The Clarion Call
Safe space solutions for Brisbane North Region
Project Report 2016
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Safe space solutions for Brisbane North region
A project report scoping safe-space models.
Responding to mental health needs in Brisbane's north region.

August 2016

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Executive Summary

The need for safe-space alternatives to emergency departments in North Brisbane reflects the full diversity of human experience.

Overview

Having choices and options depending on circumstances, preferences and geography emerges as a critical factor in concluding the need for a Brisbane North Regional Safe-Space Strategy rather than a single preferred model or service.

A review of literature highlighted diverse ways of responding, with various jurisdictions offering multiple alternatives complementary to the role that hospitals play in mental health service provision. Safe-space alternatives included residential options, day centres, making use of existing arts and community spaces, and responsive outreach options, including crisis and ongoing support teams. When stakeholders were asked who should benefit from a safe-space alternative, and to define a preferred model, the responses reflected the diversity of people and of the region itself. Advice consistently cautioned against assuming that one size fits all.

Project scope and methodology

The challenge of providing safe-space alternatives to hospital departments led the North Brisbane Partners in Recovery Program to commission a project to investigate alternatives and explore preferred options with key stakeholders, taking into account the vast geography and unique sub-regions involved.

The project used a variety of methods to generate ideas, options and potential solutions, including:

- a literature review
- workshops
- focus groups
- interviews
- an online questionnaire.

In total, 108 people provided direct input to the project, including 86 service providers from government and non-government agencies and 22 service users and carers.

The consultation phase explored questions such as:

- Is there a preferred model for north Brisbane?
- If yes, what should it be?
- Who is a safe-space response for?
- Where should it be located?
- What are the most important elements of a safe-space response?

Project framework

The project worked from a conceptual framework, acknowledging that safe-space needs and solutions can be driven by one or a combination of:

- first home needs and strengths (the self)
- second home challenges and opportunities (the dwelling or equivalent where a person resides)
- third home challenges and opportunities (the broader neighbourhood or community where a person resides).

Source: Kraybill, 2012

The project was also guided by:

- person-centred, recovery-focussed approaches
- a systemic view highlighting that services and programs do not stand alone and must relate well to the broader system, address gaps and avoid duplication.
People who present at emergency departments in a state of distress

For some stakeholders, the primary challenge is to achieve a response to people who frequently present at emergency departments in a state of distress and who may not be admitted but have a range of psychosocial needs. The consultations highlighted that people may be expressing ideas about self-harm and may have a range of other complex needs. Hospital emergency departments may not necessarily be ideal environments for those people and more options are needed to ensure that they are supported and assisted.

People who do not present to emergency departments, yet require safe-space alternatives

The consultation process also revealed a cohort of people who require safe-space alternatives and who may not present themselves to emergency departments or necessarily seek assistance, but who still require a response. For some people, there is resistance to presenting at emergency departments or going to hospital.

People who seek a range of safe-space alternatives through relationships with people and places

A third group emerged who could articulate that they worked to achieve safe-space alternatives through existing relationships with service providers, drop-in spaces, networks of family and friends, community-based activities, neighbourhood centres and connections within local neighbourhoods. There is a clear need for safe-space alternatives for this group of people, who are designing and achieving their own solutions through various relationships to people and places. In this scenario, there might still be gaps in the support someone could access, but there was a clear message that some people seek safe-space options unique to them that may involve one or more different options depending on needs and circumstances.
Who should benefit from a safe-space response?

Responses from stakeholders emphasised that different groups of people seek safe-space solutions, as shown in the following data about people seeking admission to emergency departments:

- a total of 35,951 presentations were made to North Brisbane hospitals related to mental health, alcohol and other drug use over two years from 2013 to 2015
- the three most common diagnoses of people seen at emergency departments were:
  - suicidal ideation/self-harm (6,636)
  - mental illness but no diagnosis (5,374)
  - alcohol intoxication (4,524)
  - over five per cent of those admissions were people of Aboriginal and Torres Strait Islander backgrounds
  - the single highest age category was 15–24 years (9,530).

Source: Brisbane North PHN, 2016

Other studies reflect a range of issues among people who frequent emergency departments:

- lack of health insurance
- lack of transportation
- lack of a phone
- poor access to primary care
- minority status
- chronic alcohol and drug use
- mental illness
- chronic health problems.

Source: Kushel et al., 2002:778

There are added predisposing factors, such as less stable housing, chronic health issues and a higher likelihood of spending time sleeping rough or in homelessness shelters in the previous 12 months (Kushel et al., 2002:782).

Information extracted from The Alfred Hospital's database on people aged 15 - 69 years who had three or more admissions or emergency department presentations over 12 months found that those people represented six per cent of people attending the emergency department while providing 20 per cent of all presentations (Beckmann and Hahn, 2004 - 2005).

This is consistent with a data snapshot from the Royal Brisbane and Women’s Hospital Emergency Department identifying 18 people who had presented five or more times each month for the period June–August 2015 (Footprints in Brisbane, 2016). For the month of August 2015, 25 people presented three or more times in the one week. This same data snapshot showed that 153 of the most frequent presenters went to the hospital emergency department a total of 1,878 times in 2015.

Diagnosis on presentation was most likely to be a mental health issue, toxicity or no actual diagnosis (possibly because people did not wait for assessment or treatment). The most common time of day for presentation was between 6.00 pm and 11.00 pm. People who presented experienced various issues including housing and homelessness-related issues, mental health issues, substance use and chronic health issues. A majority of presentations (58.4 per cent) were by ambulance. Forty-six per cent were discharged and 21 per cent did not wait for assessment or treatment.

Safe-space responses

The literature review identified several categories of initiatives responding to safe-space needs (Figure 1). Various models included examples that were coordinated, collaborative and integrated with the broader service system.
Consultation themes and opportunities

The engagement process highlighted several themes, issues and opportunities, which are listed below.

Make best use of existing infrastructure, services and partnerships

- A number of existing places, resources and infrastructures are accessed by people seeking safe-space options including community centres, arts spaces, sensory options and services that provide space where people can drop in and visit.

- Stakeholders consider it important that best use is made of what already exists. Some organisations indicated they could scale up and use their existing buildings subject to resource availability. Existing partnerships and consortia form a basis for examining what already exists and what could be enhanced to contribute to a safe-space response.
Diverse models responding to diverse needs

- Stakeholders expressed that building-based options and outreach capacity are both important, including outreach/in-reach to hospital emergency departments.

- People are generally supportive of both clinical and non-clinical inputs to a safe-space solution and are also supportive of team-based approaches that include peers and volunteers.

- The solutions to being and feeling safe are individually unique, and people want choices in how they address their safe-space needs.

- People seeking safe space through emergency departments are often highly vulnerable, with other significant needs and issues that need a response. A safe-space response must be able to work with extreme vulnerability in a synthesis with recovery frameworks.

- A safe-space response must be well-connected within a broader mental health system and complement existing services, thus avoiding duplication. Particularly important links include emergency departments, emergency services, Acute Care Teams, the 1800 Mental Health contact number, Step Up Step Down, and the Homeless Health Outreach Team.

- A safe-space response needs to work to achieve continuity of care and the seamless involvement of existing supports. This could include mobile, collaborative support plans including a safety plan.

- People’s broader social support networks contribute a lot to their experience of safety. It is important to note that carers, families and friends might also experience the need for safe-space solutions so they are better partnered and supported when people are in a state of extreme distress.

- Aboriginal and Torres Strait Islander specialist input highlights a preference for outreach models working with people at home and in their communities.

- LGBTI communities also seek safety in various ways and there is a challenge to build the capacity of the system to contribute to safe-space options that are accessible, diverse and inclusive.

Access and location

- There is a consensus that a response is needed outside usual business hours, although views about whether or not beds should be provided for short stays are mixed.

- The geography of the region is diverse and expanding, requiring a range of responses that are spatially sensitive and include Brisbane, Caboolture and Redcliffe.

Addressing causes and drivers

- There are concerns that a building base with/without beds will create dependencies and become a default option for people who are homeless or inadequately housed. As such, there is a concern that safe-space solutions need to address causes and drivers, and achieve longer-term sustainability.

- Safe-space responses require a clear purpose, ensuring planning and support towards sustainable safe-space solutions that are responsive to an individual’s needs.

Risk management

- A robust approach to risk management is needed in the provision of safe-space alternatives, however, this needs to be enabling and positive, with the view that risks can be managed in both building-based and outreach responses.

System gaps

- The apparent need for safe-space solutions might mask a more systemic lack of intensive, outreaching, assertive and ongoing support to vulnerable people.
Conclusion

Given the range of expressed needs, the volume of people presenting themselves to emergency departments, the importance of individually tailored responses and the diversity of geographical areas involved, this report concludes that a regional safe-space strategy is a way to promote existing options, ensure collaboration and develop responses to service system gaps.

A broader strategy could be advanced through best use of existing mental health sector governance arrangements to combine leadership and expertise in refining a strategy and achieving implementation (Figure 2). Within the strategy, this report includes scope and thinking about safe-space hubs in decentralised locations that would include outreach- and building-based services (including within hospital) and the involvement of clinical, non-clinical, peer and volunteer roles. There is considerable support for making use of existing buildings wherever possible.
Recommendations

1. That North Brisbane Partners in Recovery develops a North Brisbane Regional Safe Space Strategy (NBRSSS) to promote existing safe-space contributions and create innovative new models such as safe-space hubs.

2. That an NBRSSS is governed by Collaboration in Mind to harness leadership, expertise and support towards implementation.

3. That an NBRSSS seek funding and multi-agency contributions to provide decentralised North Brisbane hubs with extended opening hours. The hub model should include capacity for:
   - centre-based support including clinical, non-clinical and peer contributions
   - outreach staff who provide interventions in situ and at key locations such as emergency departments
   - scope for volunteer/community involvement
   - transport options and brokerage funds
   - activities, arts and sensory options
   - a project worker role to support the strategy’s implementation and governance group, include community involvement and home placements, build capacity in generalist organisations and generate a calendar and map of other safe-space alternatives
   - active approaches to working with extreme vulnerability and preventing the need for service exclusions.

4. That an NBRSSS include mapping and documenting existing safe-space groups, community centres, drop-in options, activities and arts centres. Consideration could be given to a safe-space network brand that unites these alternatives and raises their profile to the sector and to service users in a non-stigmatising way.

