Roses in the Ocean
stemming the tide of suicide

LE SUMMIT 2021

Pop-up Safe Spaces
Collated Outputs

Introduction

What is a Safe Space?

Safe Spaces are drop-in style supports for people experiencing significant emotional distress or suicidal crisis that provide warm, welcoming environments in which to reduce distress.

This innovative new service model was developed in recognition of the fact that acute, clinical services such as emergency departments are not the best fit for people in emotional pain and distress and do not address the broad range of situational and social stressors that lead to suicidal crisis.

Safe Spaces are typically staffed by peer workers with their own lived experience of crisis who can connect with others through the mutual understanding that comes with meaningful shared experience.

There is an emerging evidence base for their therapeutic value in promoting hope and healing.

What communities have told us they want from a safe space. Eight key components of a safe space

Designed and delivered by community for community

Unlike typical safe spaces, Roses in the Ocean's Pop-Up Safe Spaces harness existing community assets to meet unique and evolving local need.

Considerations that will determine a local model include:

- immediacy of need;
- demographics;
- priority population groups;
- geographical challenges;
- what an individual community wants; and
- what they have access to in terms of physical space.

What is the purpose of this workshop?

Through leading the co-design of numerous safe spaces around the country Roses in the Ocean has clearly identified common themes that have emerged about what local communities are looking for and wanting from a safe space.

Regardless of geographic region or cultural background, there is an undeniably strong appetite for non-clinical, community and lived experience of suicide led safe spaces that are locally co-designed to meet unique needs.

An exciting new venture by Roses in the Ocean, 'Pop-Up Safe Spaces', empowers communities to realise the safe space they have been dreaming of.

This workshop represents part of the ongoing co-design of resources to support the establishment of safe spaces.

Discussion 1

What is your level of confidence in community readiness and appetite for a genuine non-clinical alternative safe space?

Common themes across regions		• Community readiness • Challenges with health services/health professionals • Support for priority populations • General awareness • Introduction of a Pop-up Safe Space • Pre-existing safe space/services
STATE SPECIFIC CONTRIBUTIONS		
VICTORIA	Geelong	Focus of youth. Model needs to be light. During school holidays.
	Country VIC	Every regional community needs a safe space. People waiting in the wings. Current lack of support, horror stories from ED. Mix of individual groups – headspace, indigenous – unique to population rather than a 'no wrong door' approach.
	Ballarat	Huge appetite – higher rate of suicide than national average.
	Castlemaine	Grant for local area safe space recently approved.

QUEENSLAND	Maryborough	Community talking about what can be done in response to a number of suicides in the region. A lot of young people, men, LGBTIQA+ experiencing emotional distress and suicidal thoughts. Non-clinical and non-religious is what's needed.
	Brisbane	Each area is culturally different and needs to be locally unique. Socialising the idea of Safe Spaces is necessary. Safe spaces should be separate to pre-existing health care services. Perhaps shopping centres are an option.
	Sunshine Coast	Not a good sense of readiness yet. Thinking of cafes for safe spaces, gyms (potentially to engage men). Believe there is a safe space in the area
	Gold Coast	Community not ready. Most people are unaware of the current services – contributes to lack of readiness. Crisis stabilisation unit in Robina – not known to people and people are not willing to use.
	Townsville	Huge need as crisis area, and community ready. Appointments with health professionals to gain support is difficult. Hospitals are very off-putting for kids and youth. After hours would be best.

NEW SOUTH WALES	General	Massive appetite and demand. Stigma removed if it's a van, community hall, café. Outreach rather than waiting for people to come to the service. Lifeline have mobile coffee van – massive bookings.
	Sydney	Huge appetite. Resistance from old-school practitioners – less opened minded about non-clinical options. Limited beds in hospitals. Lots of public housing estates with community spaces as well as community centres, etc. Lots of other types of drop-in centres.
	Northern Rivers	Community ready. Resistant (risk averse) amongst health professionals.
	Northern Beaches	Huge appetite. Hospital system not yet established to support people in suicidal crisis. A lot of young people experiencing suicidal crisis.
	Bega	More than ready. Frustration with health care system. Delays getting into services.
	Wollongong	Amazing Safe Haven already.
	Hawkesbury	Community possibly ready. Challenges - fights with organisations over who's going to lead, lack of privacy in small town. Tried to get safe haven up and running, solely run by peers.

