space.

A summary of outputs from these co-designs that have informed these key components are explored in detail in the Report 'A Safe Spaces Narrative – emerging outcomes of Safe Spaces co-design'.

These key components reflect the common themes that have emerged through local communities and are faithful to locally co-designed values and principles.

The key components are:

- A trauma-informed 'no wrong' door approach
- Non-clinical support that meets the holistic needs of guests
- A compassionate and capable peer-led workforce
- A safe and accessible location
- A warm welcoming environment
- Warm connections to other appropriate and reliable supports
- Shared governance and management



Focusing also on Tier 5 spaces

With the 2021 Federal Budget funding announced for Phase 2 of the "Trialling a National Safe Spaces Network to reduce the risk of suicide" proposal - establishing standards for the National Safe Spaces Network, we have the opportunity now to safeguard the pure intent of Tier 4 & 5 spaces, and importantly focus on the development of Tier 5 Safe Spaces as a matter of priority. Tier 5 Safe Spaces are non-clinical, suicide prevention peer led residential houses where people in suicidal crisis and/or at risk of suicide attempt are able to be supported. Tier 5 residential Safe Spaces provide intensive, short-term support to allow individuals in suicidal crisis who do not require medical attention a sanctuary to manage and resolve crisis in a residential setting (rather than hospital). Staffed 24/7 by suicide prevention peer workers, individuals can stay in a safe, peaceful environment, connect with others and reflect on contributing factors to their suicidality, personal experiences, possible options for moving forward, and begin to find a path out of crisis. Maytree House, a UK model upon which Tier 5 in the National Safe Spaces Network is based, was established in 2002 and has for many years been completely staffed by previous guests of the house. Australians in suicidal crisis need places like this where they are afforded the gift of time and space to connect with themselves, with others and have people who have walked in their shoes, stand beside them as they find their way forward.

Integrity and Fidelity to co-design outputs

As we move to Phase 2 – Development of national standards for a National Safe Spaces Network, it is important to learn from the outputs of these co-design processes, listen to what people with a lived experience of suicide have told us, and ensure that in order for an existing or future Safe Space to be accredited with the National Safe Spaces Network, it must meet the high standards as informed by people with a lived experience of suicidal crisis and/or attempt who are seeking a genuine alternative.

The risk of not doing this is high. The integrity of the National Safe Spaces Network needs protecting. If it is diluted by service models that are offering a peer enhanced version of existing models, and calling themselves Safe Spaces, we will have a situation where people will not be able to trust the fidelity of the model from one Safe Space to the next. The Network will be compromised.

Ultimately suicide prevention needs to be about AND not OR. There is good reason and need for clinical services, multi-disciplinary services, peer enhanced services AND non-clinical purely peer led services.

As a matter of urgency, it is important that we arrive at a common language for naming the various Tiers of the National Safe Spaces Network and/or a way of visibly communicating which Tier within the network they represent. This transparency is key to earning and retaining trust with the people who need to use these service options, and fidelity to the nuances of each Tier.

Australia is on the cusp of 'once in a lifetime' system reform where people with a lived experience of suicide have been recognised for their integral role in leading from the front. The National Safe Spaces Network will be a world first and perhaps the greatest opportunity to change the landscape of support for people considering ending their lives.

Recommendations for future Safe Space co-design and establishment

- Education regarding the National Safe Spaces Network concept and the nuances of individual Tiers.
- Clarity and consistency regarding which Tier is to be co-designed – is it a peer enhancement of an existing Tier or is it the establishment of a new option in a Tier 4 or 5?
- Allocate adequate time and resources for recruitment into the co-design process to ensure all the relevant voices are engaged.
- Allocate adequate resourcing including adequate paid participation for lived experience participants.
- Co-design orientation workshop and/or resources provided to co-design participants and senior management to ensure shared understanding of what co-design is, its iterative nature and the importance of formal lived experience led guardianship of co-design outputs.
- Determine who are relevant stakeholders for co-design of a purely non-clinical Tier 4 & 5 Safe Space.
- Co-design participants given time and support to participate through co-design process.
- Communications piece – including internal communications by senior executives actively championing process to staff and external communications to community to raise awareness and get 'buy in' of initiative.
- Ascertain and utilize relevant policy levers and be prepared for policy reform to enable co-design outputs to be realised.
- Do whatever it takes to commit to iterative nature of co-design.
- Explore and commit to process through which iterative co-design will be embedded into culture of Safe Space to ensure ongoing meeting of needs, sustainability, and fidelity to model.
- Ensure appropriate recruitment of peers with lived experience of suicidal crisis/attempt/caring for loved one/friend through crisis (peer matching) to meet the co-design outputs.
- Ensure service providers that are chosen to deliver Tier 4 or 5 Safe Space are able to strongly demonstrate experience in delivering suicide prevention specific services, and genuine engagement and integration of people with a lived experience of suicide.