5. That individualised safety planning is more widely adopted by support providers using shared tools that are part of collaborative and coordinated support plans; and a shared support planning platform is implemented that seeks client consent for a highly coordinated approach.

6. That resources are harnessed and where necessary increased to achieve a support guarantee for people who are vulnerable and who frequently present at emergency departments.

7. That an NBRSSS is a basis for building a ‘community of practice’ and providing workforce development opportunities to enhance skills, capabilities and capacities in achieving safe-space options within individual support and safety plans and at the organisational and systems levels. Workforce capacity and capabilities are needed in working with recovery models of practice while also responding to the impact of extreme vulnerability.

8. That a culture of innovation and creativity is facilitated as part of the provision of decentralised, community and place-based safe spaces that are accessed by the broader community and accessible to people living with mental health difficulties. This could include scope to develop home placement options for example.

9. That a process is put into place whereby an NBRSSS includes culturally aware and competent approaches, and is responsive to the needs of specific community groups with identified needs. This should be achieved through organisational development, mentoring, staff from diverse backgrounds, and workforce capability development.

10. That the strategy is rigorously and independently evaluated.
1. Introduction and background

This project report details consultation and research findings for a preferred safe-space model responding to the needs of people with mental health issues in Brisbane’s north region.

It culminates in a proposed North Brisbane Regional Safe-Space Strategy that recognises the diversity of needs both in terms of geography and human experience.

This research project was commissioned by North Brisbane Partners in Recovery (PiR) to investigate a safe-space project or model that would provide alternatives to hospital and emergency department presentations for people in distress. It was envisaged that a safe-space project or model would contribute to recovery and wellbeing at the same time as hospital presentations are reduced. The original project brief stated:

North Brisbane PiR is seeking to develop a regionally suitable model for a ‘safe space’ alternative to hospital emergency departments for people experiencing psychological distress, including, but not limited to, after hours.

Anecdotal evidence from hospitals, Non-Government Organisations (NGOs) and presenters to accident, emergency and acute care teams, suggests that there is a cohort of people who present to hospitals in psychological distress who do not require immediate acute clinical care, but rather psychological or community interventions and care to meet their needs. Further, they are not getting these needs met in an acute emergency setting.

This project builds on an established platform of work including the Frequent Presenters Project funded by a LINK Grant, and the Hospital Transitions Pathway Project (which included relevant research and recommendations). North Brisbane PiR also commissioned an Atlas of Mental Health Services for Brisbane North, which drew conclusions and made recommendations about alternatives to hospitalisation (Mendoza et al., 2015).
2. Project scope and geography

The project had the following objectives:

1. To research ‘safe space’ models world-wide and compile a literature review that outlines each service model, staffing arrangements, operational costs and evidence based-evaluation. This will provide the foundation to take further actions forward. Models may include centre-based services and mobile services.

2. To consult with local organisations and key informants, including PIR agencies, the HHS, consumers and carers, and the project reference group to determine a best fit-model for the Brisbane North region. Given the region is diverse in needs and service access, multiple models may be proposed following consultation.

3. To develop specific proposal/s for future use in applications for funding the model/s. This will contribute to the final report.

The geography of Brisbane North PHN region is broad and diverse, including a population of over 900,000 and an area of 4100 km² spanning densely populated inner city areas, outer suburban areas, peri-urban areas, satellite cities and rural locations (Figure 3) (Brisbane North PHN, 2016).

Source: Commonwealth Department of Health website, accessed 1 June 2016.

Figure 3: Map of Brisbane North Primary Health Region

2 The Brisbane North Primary Health Network includes, but is not limited to, the following locations: Aspley, Bongaree, Brisbane, Burpengary, Caboolture, Chermside, Enoggera, Indooroopilly, Kilcoy, Moggill, Mount Glorious, Petrie, Redcliffe, Samford, Strathpine and Toowong (Australian Government Department of Health, 2016).
3. Methodology

This investigation used mixed methods involving literature research and review, data analysis and engagement with key stakeholders. The methodology included the following key elements:

- **a literature review** exploring safe-space models from Australia and overseas
- **data analysis** on the profile of people accessing emergency departments because they are in distress
- **interviews** involving 32 people
- **four regional workshops** in Inner Brisbane, mid-north Brisbane, Caboolture and Redcliffe, involving 47 participants
- **presentation to a North Brisbane interagency meeting** involving approximately 90 participants
- **one culminating workshop** involving stakeholders in a process of refining a model for the region, 22 participants
- **an online survey** completed by 14 people, with the purpose of providing an online option as well as a way for workshop participants to provide follow-up information and ideas that they thought of subsequent to the workshop/interview
- **three focus groups**, two with Queensland Health (one in inner Brisbane and one in Caboolture) and one with consumers of mental health services
- **two project reference group** meetings to review material and provide guidance towards a preferred model, involving two consumer/carer representatives, two senior support facilitators from PiR and a representative from the Brisbane North PHN PiR team

Participation in the interviews, workshops and focus groups included people with the following interests and roles (Table 1). The organisations involved in workshops, interviews, surveys or focus groups are listed in Appendix 6.

### Table 1: Category and role of people involved in the engagement process

<table>
<thead>
<tr>
<th>Interest/role</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Mental health and other non-government services</td>
<td>65</td>
</tr>
<tr>
<td>Queensland Health</td>
<td>21</td>
</tr>
<tr>
<td>Consumers and carers</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>108</strong></td>
</tr>
</tbody>
</table>

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3 The literature review included the following key search terms and phrases: alternatives to presenting to emergency departments for people with mental health issues; alternatives to hospitalisation for people with mental health issues; safe space services for people with mental health issues; safe houses for people with mental health issues; day centres and day hospitals for people with mental health issues; residential options for people with mental health issues; assertive community treatment; mobile crisis outreach teams (mental health); profile of people who turn up to emergency departments on hospitals. Reference lists included in sources of information were then reviewed and relevant references were also examined.

4 See Appendix 1 for the interview questions.

5 See Appendix 2 for a workshop agenda and promotional flier.

6 See Appendix 3 for a workshop agenda.

7 See Appendix 4 for the survey questions.
The regional workshops included some creative methods of engagement designed to elicit people’s experiences and ideas by combining:

- a presentation and discussion of the literature review
- physical warm-up activities reflecting sensory approaches that can make a positive contribution to mental health and wellbeing
- tactile art activities, which have been recorded for further review and consideration and as input to the consultation
- a prioritisation process asking people to highlight the three most important things about a safe-space model for North Brisbane.
4. Literature review: a summary

4.1 Background research

This project builds upon earlier work by the North Brisbane PiR to research mental health needs and responses. In particular, two important pieces of work have informed the need for this project:

- The Metro North Hospital and Health Service (HHS) funded a ‘frequent presenters’ project in their recent LINK grants to understand the reasons for frequent presentations and to link presenters to more appropriate care. This project is currently underway and the staff from this project have provided input to the Safe Space Research Project.

- The North Brisbane PiR funded the Hospital Transitions Pathway Project in 2015, which was delivered by ConNetica. This project recommended the implementation of a strategy to reduce the number of mental health emergency department presentations at North Brisbane hospitals and suggested three possible models:
  - crisis or safe houses
  - crisis resolution or home care teams
  - acute day centres.

Also funded by North Brisbane PiR and delivered by ConNetica in collaboration with the University of Sydney, was the Integrated Mental Health Atlas of Brisbane North. The Atlas recommends developing alternatives to hospitalisation in the community for the Metro North Brisbane region and these recommendations helped to shape the current project’s scope and purpose, to:

- increase the number of sub-acute beds, especially due to the lack of alternatives to hospitalisation
- develop alternatives to hospitalisation, such as day hospitals, and residential facilities in the community, such as crisis houses
- Develop day-care centres staffed with highly skilled mental health clinicians and other professionals who can focus on rehabilitation
- Develop day-care centres related to employment (‘social firms’ or ‘social enterprises’) for people with a lived experience of mental health issues to promote their recovery
- Incorporate system thinking into policy and planning.

4.2 A conceptual framework

4.2.1 A systems approach

The Hospital Transitions Pathway Project identified the importance of broader system functioning as a context for specific initiatives. A whole-of-system approach to transitions from hospital was recommended. This current project adopts a conceptual framework that includes systems thinking and responses as a basis for addressing the drivers for and solutions to frequent emergency department presentations and the need for safe space. A systems view allows a model to articulate its role, relationships and position in a broader landscape of service delivery. It helps to avoid duplication, and builds opportunities for service integration, care coordination, synergy, choices and active referrals, depending on client needs. It is the best context for continuous improvements and developments. As such the scope of the literature review and final recommendations is to not only describe specific initiatives that are physical spaces but to also locate these initiatives in the broader landscape of mental health responses.

4.2.2 Person-centred, recovery-focused models

Recent responses to mental health issues have seen an active withdrawal from institutional forms of care...
to community-based approaches. This occurred without comprehensively planned approaches to a community-based service system, leaving many people without basic mental health care or a broader system of social and community support that contributed to total wellbeing. Inadequate housing compounded the struggle for wellbeing and recovery, resulting in decades of steady reforms to embed more services in the community, provide more outreach to people in situ and define the scope and breadth of community-based care to achieve integration across health and social needs.

As approaches to mental health issues evolved, there was recognition that while institutional forms of care had largely receded into history, there remained significant challenges to achieve person-centred approaches, underscored by a broader understanding of recovery. While several service delivery models exist for the provision of safe space, regardless of the approach taken in Brisbane’s North, some particular themes and principles are known to achieve better overall responses. As such, a North Brisbane Safe-Space Initiative will have a greater chance of success if informed by:

- person-centred approaches which recognise that, while people may share some common concerns, they are also unique, and require tailored, individual responses to their needs. This should include a choice of options and providers depending on preferences and need.
- working with the person to identify needs and appropriate responses to those needs.
- recovery-oriented mental health practice in which recovery is defined from the perspective of the individual living with a mental illness and means: … gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services.

Source: Jacobson and Greenley, 2001:482

The principles of recovery-oriented practice are concerned with the uniqueness of the person, providing real choices, listening to people about their preferences and hopes for the future, partnership with the person and a respect for human dignity (Australian Government Department of Health, 2016). There is also a commitment to evaluation embedded in recovery practices so that initiatives, ideas and assumptions are tested in a transparent way as a basis for continuously improving practice, services, systems and overall accountability and quality (Australian Government Department of Health, 2016).