AUSTRALIAN CAPITAL TERRITORY	Community ready. Not ready for true non-clinical approaches. No known SP network – very mental health focused. Looking to build a safe haven café, but within the hospital.
SOUTH AUSTRALIA	Huge appetite. Tested concept through stakeholder forum – HP's want to be able to receive referrals from GP's – open to feedback.
WESTERN AUSTRALIA	Lack of awareness. Safe haven open, with limited hours – 3-4 hours on Thursday, Friday, and Saturday (late afternoon/evening).
TASMANIA	Very strong need in this area. Sometimes there is ambulance stacking therefore little attention given to people in suicidal crisis – causes walk outs.

Discussion 2

What barriers do you foresee that will need to be overcome?

Common themes across regions	• Funding:
	  o Financial and resourcing of co-design operation.
	• Correct staff and training.
	• Lack of support – from community, health professionals, services.
	• Location/type of service.
	• Management, privacy, and risk:
	  • Managing policy and procedures
	  • Risks of non-clinical – safety of staff and guests – e.g., intoxication, etc.
	  • Health professionals are risk averse
	  • Recognition in small towns
	• Diversity inclusion:
	  • How to get staff trained to be educated and appropriately run the service.
	  • Need a leader or promotor.

STATE SPECIFIC BARRIERS	
VICTORIA	Ignorance in town planning – have 20 acres of farmland want to use for safe space but 'change of use' requirements are costly and difficult to navigate permits. Risk aversion from significant groups that are key stakeholders. Big organisations seem to be protecting turf or afraid to step away from the clinical model.

QUEENSLAND	Legal binding locations, mine-field etc. – food banks were shut down due to food poisoning. Someone in crisis may not be able to make decisions to go somewhere – moveable or preventative service may help. Stigmatising, being recognised.
NEW SOUTH WALES	Big costs involved. Getting enough people on board to staff. Challenge is size of regions: limited public transport in regional areas, existing services are a long distance away. Bus idea could work – faces own challenges – driver, insurance, costs, etc. Limitations based on funding & time – had to give funding back as safe space wasn't completed within timeframe. Lack of privacy in small towns.
AUSTRALIAN CAPITAL TERRITORY	Peer work force exists but aren't working closely with bodies who can support.
WESTERN AUSTRALIA	Money will always be an issue – how does community raise money? Finding people to staff. Idea of bus that can move around – use for education safe talk while not a safe space. Education on what is peer support and how we can help.

Discussion 3

What resources would be helpful? / What support would you like from Roses in the Ocean?

Design & Implementation	Training & Recruitment	Location & Accessibility	Awareness & Engagement
Lived experience representation. Community readiness. Guidance on how to facilitate community consultation. Trained facilitators during community consultations. Establishing working groups. Funding/fundraising resources and support. Community-led. Model pack ('help to prepare the soil') – Guidelines, FAQ sheets with responses, safe language, contact lists, public liability, insurance, safety & security.	Capacity-building training for peers, e.g., crisis support. Staff awareness of suicide vs. mental health.	Free parking, accessible by public transport. Need for outreach. Utilising resources already available, e.g., schools, etc. Changing locations to meet demand, e.g., park to meet young people, bowling club to meet older people Regular space as well as moveable space.	Communication across all stakeholders, relationship building and managing partnerships. Engaging with community leaders for priority populations to discuss requirements, e.g., CALD communities. Engagement with existing services. Awareness of different communities within the region – farmers, businesses, etc. Working groups / working group members from priority populations to engage with their communities (e.g., Aboriginal and Torres Strait Islander, CALD, etc.). Media collateral. Concept papers and other evidence-based documents or studies to engage support.

Discussion 4

What would be needed to ensure fidelity of model, iterative co-design, sustainability of safe space?

Training and support	Post implementation review and communication	Model pack
Ongoing training. Right peer workers. Knowledge and resources are applied. Keeping employees engaged. Sustainability of staff Model of care. Access to like-minded people. Support from Health Professionals – co-learning opportunities. Support structure for peer workers. Capacity building within community. ECPR training.	Post implementation review is necessary – what went well and what didn't – 3-6 months post, then every 6-12 months after. Findings fed back into a register outlining key learnings. Developing network between existing safe spaces. Transparency around what has worked and what hasn't. Communication / feedback about what's happening at the pop-up safe spaces back to stakeholders. Constant evaluation. Asking guests and not assuming. Anonymous surveys. Audit processes. Mystery shopper concept.	Model of care. Guidelines and checklists.