Safe Spaces in suicide prevention policy and strategy

Throughout Australia, governments, policy makers and communities are struggling for real solutions to the challenge of reducing suicides from their current unacceptable level. Although the national suicide rate is somewhat stable at present, over the long term, there has been a steady increase with seemingly no definitive answer for sustainably reversing this trend. Non-clinical alternatives to emergency, increasingly referred to as Safe Spaces or Safe Havens, need to be urgently considered as a significant part of the solution.

Part of the challenge confronting suicide prevention policy rests with the continued expectation of the mental health system to carry most of the responsibility for preventing suicides.

Support for people in suicidal crisis continues to be almost universally delivered through the mental health system. This is despite the growing realisation that 'whole of government' or community-based approaches are needed given that many causal factors for suicide are located outside the mental health system.

Mental health systems are themselves in crisis throughout the country, with huge pressures relating to growing demand and increasingly complex presentations by people with severe mental illnesses.

Emergency departments are not well designed for people experiencing suicidal thinking, where they are usually triaged at low risk and required to wait for sometimes many hours for an assessment that often leads only to a referral back to their GP. Even where a bed is available, inpatient stays are often inappropriate or unnecessary for people experiencing suicidal thinking, and may involve little more than stabilisation on a new medication regime, itself absorbing weeks of hospital care. In some cases, people at risk of suicide who have presented to emergency have been subjected to restraint, detention under state mental health legislation, and involuntary treatment. These responses further disincentivise help seeking.

It is widely recognised that the clinical mental health workforce is facing severe shortages especially, but not only, in rural and regional areas. It is likely to take many years of sustained education of new clinical professionals for there to be sufficient workforce availability to staff the clinical positions in place now, let alone in the future where demand is likely to have increased even more.

Key groups at risk of suicide are less likely to come forward voluntarily for help from hospital-based emergency and mental health services. Roughly three quarters of Australian suicides are among men, a group hesitant to approach the mental health system due to the stigma still attached to mental illness. Other groups at high risk, such as Aboriginal and Torres Strait Islander people, and the LGBTI community, have long histories of alienation and poor treatment from the mental health system.

Sadly, even when provided substantial investment and support, mental health services have struggled to deliver innovative service models that truly reflect the needs and desires of people with lived experience of suicide. Instead, they usually revert to compromised and insufficient models that while more convenient for the mainstream health system to deliver, continue to provide insufficient services for people at risk of suicide. 'Alternatives to emergency' in the mental health space have often manifested as heavily security-laden, biomedical spaces, with uniformed staff behind caged counters, prison-like 'safe assessment rooms' and even seclusion rooms where agitated patients and patients exhibiting aggression as a result of their distress and/or treatment in the service, can be confined.

These spaces are designed principally for people with severe mental illnesses presenting with aggressive behaviour and requiring the attention of police. Obviously these are inappropriate places for people experiencing suicidal distress, that can in fact intensify feelings of trauma and hopelessness, and discourage people seeking help. Unfortunately, this simple recognition still remains unacknowledged by large swathes of the current mental health system.

Non-clinical alternatives to emergency, or Safe Spaces, are an essential but under-invested part of the solution that governments and policy makers are seeking, and that communities are increasingly demanding. Unlike emergency departments, non-clinical alternatives can deliver a less intense, less frightening option for people experiencing early signs of suicidal thinking, where the source of their distress can be sensitively explored and addressed. They can also provide a more appealing and safer service for people whose suicidal crisis has become advanced, where a more urgent and bespoke response is required than can be provided by an emergency department. Of course, they also promise less expensive care and support than costly emergency presentations and inpatient stays.

Genuinely co-designed, peer based services that are built and delivered by people with lived experience of suicide, providing effective follow up and strong links into a wide range of local community services are currently rare, but such models are gradually becoming within reach as more innovative solutions are considered.

Their proliferation would transform the national suicide prevention system and make available

perhaps the best offering Australians have yet had for reducing immediate feelings of suicidality, assisting distressed people through the causes of their despair, and de-stigmatising the act of seeking help, whether it be early or when suicidal risk has become especially acute. National and state suicide prevention strategies are incomplete without significant priority for this important new approach.

1300 411 461
enquiries@rosesintheocean.com.au
www.rosesintheocean.com.au

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