4.2.3 The scope for creating safe space: first home, second home, third home

A variety of factors can contribute to people seeking acute hospital care or some other type of safe-space solution. A framework is suggested here which highlights that people’s wellbeing is influenced by a number of factors; some that relate to the person’s own self and some that are more to do with context and broader circumstances. This framework offers a basis for thinking about the scope of responses to people with complex needs and is consistent with recovery models in its articulation of the range of factors that affect and influence wellbeing. As a framework it is helpful in scoping meaningful responses to mental health and feelings of safety.

Kraybill (2012) points out that all of us ‘reside in three homes’ (Figure 4). These three homes basically refer to ourselves (first home), some kind of dwelling (second home) and the broader community (third home). These dimensions of home are explained more fully in Appendix 6 with proposed implications and questions relevant to the scope and purpose of safe-space responses.
Kraybill’s model highlights that people may ‘not feel at home in their own bodies (and) minds … have no housing to call home (or inadequate, unsafe housing) and are disaffiliated from a meaningful role and purpose in the larger community’ (2012:2). If one or more of these experiences can drive the search for safety, then perhaps one or more of these elements might contribute to defining a safe-space response to mental health issues.

This model should not be read as a linear progression or a hierarchy. A fundamental point that Kraybill makes is that this framework creates multiple possible starting points and each is in a relationship with the other.

4.3 Who should benefit from a safe-space response?

The question of safe-space alternatives is often discussed because some people frequently present themselves to emergency departments needing alternative types of assistance for psychosocial needs. In one study of emergency department use, it was found that homeless people, for example, have high rates of emergency department use compared with the general population (Kushel et al., 2002). Several surrounding factors were identified in this study including:

- lack of health insurance
- lack of transportation
- lack of a phone
- poor access to primary care
- minority status
- chronic alcohol and drug use
- mental illness
- chronic health problems (Kushel et al., 2002:778).

In this particular study, 40 per cent had used an emergency department at least once in the previous year, which is three times the rate for the broader United States population (Kushel et al., 2002:782). The researchers concluded that:

“Predisposing and need factors—less stable housing, chronic medical illness and victimisation—predominated … the majority of respondents...
exhibited high levels of housing instability, spending on average three months a year on the street or in shelters” (Kushel et al., 2002:782).

In 2002, information extracted from The Alfred Hospital database on people aged 15–69 years who had three or more admissions or emergency department presentations over 12 months were found to represent six per cent of people attending the emergency department while providing 20 per cent of all presentations (Beckmann and Hahn, 2004–2005).

The following data is provided from hospital emergency department presentations compiled by Brisbane North PHN and sourced from Queensland Health (Table 2). This data illustrates the extent of presentations to emergency departments related to mental health, and alcohol and other drug issues. It shows that the highest number of presentations were at the Royal Brisbane and Women’s Hospital (RBWH) and Prince Charles Hospital combined, which is reflective of the population density of Brisbane. This is followed by Caboolture Hospital, with the total across all hospitals being 35,951 presentations over a two-year period 2013–2015 (equalling 6.9 per cent of all presentations). The lower rates of presentation at Redcliffe Hospital most likely reflect the absence of a specialist mental health unit rather than lower rates of need.

Table 2: Emergency department presentations for mental health/alcohol and other drug issues in Brisbane North Region by hospital, July 2013–June 2015

<table>
<thead>
<tr>
<th>Hospital location</th>
<th>Number of mental health related presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBWH</td>
<td>18,855</td>
</tr>
<tr>
<td>Prince Charles Hospital</td>
<td>7,194</td>
</tr>
<tr>
<td>Caboolture Hospital</td>
<td>6,046</td>
</tr>
<tr>
<td>Redcliffe Hospital</td>
<td>3,856</td>
</tr>
<tr>
<td>Brisbane North region combined</td>
<td>35,951</td>
</tr>
</tbody>
</table>

Source: Brisbane North PHN, 2016

The age profile shows the highest number of people in the age category 15–24 years and the second highest in the range 25–34 years (Figure 5). These figures show that 49.5 per cent of hospital emergency department presentations involve people aged between 15 and 34 years.
Figure 5: Emergency department presentations for mental health related reasons by age, 2013–2015

Figure 6: Suburbs where people presenting to emergency departments live/travel from, 2013–2015

Figures 5 and 6 are charts illustrating data from Brisbane North PHN, 2016.

Figure 5 shows the distribution of emergency department presentations by age group. Peaks are observed on Mondays, Tuesdays and Thursdays, with a stabilization over the weekend. The only exception was Redcliffe Hospital, where presentations peaked on Saturdays. Presentations over the weekend were most likely to be related to alcohol and other drug use.

Figure 6 highlights the 15 most common suburb areas where people present to emergency departments. It is important to note that 809 people cited no fixed address, indicating possible homelessness.

Source: Brisbane North PHN, 2016

Figure 5: Emergency department presentations for mental health related reasons by age, 2013–2015

Figure 6: Suburbs where people presenting to emergency departments live/travel from, 2013–2015

Analysis of presentations by day of the week shows peaks on Mondays, Tuesdays and Thursdays, stabilising on weekends (Figure 7). The only exception to this pattern was Redcliffe Hospital, where presentations peaked on Saturdays. Presentations over the weekend were most likely to be related to alcohol and other drug use.

Source: Brisbane North PHN, 2016

Figure 5: Emergency department presentations for mental health related reasons by age, 2013–2015

Figure 6: Suburbs where people presenting to emergency departments live/travel from, 2013–2015
Across the Brisbane North region, 26 per cent of all presentations were related to alcohol and other drugs (Figure 8). Presentations to the Royal Brisbane and Women’s Hospital involved a higher proportion of diagnoses related to alcohol and other drugs at 37.3 per cent.
Other key trends and factors include:

- A significant proportion of presentations were assessed as category four or five and therefore a low level of acuity (35.8 per cent). The most common category of assessment was category three.
- The average length of stay while in the emergency department was three hours and 12 minutes, although this varied by sub-region.
- Presentations were consistently high between 11.00 am and 6.00 pm and remained significant between 6.00 pm and 11.00 pm, tapering off between midnight and 6.00 am.
- 5.8 per cent of presentations were by people who identified as being from an Aboriginal and/or Torres Strait Islander background.

### 4.4 A review of models

#### 4.4.1 The scope of responses identified: an overview

The literature reviewed identified various types of responses, which are summarised here (Table 3). This builds upon the three models identified in the Hospital Transitions Pathway Project report identified in section 3. Note that the review explored outreach-based models and building-based models on the suggestion of Brisbane North PiR.

#### Table 3: Overview of types of models

<table>
<thead>
<tr>
<th>Type of response</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Crisis resolution or home response teams</td>
<td>Offer an alternative to admission during mental health crises. Includes rapid assessment, home treatment and facilitation of early discharge from hospital. These were implemented nationally from 2000 in England and are also prevalent in Norway. There are examples of crisis treatment teams in various jurisdictions, including parts of Australia.</td>
</tr>
<tr>
<td>2 Assertive community treatment</td>
<td>Assertive community treatment differs from traditional case management approaches in the following ways: assertive community treatment teams are multidisciplinary; caseloads are smaller, allowing for more intensive contact; community-based services are directly provided rather than brokered to other organisations; the teams are available 24 hours a day, seven days a week.</td>
</tr>
<tr>
<td>3 Crisis or safe houses</td>
<td>These vary in their approach and model. Some are fully staffed by mental health professionals, which in some instances include psychiatrists and/or mental health nurses. Some examples of safe houses or safe spaces may not be staffed by mental health professionals and also may include high levels of involvement and staffing by peer support workers. Some safe-space-safe place models include the combined involvement of mental health professionals, peers and volunteers. An example of a host family program was identified, which is based in the UK.</td>
</tr>
<tr>
<td>4 Acute day centres or day hospitals</td>
<td>Acknowledged as a possible alternative to hospitalisation for people otherwise requiring acute care.</td>
</tr>
<tr>
<td>Type of response</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>5</td>
<td>Community or cultural/arts-based inclusion initiatives</td>
</tr>
<tr>
<td></td>
<td>These types of initiatives include:</td>
</tr>
<tr>
<td></td>
<td>• community-based cultural and arts centres</td>
</tr>
<tr>
<td></td>
<td>• community or neighbourhood centres/houses</td>
</tr>
<tr>
<td></td>
<td>• diverse, decentralised, mainstream arts, cultural and community activities where barriers to access are overcome</td>
</tr>
<tr>
<td>6</td>
<td>Sensory-based approaches</td>
</tr>
<tr>
<td></td>
<td>There is evidence that sensory-based approaches to health and wellbeing can contribute to recovery and a reduction in trauma. The following is an extract from a New Zealand based initiative:</td>
</tr>
<tr>
<td></td>
<td>“Sensory modulation involves providing a range of activities that engage the senses in a safe environment. Smell, touch, sound, sight and even taste may be engaged as well as sensory motor functions, such as rocking or squeezing, to reduce distress, induce calmness and create a feeling of being in control. Until recently, sensory modulation has been most commonly used in the treatment of dementia and intellectual and developmental disorders in young people. However, evidence is beginning to emerge that this approach can be helpful in ‘avoiding the use of restrictive interventions and in promoting recovery-oriented treatment environments’ “ (Champagne &amp; Stromberg, 2004).</td>
</tr>
</tbody>
</table>

Note that some of these responses co-exist and are complementary. The following sections provide some examples of each category of response as a basis for considering preferred models for North Brisbane.

### 4.4.2 Outreach, home-based responses

**Crisis resolution or home response teams (UK, Norway)**

Crisis Resolution Teams (CRTs) were developed as an alternative to hospital admission during mental health crises (Wheeler et al., 2015:1). They were implemented across England from 2001 onwards and have also been widespread in Norway and other western countries (Hasselberg et al., 2011:1). Some individual studies suggest that CRTs can help reduce hospital admissions and increase the levels of satisfaction about services among service users.

Some key features of CRTs are:

- rapid assessment
- treating service users at home wherever possible
- working to facilitate early discharge from hospital (Johnson in Wheeler, 2015:2).

They offer an alternative to hospital care with the aim of treating people in the least restrictive environment with the minimum disruption to their lives. CRTs typically aim to offer 24-hour access, intensive support and a gate-keeping function (controlling access to inpatient beds and assessing suitability for home treatment before admission) (Wheeler, 2015:2).

Available guidelines for CRTs cited by Hasselberg et al. (2011:1) include:

- rapid assessment
- intensive short-term treatment
- specialist multidisciplinary team interventions
- reduced use of coercion
- collaboration with the wider mental health system and families/networks
- gate-keeping functions for acute wards (more than outpatient clinics or inpatient wards).
Wheeler et al. embarked on a review of CRTs through examining available studies to consider the qualitative and quantitative evidence regarding the key service delivery models and ‘critical components’ of CRTs (2015:2). They examined three important questions:

I. What characteristics of CRTs are associated with positive outcomes in empirical evaluations of CRT services?

II. What do service users, carers and staff identify in qualitative studies and surveys and quantitative questionnaires as important elements influencing CRT service quality?

III. What recommendations do government agencies and non-statutory organisations and experts make regarding CRT service delivery?

The researchers highlighted some implications for both policy and practice:

- extended opening hours
- inclusion of a psychiatrist within the CRT team
- time for staff to engage with service users and listen to concerns in contrast to an approach that is only task-focused
- provision of a range of support offerings, including for practical problems
- continuity and limiting the number of different staff a person would see across a period of support.

The literature review also found important information about stakeholders’ priorities for CRTs (Table 4). An earlier study from the UK in 2001 is also included in this table to illustrate consistency in a summary of key service characteristics.

### Table 4: Most commonly reported themes from qualitative studies of CRT stakeholders’ views

<table>
<thead>
<tr>
<th>Most commonly reported themes from qualitative studies of CRT stakeholders’ views (Wheeler et al., 2015)</th>
<th>Components of home-based services considered to be essential or very important (Burns et al., 2001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good communications and integration with other mental health services</td>
<td>Home visiting, and assessment and treatment in the home environment</td>
</tr>
<tr>
<td>Provision of treatment at home</td>
<td>Skilled, well-trained staff and having a team with a broad range of special expertise</td>
</tr>
<tr>
<td>Limiting the number of staff visiting a service user</td>
<td>Experienced, community-oriented psychiatrists</td>
</tr>
<tr>
<td>Adequate staffing, including out of hours</td>
<td>A well-organised and managed team</td>
</tr>
<tr>
<td></td>
<td>Good gate-keeping and prioritisation</td>
</tr>
<tr>
<td></td>
<td>Willingness to take reasonable risks</td>
</tr>
<tr>
<td>Good staff record-keeping and information sharing</td>
<td>Reasonable case load size</td>
</tr>
<tr>
<td>Staff with time and willingness to just listen to service users</td>
<td>Attention to social needs as well as clinical needs</td>
</tr>
<tr>
<td>Rapid CRT response and availability of treatment during a crisis</td>
<td>Good liaison between health and social services</td>
</tr>
<tr>
<td></td>
<td>Access to out-of-hours and extended-hours services</td>
</tr>
<tr>
<td>Clear inclusive eligibility criteria</td>
<td>Cross agency working with good links to primary care and knowledge of local support systems</td>
</tr>
<tr>
<td></td>
<td>Coherent and integrated service framework</td>
</tr>
<tr>
<td>CRTs provide a clear bridge to longer-term interventions and care</td>
<td>Crisis services</td>
</tr>
</tbody>
</table>
Crisis assessment and treatment teams (CATT) report
Victoria and ACT, Australia

Australia has examples of crisis assessment and treatment teams that emerged as a result of deinstitutionalisation policies in the 1980s (Carroll et al., 2001). In Victoria and the ACT there are examples of crisis assessment and treatment teams that operate over extended hours and in some instances 24 hours a day, seven days a week. Contact is made through a central triage hotline and services are mobile and outreaching.

These teams assess all people who are being considered for hospital admission and whether ‘a less restrictive setting is more suitable’ for them (Eastern Health website, 2016). ‘CATT services also provide treatment and support for people whose acute mental illness can be managed in the community as an alternative to hospitalisation’ (Eastern Health website, 2016).

In one CATT team example operated by Mercy Health, referrals can be made by GPs, carers, the person experiencing the crisis situation and other stakeholders involved in the care of a person (Mercy Health Website, 2016). A CATT team in Melbourne’s northern suburbs (NCATT) will visit a person within two hours of a referral being accepted and can provide up to twice daily contact during the period of a CATT service (Carroll et al., 2001:439).
The scope of services include assessment, problem solving, advice, education, dispensing and supervising medication and assistance with a range of other issues depending on the needs of the person. In the example of NCATT in Melbourne, all people or agencies seeking an admission are referred first to NCATT. NCATT then assesses the suitability of community-based crisis treatments and only people who are assessed as being unsuitable are referred to hospital (usually because of a history of non-compliance, extreme disturbance or the risk of harm) (Carroll et al., 2001). As shorter hospitalisations are preferred, the NCATT is also involved in managing people’s treatment for the period of time considered necessary after they return home. Staffing includes psychiatric nurses, a psychologist, a social worker, a psychiatric registrar and a consultant psychiatrist. There is also an administrative staff. NCATT treats people with a range of mental health issues including major mental illnesses, situations involving the use of psychoactive substances, stress-related disorders, mood disorders and personality disorders. NCATT is considered to have helped the shift from institutional forms of care to community-based care, thus reducing hospitalisations.

**Assertive Community Treatment — USA and UK**

Assertive Community Treatment (ACT) is an approach to community-based care prevalent in North America and the UK, which involves multidisciplinary teams who provide ‘wraparound’ outpatient care available 24 hours a day, seven days a week. It is generally focussed on meeting the needs of people with severe and persistent mental health issues and has an explicit aim of supporting people to live in the community and avoid lengthy hospitalisations (Gaynes et al., 2015:12).

Assertive community treatment differs from traditional key support approaches in the following ways:

- assertive community treatment teams are multidisciplinary
- caseloads are smaller, allowing for more intensive contact
- community-based services are directly provided rather than brokered to other organisations.

ACT draws on an extensive evidence base and generally assists people with a range of complex circumstances, including severe and persistent mental illness, recent history of repeat psychiatric hospitalisations, criminal justice system involvement, homelessness and dual diagnosis (Gaynes et al., 2015:12). Teams usually involve social workers, rehabilitation therapists, nurses and a psychiatrist with a low ratio of staff to people being assisted of 1:10. It is characterised by assertive community outreach as a key mechanism for achieving engagement and reducing the risk of low or no contact with the person. ACT intends to reduce the complexity of coordinating care so that the person does not have to work as hard to achieve an integrated response. People can be supported through most mental health crises without hospitalisation and ‘thus provide care in the least restrictive alternative’ (Gaynes et al., 2015:13).

**HARP — Victoria, Australia**

The Victorian Government’s Hospital Admission Risk Program (HARP) Model was developed in response to the demand for emergency department services with reflections about the broader implications of deinstitutionalisation, lack of supported accommodation, the risk of homelessness, and social isolation. The program also reflected on service system fragmentation and complexity as a context for needing to work on improved service integration and ways of ensuring people are assisted in a coordinated way.
The program aimed to ‘develop and implement innovative models of care to better manage emergency demand in public hospitals through alternatives that involve the hospital and community’ (Beckmann and Hahn, 2004–2005:11). The model worked with people aged 15–69 who had three or more emergency department presentations in a 12-month period. A group of agencies from Melbourne’s inner south-eastern suburbs joined together to develop and propose a model that was aimed at improving psychosocial wellbeing among people with a mental health issues.

In the absence of any coordinating entity, people who rely on multiple health services for continuing care and their quality of life must themselves provide the ‘glue’ in the health system, organising and linking the care that they receive in the primary, community health and acute care settings. In many cases the target group of the ConnectED project is unable to provide the glue to ensure their care needs are met in a coordinated way (Beckmann and Hahn, 2004–2005:10).

The program came about following a six-month research and consultation project that examined needs and possible responses. A proposal resulted for a multi-agency, multi-skilled team to:

- undertake assertive outreach
- work collaboratively with other services to ‘provide enabling, holistic care to people with high needs’ (Beckmann and Hahn, 2004-2005).

A particular emphasis was on integrating hospital and other community-based supports. It was formed through a multi-agency team. The client group was ‘not homogenous’ but included people with personality disorders and alcohol and other drug issues. The project included a flexible fund, community development role and ‘stop-over’ beds that provided access to short term accommodation.

The City of Port Phillip was the fund holder, and nine participating agencies employed key workers with backgrounds either as nurses, mental health nurses or social workers with experience working with the targeted client groups. The following case study illustrates the complexity of circumstances that can be present.

Joe was referred to the project due to multiple presentations to the hospital emergency department as a result of suicide attempts or fitting. Joe had a past history of epilepsy, post-traumatic stress disorder, depression, alcohol usage since he was about 10 years old, and multiple physical problems. He was living in a private hotel and drinking heavily—mainly methylated spirits. His room was untidy, his medications all over the floor, and he had not washed his clothes or himself for some time. He often did not take his medication as he felt it caused him to fit and was prone to overdose. He realised that he was in crisis but was unable to achieve the consistent level of functioning or sobriety to plan or keep appointments.

Source: Beckmann and Hahn, 2004-2005:10

4.4.3 Crisis houses or safe-space/place initiatives

This project reviewed a number of safe-space/place initiatives that vary in the extent they are part of a broader mental health system and in how they are funded and staffed. Some have very high levels of involvement by peers, for example, while others involve a mix of inputs spanning mental health professionals, peers and volunteers, clinical and non-clinical responses. Houses are usually community based and reflect a calming, home-like environment.

Crisis houses and other similar approaches have been developing over some decades and generally have quite strong support from service users (Joint Commissioning Panel for Mental Health, 2013). Crisis house approaches include several broad types (Table 6).
SAFE SPACE RESPONSES FOR BRISBANE NORTH REGION

Table 6: Types of crisis houses responding to psychological distress

<table>
<thead>
<tr>
<th>Type of crisis houses</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Clinical crisis houses</td>
<td>Similar in many features to hospitals but located in community settings. Include residential services with staff on site 24/7. High level of clinical staff on site involved in providing care.</td>
</tr>
<tr>
<td>2 Specialist crisis houses</td>
<td>These services may share similar features to clinical crisis houses but are aimed at specific groups such as women and people with early psychosis.</td>
</tr>
<tr>
<td>3 Crisis or safe houses</td>
<td>Provide a small number of beds aimed at short stays and are fully integrated with Crisis Resolution and Home Care Teams (CRHT).</td>
</tr>
<tr>
<td>4 Non-clinical alternatives</td>
<td>Mainly managed by the voluntary sector with few clinical staff but many have forged strong links with the CRHT teams.</td>
</tr>
<tr>
<td>5 Survivor-led sanctuary and support</td>
<td>One example is Leeds Survivor-Led Crisis Service in the UK, established in 1999. It provides services that are an alternative to hospital for people with an acute mental health crisis. Dial House provides one-to-one support and time out during weekend evenings until late when most other services are not available. There is also a nightly helpline and peer-led group work.</td>
</tr>
<tr>
<td>6 Host families</td>
<td>Hertfordshire Partnership NHS Foundation Trust set up the first UK Host Family Scheme in 2010. A host family provides a caring, family environment and is supported by a specialist mental health team that also provides ongoing assistance. The person is visited every day by the mental health team and staff are available 24 hours a day to provide additional support to the person and host family.</td>
</tr>
</tbody>
</table>

Table 7: Specific safe-house initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soteria Houses California Berne (Switzerland)</td>
<td>Developed in California and expanded to Europe. Aimed at providing care to people with first or second psychoses. In relation to Soteria Berne, which was an iteration of Soteria (US): Our primary goal was not to develop an almost drug-free treatment strategy, but to implement an as good comprehensive psycho-socio-biological treatment of acute schizophrenia patients as possible, by combining all available psycho-socio-biological knowledge on therapeutic factors in innovative ways, including the Soteria experience. Given the central role that emotional tensions play, from the perspective of affect-logic, in the outbreak and/or exacerbation of psychotic symptoms, the creation of a therapeutic setting that consistently reduces emotional tension appeared as crucial (Ciompi, 2004). Soteria Berne collaborated closely with a local psychiatric hospital and some people were transferred there when they needed acute treatment (10–15 per cent). The average stay was 54 days. Soteria Berne described some important practice principles that guided the mode.</td>
</tr>
</tbody>
</table>

Source: Joint Commissioning Panel for Mental Health, 2013:15

Table 7 includes a summary explanation of some specific safe-house initiatives relevant to this discussion. They are further elaborated upon in the full literature review available as a separate publication.
### Initiative | Description
--- | ---
Banner Psychiatric Centre (BPC) Phoenix, Arizona | Based in Phoenix, Arizona, Banner provides people with what is termed a ‘behavioural health crisis’ with an alternative to presenting to an emergency department (ED) for assistance (Little-Upah et al., 2013). Driven by a concern about the number of emergency department presentations and the length of time people stay there while waiting for arrangements to address their mental health issues, Banner Health has attempted to respond with alternatives to lengthy waiting times in ED. It was noted that lengthy waits in an ED has impacts on ED resources, the wellbeing of those people seeking assistance and others using the service. The model included the following elements:
- A primary goal of moving people from the ED to a safe, secure and appropriate care setting in as timely a way as possible
- A centre was opened in September 2010, staffed 24/7 by a psychiatrist or behavioural health nurse practitioner along with other behavioural health support staff
- A transfer process was developed including assistance from a call centre staffed 24/7 by registered nurses who matched people to available resources
- Once placed at the Banner Psychiatric Centre, a person is assessed as soon as possible, stabilised, and either discharged to the community or admitted to the inpatient setting
- BPC only works with voluntary patients
- The Centre provides assistance for less than 24 hours
- It has resulted in deferring 70% of behavioural health inpatient admissions to outpatient options
- Assistance provided includes emergency intake and assessment, behavioural health crisis intervention, medication services and stabilisation, counselling, referral to community resources and coordination of care with service clinicians
- Little-Upah et al. (2013) report that the model has freed up acute beds and reduced the amount of time people spend waiting in EDs. The Centre receives referrals from the ED and through people walking into the service

The Living Room Chicago, Illinois | The Living Room is an ‘outpatient voluntary program for persons in emotional distress’. It was established as a way of overcoming some of the issues experienced by people in emotional distress as they access emergency departments (Heyland et al., 2013) In its first year of operation the following key milestones were reached:
- 228 visits were hosted involving 87 people, who are referred to as guests
- Guests were diverted from emergency departments on 213 of those visits (93 per cent)
- This equates to a cost of $550,000
- 84 per cent of those people experienced an alleviation of their crisis to an extent that they could return to the community. These people reported an average decrease of 2.13 points on the Subjective Units of Distress Scale
- Accommodation for up to six guests at a time
- Minimised wait times
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
</table>
| SAFE SPACE RESPONSES FOR BRISBANE NORTH REGION | • funding through an initial special project grant (for two years) and now bills eligible people to Medicaid  
• the environment is warm and welcoming with carpeted floors, artwork on the walls, comfortable furniture and soft lighting. It is called the Living Room because it is designed to look like a welcoming home  
• the environment was designed to feel safe and not likely to result in feeling overwhelmed because of excessive stimuli including television or an excessive number of people  
• peer counsellors are experienced and trained  
Early outcomes suggest community crisis respite centres are a cost-effective alternative and can help people to alleviate a crisis and reduce their use of an emergency department option. It should be noted that this information is based on a program description by the staff that has been published in a journal. They highlight the lack of program funding for similar initiatives.  
Theresa Fisher (2015) recently reported on the research about the Living Room, saying:  
“Illinois opened the first of its five Living Rooms in 2011 as a non-clinical crisis centre for people in the throes of a mental health meltdown. People can drop in to get immediate help and access to resources for longer-term care. A mental health crisis, to use the same definition as The Living Room does, is ‘a state in which an individual becomes overwhelmed and their usual coping mechanisms are not adequate, which leave them with disorganized thoughts and life processes … if a crisis state is not properly treated, the condition can quickly escalate, leading to a mental health emergency.  
As the name suggests, the centers are supposed to feel more like homes than hospitals. When guests walk into the Living Room … staff members greet them ‘with open arms’ and offer beverages—anything to make them feel at home, supported and in control of their own treatment” (Fisher, 2015).  

<table>
<thead>
<tr>
<th>Initiative</th>
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</tr>
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</table>
| Bristol Sanctuary | Bristol Sanctuary is run by St Mungo’s, Broadway, and is the first of its kind for Bristol (Bristol Mental Health, 2016). It commenced operation in April 2015 and is a place that ‘feels safe, comfortable and welcoming where people who are experiencing severe emotional distress can go for help out of normal working hours’. People have options to talk to a staff member or to others at the Sanctuary, or participate in other activities such as cooking, reading or resting. There is involvement by service users in the development of the service.  
Access is through a telephone triage service and the Sanctuary can assist 10–12 people each night. It is open Friday, Saturday, Sunday and Monday nights from 7:00pm to 2:00am. The program refers people to appropriate mental health services as required. |

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**Initiative** | **Description**  
--- | ---  
Host families | Hertfordshire Partnership NHS Foundation Trust initiated a host families program ‘aimed at providing an alternative to hospital for people who are going through a period of mental ill-health’ (Hertfordshire Partnership NHS Foundation Trust, 2016). It was based on a model from Lille France (Kamera, 2014). The following information is drawn from the program brochure and a presentation by program coordinator Nick Kamera.  
A host family provides:  
- a caring, family environment for a guest, which avoids hospital and focuses more on home, family and the community  
- options for people to leave hospital as soon as possible  
- ways of staying in touch with the community, family and other social connections  
A host family is not required to provide professional support for the person’s mental health issues. The guest is supported on a daily basis by professional staff from the Trust, who give a guarantee of responding within 30 minutes, 24 hours a day, every day. The program includes a project reference group consisting of service users, carers and community services representatives. A support network has been developed for host families. So far eight families have been recruited, with 42 people hosted. An evaluation has been designed and commissioned.  
The literature search found reference to a host family program responding to mental health issues piloted around 1997 in Caboolture, Queensland, which has been referred to in subsequent consultation with key stakeholders. It was reported by key stakeholders as playing an important role and that the model was a valuable contribution.  

Specialist safe spaces | In a number of examples, there are specialist responses to specific groups such as women. One example is Link Up in Bristol, which was established in 2010 as an alternative to psychiatric admission for women experiencing a mental health crisis (Bristol Mental Health, 2016). It can accommodate up to 10 women and provides support for up to four weeks. Like other safe-space alternatives, the physical setting strives to be welcoming and community based with many of the features of a home.  
It is staffed 24 hours a day, seven days a week and referrals can come from professionals, services and the people requiring assistance themselves. The service delivery model is a social-care model of recovery designed to address immediate crisis and longer term recovery goals. There is a focus on resilience, support networks and how better health and wellbeing will be maintained when a person returns to live at home. There is also a group work program and each person draws up an individual support plan based on an assessment and the mental health recovery star.
Bristol Greenway Centre

Bristol Mental Health opened a community mental wellbeing centre in late 2014 that provides a base for staff from a recovery and assessment service, complex interventions services and a crisis service (Bristol Mental Health, 2016). The Centre operates seven days a week and includes clinic rooms, although it is intended that most people will be seen at home or in other decentralised community-based settings such as general practitioners.

The Centre is run by the Southmead Development Trust and is well located in terms of transport. Interestingly, it hosts a wide variety of community, business, training and health organisations, including a café, church and printing company. It has a range of meeting and event spaces as well as space for sport and other leisure activities. It is very much ‘place focussed’, responding to needs in the northern region of the city and its location is such that service users and service providers will have shorter distances to travel. The Southmead Development Trust is also focussed on contributing to a community plan for the area in which mental health would be the priority.

The style of the centre, its culture and focus were carefully considered in a deliberate attempt to achieve a ‘low-stigma’ environment with a commitment to community linkages and collaboration, as evidenced in the following quote from the assessment and recovery service manager:

> Because the Greenway Centre is so diverse and is not solely a healthcare facility, it is a great low-stigma environment for people coming for appointments and will help Bristol Mental Health staff to link-in with other sectors of the community in North Bristol (Bristol Mental Health, 2014).

Community and peer-led initiatives

The literature search process found a number of initiatives that were community based and tending away from clinical staffing and more towards peer-led initiatives. Sometimes staffing involved a combination of professional staff and peer support staff. Programs included elements such as residential respite, activities, time out and telephone support. Some shared characteristics with the Living Room. Initiatives include some or all of the following elements:

- a residential component
- usually a small facility with home-like features and a deliberately soothing and calming environment
- optional activities and choices for a person including quiet spaces, talking to someone and participating in activities such as household chores and cooking
- telephone support
- extended hours including examples staffed 24/7
- information, advice and referral to a broader range of services
- recovery focussed, including the use of recovery planning tools
- staffing can be by professional people, a combination of professional people and peers, and there are examples that are entirely peer-led
- often a house in suburban areas
**Mental health safe houses in New York**

A new program is taking an innovative approach to helping New York adults with mental health issues and those who may be on the brink of a psychiatric crisis. Called Parachute NYC, the program is funded federally and has resulted in the establishment of respite centres where people can attend and talk through concerns with staff who have experience of the mental health system (Debucquoy-Dodley, 2015).

The Centres are described as a ‘soft landing’ by the CEO of the organisation that runs the service. It is deliberately mindful that many people, for whom there are better options, end up using hospitals or staying in hospitals. Parachute NYC offers a range of services and centres located in four different boroughs. They include apartment-style common rooms and bedrooms. The services are free and the environment is comfortable and supportive. People who attend do so voluntarily, have access to trained staff and can reside there for up to 10 nights. Meals are available and medical assistance can be recommended where it is deemed necessary but does not happen on site. A focus is on people working to develop recovery and relapse prevention skills, with access to peers they can relate to. There is phone access and counselling as well as a mobile treatment centre. Staff are often peers with lived experience of challenges such as homelessness and substance use.

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</tr>
<tr>
<td>Psychiatric emergency services (PES)</td>
<td>Developed in response to the inappropriateness of emergency departments for people in distress, they may be located on a hospital campus or in the community (California Hospital Association, 2014). The interior is deliberately more calming and welcoming than a medical emergency room. PES usually include décor, lighting, sound/music and open spaces designed with the goal of encouraging healing and recovery. PES contrast with hectic, noisy emergency departments. PES aim to provide professional and cost-effective services to people experiencing a mental health or substance use crisis. They strive to stabilise people and avoid hospitalisation wherever possible. People can walk in to access the service or referral can be through other emergency services and referrals. PES also provides a crisis phone service 24 hours a day, seven days a week. They avoid exclusionary policies and ensure a complete assessment and appropriate treatment for anyone requiring their services. They do not use coercion and work with people in a therapeutic relationship. Treatment involves the least restrictive alternatives. Aftercare plans are developed. Staffing includes physicians and mental health professionals around the clock who provide access to a full range of services, including medication management, crisis intervention and stabilisation, and screening for inpatient treatment. Linkages are forged with broader mental health and other services depending on the plan developed. They are usually 23-hour 59-minute treatment facilities that avoid hospitalisation for the vast majority of people who present. ‘A PES is not a “medical emergency department”, nor a “community clubhouse model”, but a blend of both, which is community-based and uses the Recovery Model concept’ (California Hospital Association, 2014).</td>
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### Initiative Description

**Assertive housing models**

There is significant emphasis on the Housing First and Supportive Housing models that have developed in North America in recognition of the needs of homeless people, including rough sleepers. There is a growing emphasis on Housing First in Australia with the emergence of supportive housing models in various jurisdictions, including South Australia, Victoria, New South Wales and Queensland. In Brisbane, Common Ground housing based in Hope Street, South Brisbane, accommodates 140 people in single units with full concierge facilities (24/7) and robust, independent support for people living there provided through Micah Projects. The facility has common spaces, community rooms and is linked to various community activities and visiting support services.

Given that people who frequently present in emergency departments generally have a complex range of issues and include an over-representation of homeless people, Housing First and Supportive Housing are important models to consider. A definite consideration with Housing First models is the relative cost of permanent housing with support compared to repeat presentations in emergency departments, institutionalisation, and the involvement of emergency services. Permanent housing solutions with robust, ongoing support were found to be a less expensive option with improved social outcomes for the people housed.

### 4.4.4 Community, arts and cultural centres

**Arts and cultural centres and activities**

A range of innovative initiatives exists across various countries that focus on access to arts and culture in ways that foster recovery and community inclusion. These initiatives variously focus on people’s strengths and the enjoyment of creative pursuits. Some focus on genuine opportunities to develop skills and vocational pathways, and for others, there is scope to focus on the enjoyment of art and culture as a basis for relaxation, diversion, wellbeing, enjoyment and recovery.

In some instances, arts and cultural pursuits are integrated as part of a recovery plan to be maintained alongside other strategies designed to increase safety, wellbeing and stronger social and community connections.

There are notable examples of community arts initiatives that include various program designs and also various types of buildings, both hospital-based and, more often, located in residential communities. This literature search found initiatives in Australia, New Zealand and Canada, although it is known that examples are widespread in various locations. Some program elements identified in a review of these models include (in various combinations):

- specific mental health arts centres
- studio spaces available to people
- staffing arrangements including specialist arts and cultural workers
- staffing arrangements that include peer support workers
- modalities including visual arts, performance, photography
- community arts spaces in response to crisis and trauma (such as post-earthquake)
- spaces that are safe, relaxing, creative and respectful—the design of the space itself is important
- arts and cultural activities that are deliberately linked to recovery approaches and recovery goals
- use of neighbourhood settings linked to ideas of non-institutionalisation and social inclusion
• various types of linkages to other services, support and resources.

The opportunity with arts and cultural activities/centres is that they can be integrated as part of many of the centre-based options outlined in this review and are also used in some examples of hospital-based care.

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**Case Study**

In Brisbane, Access Arts has existed for over three decades, working to offer a range of accessible arts opportunities inclusive of people living with a mental health difficulty. In one case study, Access Arts was funded to deliver a model utilising community based arts projects to support people’s integration into their communities (Radbourne et al., 1995). The project was delivered by Access Arts. The Artist in Residence Program at the Winston Noble Unit which was part of the Prince Charles Hospital was involved and a key element of success. A main feature of the project was its conceptualisation as a wellness-based approach with attention on creativity, imagination and the person’s potential for self-expression. It was not a form of therapy as such. Nundah House, a community-based treatment facility was utilised along with community-based settings in Kedron/Wooloowin (Melrose Park) and Caboolture. The program included wider community involvement in arts activities because of active expressions of interest by local people in the Wooloowin area in using the local park for activities which achieved better community connections and integration. There were linkages with the Winston Noble Unit Day Centre and Access Arts also leased a small building from the Department of Main Roads which was called the Art Surgery.

Different types of activities were included including sculpture, mosaics and story-telling. Artists were selected on the basis that they showed capabilities in certain forms of art and an enthusiastic and capable style in embracing dynamic community projects. An evaluation was conducted and published. Feedback from participants included that:

- Self-esteem was developed
- Friendship networks had increased
- There were fewer dependencies on facilities such as the Day Centre
- There was satisfaction at contributing to an improved public realm through community-based art installations (such as in Melrose Park).

Radbourne et al., 1995.

The evaluation showed statistically significant improvements in symptomology, increases in social contact and general improvement in living skills assessed and compared between the beginning and end of the project.

Another Brisbane-based example at the Princess Alexandra Hospital engaged people in creative activities, and people were actively linked back to arts organisations in their local community for continuation of creative activities geared to improved wellbeing and recovery.

These examples of community arts programs use various types of artistic methods which are also linked to locality and a sense of place. This is significant because one element of feeling safe and a sense of belonging is the quality of the relationship that exists between a person, and the broader community in which they reside. A strong sense of the public realm, connections and positive experiences in physical spaces, and activities which actively achieve place-making outcomes have definite potential in contributing to feelings of safety, connection and belonging.
Community Centres

In an analysis of the roles and functions of localised community and neighbourhood centres in Brisbane, it was concluded that:

Community and neighbourhood centres operate in a localised way to respond to a range of issues and opportunities. They have capacity for flexibility and responsiveness and to shift priorities and resources as new needs emerge. They work in ways that engage local people in local solutions and as such play a critical role in community capacity building.

National and state level research into the role of community and neighbourhood centres demonstrates they provide wide ranging activities and programs targeting diverse stakeholder groups. In most instances, they also undertake community development work focussed on reducing isolation, increasing engagement and building social cohesion.

Source: West End Community House, 2011:5

This analysis included numerous case studies relating to the scope of work that the participating centres were involved in:

- as hubs of services
- as facilitators of local participation in planning and development issues as well as community change
- by contributing to consortium arrangements with other partners that improve outcomes for disadvantaged people
- through active outreach and innovative approaches to reaching and engaging local people
- by building community connections and relationships, including through reconciliation with Aboriginal and Torres Strait Islander communities
- by improving the inclusion of culturally and linguistically diverse communities.

Source: West End Community House, 2011

In some notable examples, community centres had open-house programs which actively included people with diverse needs, including people living with mental health issues. The focus was partly on social connections and a feeling of belonging. People could variously access things like computer hubs, community information, visiting services, counselling, activities such as art/craft and music, community meals and gardening. Centres supported informal ‘drop-in’ options, which were supported by a combination of paid and volunteer staff. They often also included visiting services and other activities such as self-help groups, 12-step programs and other options focussed on wellbeing such as exercise, dance and yoga.

Much of the work of community centres and community cultural development helps transform community space into places of belonging. Tuan (2001) describes this transition from space to place by explaining that space holds a lot of opportunities and spaces become places with human activity and occupation. The potential for community spaces to become places of safety and belonging may well be realised by refocussing on localised community infrastructure that already exists, and that could be extended or modestly adapted to mindfully welcome, include and respond to people in a state of distress.

North Brisbane PiR funded a project examining the use of community centres by people experiencing mental health difficulties (SANDBAG, 2014). The project illustrated that centres were definitely accessed to varying degrees by people living with mental health difficulties. People sought a variety of things from their participation in centres, which varied in their approach to inclusion and access. This project documented the funding issues that resulted in significant pressures on worker time and reduced time for relationship-based contact with people who visit. Nonetheless, the centres demonstrated that they are accessed by people and certainly represent decentralised and place-focussed infrastructure, contributing to available
places to go.

**Sensory-based alternatives in mental health care**

Sensory-based alternatives and sensory modulation have been recognised as a way of reducing trauma and improving wellbeing among people in a state of psychological distress (Chalmers et al., 2012; Te Pou, 2009). In some settings, the use of sensory modulation is used as a de-escalation tool and is actively linked to the purpose of reducing seclusion and restraint (Te Pou, 2009). This can include setting up sensory rooms in inpatient units, but is an approach equally relevant to various centre-based approaches, including non-hospital crisis facilities, community centres, community arts venues and people’s homes. Sensory modulation approaches have been implemented across various jurisdictions including in Australia. It usually involves setting up sensory rooms accompanied by workforce development to achieve appropriate and effective use-sensory modulation options.

This approach moves away from a single focus on talking approaches to providing assistance towards a greater focus on the body-mind connection (Wilson, 2009).

Sensory modulation involves providing a range of activities that engage the senses in a safe environment. Smell, touch, sight and even taste may be engaged as well as sensory motor functions such as rocking or squeezing to reduce distress, induce calmness and create a feeling of being in control … evidence is beginning to emerge that this approach can be helpful in ‘avoiding the use of restrictive interventions and in promoting recovery-oriented treatment environments’ (Wilson, 2009; Champagne and Stromberg, 2004, quoted in Wilson, 2009).

In 2009, several sensory modulation facilities were established in New Zealand. The facilities were set up in inpatient units including a service for children and adolescents (Wilson, 2009). The process of establishing the units involved a combined focus on appropriate space and equipment, and change management involving the identification of champions and a deliberate approach to training and workforce development. It resulted in nearly 200 clinicians being trained in sensory modulation theory and use of associated tools. The training was intensive and was accompanied by guidelines and protocols. Equipment included massage chairs, bean bags, rocking chairs, ambient lighting, access to music, weighted blankets, scented oils and objects such as soft toys and fabrics. Service users who found this approach helpful were encouraged to use similar approaches when they returned home.

A review of sensory-based units within psychiatric hospitals in Australia showed some initial resistance by staff, which supports the need for workforce development, guidelines and protocols (Chalmers et al., 2012). Preliminary findings by Chalmers et al. in terms of reducing distress and inducing calm have been encouraging. They note that discussing these practices with service users has increased the instances when people trigger use of a sensory room themselves. Other considerations are safety planning, cost and integration into community settings and community case management approaches.

Based on 30 years of research into assisting people with trauma and severe mental health issues, Van der Kolk (2014) provides a summary of cutting-edge research that supports the use of a range of therapies including traditionally non-clinical interventions such as yoga, drama and improvisation, mindfulness, therapeutic massage, Feldenkrais and mindful self-leadership. Creative and movement-based activities are becoming an integral part of therapeutic intervention for healing people who have experienced childhood or adult abuse, trauma and/or violence, and whose behaviour has consequently often been labelled or diagnosed, such as with bipolar illness, post-traumatic stress disorder and borderline personality disorder. Other research in neuroscience is increasingly supporting the role of exercise and mindfulness as a mechanism for changing the brain and improving brain plasticity.
While some of these examples are drawn from hospital settings, it would appear that these elements are also applicable to community settings such as crisis centres, residential facilities, community arts facilities and community centres. The scope for wellness recovery plans and individual safety plans to include sensory modulation options transferred to people’s usual living situation suggests it is relevant and applicable beyond acute hospital settings.

**Day Centres**

Day services for people using mental health services have gradually focussed on social inclusion goals rather than building-based approaches (Bryant et al., 2011). There is a history of mental health day centres in North Brisbane with one notable facility, which used to be located at the Prince Charles Hospital. Winston Noble Unit was operating group programs for two groups of clients for two days each. All clients in attendance were case managed by one staff member in a multidisciplinary team consisting of a consultant psychiatrist, psychiatric registrar, nurse, occupational therapist and social worker. The establishment of day centres has a reasonably long history. One examination of client experiences in four day centres in the UK found that people attended because of a sense of purpose and belonging (Catty et al., 2001), with some describing it as a lifeline. While group programs were available, many people used the centres as a place to drop in.

A project exploring this shift through the perceptions of service users has helped to identify the meaning and value of day centres to users (Bryant et al., 2011). Service users were asked to take photographs that illustrate their views about the space. Learning from this process included that day services provided people with a safe place to go, make contact with others and work on other recovery plans. When there was constant change among staff and in the organisation, there was an impact on the value and safety of the space where people were. The project concluded that safe spaces are centrally important in offering people ‘refuge, social contact and meaningful occupation’ (Bryant et al., 2011:611).

Various examples of day centres exist, including those in the private health system. One such example is the Kahlyn Day Centre in South Australia, which includes deliberate alternatives to inpatient treatment for more severe and acute presentations, including access to community services (Kahlyn Day Centre, 2016). Kahlyn includes access to treatment for people with drug and alcohol difficulties and innovative day programs that are uniquely tailored to a person’s needs. There is a selection of groups and individual sessions with the main objective being:

To provide a supportive environment created by professional staff, dedicated to maintaining and enhancing the independent functioning of each patient (Kaylyn Day Centre, 2016).

Specific objectives include to:

- reduce or eliminate the frequency of inpatient hospitalisation
- develop self-recognition of symptoms and a management plan
- promote awareness and teach skills, which allows patients to take responsibility and control their own lives
- assist recently discharged patients who may still require support
- offer choices to people who may not need or benefit from acute hospitalisation.

Attendance at the Day Unit program can be sessional, half days or full days. Programs of assistance can be designed for individuals.

A range of day-centre options is also available in other jurisdictions such as the United Kingdom: ‘These Centres are designed to provide a therapeutic program that works in partnership with service users to identify their needs, develop a care plan, work towards goals and review
progress’ (Central and North West London Trust, 2016).

These services support people with enduring mental health problems to build sustainable coping strategies, break social isolation, and promote social inclusion through meaningful activities that build networks and training that may lead to employment.

4.5 Evaluation

The theme of evaluation is important: various studies highlight a lack of robust measurement of safe-space/hospital alternatives (Wheeler et al., 2015). A North Brisbane initiative should take the question of evaluation very seriously to ensure that a data framework is established early that can contribute to both formative and summative evaluation, drive continuous improvements and provide a basis for robust measurement of outcomes to inform for continued investment.

An evaluation framework could incorporate client support and care planning tools such as the Subjective Units of Distress Scale (Kim et al., 2008) and the Outcomes Star (Triangle Consulting, 2016). This could help provide data linked to actual support and case management, to engage people in measuring their own progress and experiences over time as a basis for comparison. Such tools might also be combined with other measures such as a history of hospitalisation/presentation to emergency departments compared over time, and quality-of-life measures across other domains such as housing, health and social connectedness.

Evaluation combining quantitative and qualitative data will be a basis for engaging key stakeholders in perceptions and opinions of outcomes and success. A facility to track individual progress over time should be considered with links to research institutions and partnering services with a shared commitment evaluation.

4.6 Discussion

This review takes into account literature and initiatives spanning a range of options as follows:

- crisis home outreach teams designed to manage crises and distress in the context of people’s own homes
- ongoing assertive community treatment designed to wrap around support, assist across varied life domains and reduce hospitalisation
- crisis houses and safe-place initiatives that include options on the spectrum from clinical services through to peer-led community-based options. Some of these include specialist safe spaces such as facilities for women
  - community centres
  - community arts programs
  - sensory-based options
  - day centres.

These approaches are often designed to include:

- smaller spaces in contrast to larger hospital environments
- attention to design, furnishings, lighting and mood geared to induce calmness rather than escalation of crises
- multidisciplinary staffing and/or team-based approaches including scope for volunteers and peers. Many initiatives involve a combination of clinical and non-clinical inputs
- complementary and mutually reinforcing elements defined within a broader system. Many crisis houses and crisis home/outreach approaches have strong links to broader referral networks including hospitalisation when it is needed, as one example
- building-based and outreach models
- activities and opportunities for broader community connections and the development of interests through community centres and community arts activities
an emerging application of sensory modulation.

Wherever possible, this review has referred to independent evaluations as a basis for exploring impact and outcomes. In a number of instances, researchers who have conducted meta-analyses of research reports/articles about key options (such as crisis housing/safe spaces and crisis home teams) have lamented the lack of independent and rigorous research as a basis for reliably drawing conclusions about efficacy. In some instances, initiatives appear to have some benefits, not least a preference by service users for environments that are less stressful than emergency departments and acute wards, and a preference for supportive human relationships that are conducive to wellness and recovery.

It is possible to imagine some of these approaches co-existing. Crisis home teams could be complementary and a two-way referral point for crisis houses and safe-place alternatives, for example. Community centres, community arts programs and sensory-based options could be integrated into recovery action plans and individual safety plans, providing a range of decentralised, locality-based options for social connections and social inclusion. Given that most people access a range of places and spaces in the process of meeting varied needs, one possibility is that safe spaces for Brisbane’s North may not emerge as one space but various spaces, designed to be local and accessible and building on existing infrastructure as a way of reducing cost and barriers to implementation. Guidelines and workforce development that support decentralised locations to adopt the identified features of safe spaces could also contribute to a broader network of opportunities for people with the added strength of being place-based.

While this is a definite possibility, North Brisbane lacks crisis home teams available 24/7, assertive community treatment teams and any safe-space options with residential facilities that are specialised to the needs of people in psychological distress. These options, if they existed, would be complementary and mutual referral points, reinforcing options and opportunities to avert hospital presentations and hospital admissions. They are definitely well-developed responses in other jurisdictions and form part of a broader service delivery landscape in which there are options and choices when a crisis emerges.

The example of Crisis Assessment Treatment Teams in Victoria and the ACT highlight an approach that is structured as part of a broader system which includes centralised triage and diversion from hospital by the teams, unless inpatient options are deemed completely essential for a person’s wellbeing. These teams have a defined role that is legitimised in the broader system. As such, it brings considerable focus to reducing presentations to hospital and achieving community-based treatment, even in the midst of a crisis.

Some examples raise issues of risk, including the risk of self-harm and the risk that dependencies develop because of weaknesses in the service delivery model. There is a challenge to carry forward an approach to risk management that is enabling and practical, drawing on those many examples of safe-space models that are clearly managing risk and ensuring appropriate broader connections within the service system that provide people with options for active referral depending on their needs.
5. Consultation report: issues, themes and opportunities

The consultation process engaged people from various agencies and interests in a discussion about safe-space alternatives in the Brisbane North Region. The consultation results are expressed as issues, themes and opportunities as a basis for resolving a preferred approach.

5.1 Who should benefit from a safe-space response?

Responses to this question included:

- ‘anyone who needs it’
- people with suicidal ideas or who are a risk to themselves and yet may not be identified as having a mental illness or requiring hospital admission
- people who are actually frequent presenters to emergency departments of hospitals, including people affected by alcohol and/or other drugs, and people with personality disorders
- eligibility should not require a mental health diagnosis.

The consultation process engaged two people who described their own concern with safe-space alternatives as emerging from the suicide of a very close relative. Carers were involved and included in the engagement process and described their own concerns with a lack of safe-space alternatives and the impacts on a person’s supportive natural helping networks. A number of the initiatives cited in the literature included conscious recognition of broader support networks, including family members, as part of their model.

For Queensland Health and community services sector staff, the question about who the safe-space alternative is for raised many exploratory questions. It emerged that there are probably two clear cohorts of people:

- people who have been identified as frequent presenters to emergency departments
- a broader cohort of people who identified experiences of needing to be somewhere safe and to have more support and assistance at times when they need to feel safe and are in distress.

Diverse age groups were identified by stakeholders, highlighting that safe-space options are needed for very young people and older people. It was felt that diverse options are needed to respond to varied ages but that, if a preferred model included a safe-space building/facility option, it should be available to people 18 years and older, with no upper age limit. Linkages with appropriate specialist services would be a way of ensuring that appropriate referral pathways and active referral processes could achieve improved responses to people requiring specialist services. The needs of people younger than 18 years were also raised as important.

It was highlighted that frequent presenters to emergency departments may experience high levels of alcohol and/or other drug dependence.
and may be intoxicated upon presentation. Any safe-space response needs to be able to manage and respond to the issue of intoxication without exclusion. It was also highlighted that frequent presenters to emergency departments may also disproportionately experience personality disorders, driving the need for an environment that helps to provide structure, support and linkages to other ways of coping at times of not feeling safe.

The consultation generally highlighted the diversity of human experiences in the search for safe space/places. This diversity often drove respondents to highlight the need for more than one type of response and to realise that ‘one size does not fit all’.

5.2 What is the preferred model for a safe-space alternative?

Extending from advice that diverse people with varied circumstances would benefit from safe-space alternatives, there were multiple responses to the question of a preferred model. Most commonly, in interviews, surveys, focus groups and workshops, it was highlighted that a composite approach with options and choices is important, which is highly consistent with a recovery framework and person-centred and directed care.

Some respondents went further to suggest a relationship between different options, with a ‘stepped’ approach based on need and circumstance. One piece of artwork generated in a regional workshop expressed this as having choices (Figure 9).

Figure 9: Artwork produced at a regional workshop
The varied suggestions for safe-space options included:

- the need for a facility, home-like, comfortable and most probably community based
- the need for outreach services that could meet people where they are (at home, improvised dwelling, street etc.)
- potential benefits in working to strengthen existing infrastructure, including safe-space drop-in options provided by mental health services such as Mental Illness Fellowship Queensland and building on the work that community and neighbourhood centres already do. Other existing infrastructure mentioned in the consultation phase included Pearl (Sunshine Coast), Brook Red and ARAFMI respite houses. There are some infrastructure options with existing services, such as Brisbane Youth Service, where a building base is available, and could be adapted to provide after-hours safe-space options extended from existing daytime support and clinical services
- some respondents talked about highly individualised approaches to creating safety for themselves, including a network of community-based options; not necessarily part of the mental health or community services system but including local shops, GPs, pharmacies, libraries, parks, coffee shops etc.
- strengthening community arts, culture and recreation options. The consultation process identified some existing spaces and activities that needed minimal support to be more sustainable, including an Arts Program based in the Redcliffe Community Hub
- the importance of in-reach/outreach to emergency departments by a safe-space service provider that links well to other support options depending on a person’s needs. This was expressed as a practitioner outreaching/in-reaching to the emergency department (not necessarily employed by Queensland Health but through a partnership with an NGO provider) providing a response to people presenting in distress who did not require hospitalisation
- using sensory modulation options across all/any other approaches.

The most common response to a preferred model was that a combination approach was needed which highlights the potential in a stronger systems approach to addressing safe-space needs in Brisbane North. Because some existing options are operational (some marginal and needing support), there is an opportunity to consider a Brisbane North Regional Safe-Space Strategy rather than just a single safe-space model. The consultation phase did not reveal a single preferred approach and yet strongly articulated the diversity of people’s needs as driving the need for different responses scaled and responsive to those needs. One service provider that was interviewed highlighted that they use safety plans within the context of broader support plans. Safety plans identify specifically how a person wants to respond and work with services at times when safety is an issue at different levels of intensity. Given that a range of safe-space options has been identified, individual safety plans could offer a way of harnessing unique solutions for people while also addressing the drivers causing people to not feel safe.

A combination approach would still benefit from the addition of safe houses and crisis outreach capacity. However, given that the region does lack these alternatives, the potential in a broader strategy is that existing options and opportunities might be strengthened while service system gaps are identified and collaboratively addressed by key stakeholders in a developmental process to achieved needed additions/changes.
Comments from participants highlight the need for diverse options responding to diverse people:

- ‘All models have their benefits and limitations’
- ‘We need a bit of everything …’
- ‘Outreach and building-based care with access to professional and peer support … I think you need both outreach and a building to cater for the needs of consumers. You need both professionals and peers to give comprehensive support’
- ‘Non-clinical and personal. Grounds with open spaces and a building with private rooms and a common room. It would feel calming and welcoming. Carers and family would be welcome. It would be a creative space. There would be professional and peer staff’
- ‘Needs to fill the gap between emergency triage and hospital admissions and independent living in the community with safe spaces, recovery centres and community care units’
- ‘I think the community outreach service with a crisis response would be great. The option of an emergency bed would also be fantastic’
- ‘Some people would not feel the need to go to ED if they had the knowledge that someone would come and sit/talk with them. De-escalation is always an option for some’
- ‘The safe space would be staffed by a multidisciplinary team. There would also be peer workers there. There would be a place for someone to lie down and safely store belongings. It would be welcoming, warm and inviting. Limited rules and very organic. Food and drink would be available—also some tactile things e.g. blankets, cushions.
  There would have to be access to some clinicians’
- ‘A combination of all would allow for a more holistic approach that includes both crisis, 24-hour and a range of staff options and different services and focus areas’
- ‘Adopt elements from all approaches’
- ‘Casual space but both clinical and non-clinical support from mental health workers including peer workers (with) the inclusion of practical facilities and amenities such as bathroom facilities. The space would feel inviting, refreshing and soothing with numerous seating arrangements—private spaces for confidentiality purposes but also spaces that can create and encourage conversation’
- A model ‘that is responsive to the diverse needs of every individual: phone service, drop-in service, groups, individual services, clinical, non-clinical’
- ‘I would think that a soft approach where people can come and just chat (and) possibly get some clinical intervention if appropriate, but a space where they can just talk through their anxiety/issue with the intent to stay out of ED/hospital’
- ‘I think it is about getting the person to calm and settle to see the solution/their capacity to work through the heightened times. Building strategies and resilience into these times, building their confidence in taking control. I believe it is important to have an NGO manage and run a service like this with Queensland Health staff partnering, as this model needs to be based in the community and not associated with a hospital setting/environment’
• ‘The most immediate need is to provide an after-hours accessible location/s on the Northside providing a space where people experiencing distress might access psychosocial support and the ability to be assessed to access other places in the mental health continuum of care. This might include using a space like the 139 Club or Espresso Train or “Cup from Above” at Aspley’

• ‘The safe space would be supportive, provide coffees and food and social interactions … Workers would need to be mental health professionals, able to assess levels of distress and provide clinical intervention if required. Perhaps the Acute Care Team could come to the space to provide this type of support’

• There would be ‘close collaboration between the clinical hospital programs, the Step Up Step Down initiative, the safe space, early responder contacts like working directly with police, the ambulance and the Acute Care Team’

• ‘Can we please consciously build a safe space as an integral part of the continuum of mental health support?’

5.3 Hours of operation

Respondents frequently highlighted that the need for safety is not confined to usual business hours. It was often stated that a safe-space response needs to include 24-hour, seven-day-a-week options. In one workshop, for example, when people were asked to state their three most important elements of a safe-space response, having 24-hour/seven-day options was frequently identified (Figure 10). Some stakeholders were concerned about the cost of 24-hour/seven-day options and considered extended hours important without the provision of beds.

Figure 10: Whiteboard responses to the question of the three most important elements of a safe-space response
Some respondents moderated the preference for 24/7 options with a suggestion that some targeted, extended hours are important, with one suggestion that this be until 11.00 pm.

5.4 Service gaps: integrated building-based and outreach options

While diverse options for safe-space models were identified, a significant gap was considered to be having safe-space alternatives with outreach capacity encompassing emergency departments (variously referred to as in-reach/outreach).

People most often viewed a safe-space alternative to emergency departments as a place characterised by the following:

- home-like, comfortable, with various rooms including private/semi-private space and common rooms
- community based, like a house⁹
- non-clinical in appearance, operations and culture even if clinical support is provided
- outdoor space including space for smoking
- soft furnishings, purposeful use of colour and texture
- active approaches to sensory modulation through lighting, colours, touch, taste, movement
- things to do/experience (cooking, music, computers, art, sensory activities, games, television etc.)
- non-stigmatising with a positive brand and culture which created optimal potential for positive community relations and even community involvement through volunteering
- with drop-in options and some capacity for brief residential stays, although concerns about residential options have also been raised.

If a residential option is included, the question of length of stay yielded varied responses. There is a genuine concern about creating dependencies, and such a facility being an attractive alternative to homelessness and inadequate housing situations. People are keen to ensure that drop-in options are available and that a residential component is highly purposeful and time-limited with a focus on linkages to robust support and safety planning with key worker support where needed.

Some concerns about the management of a space with residential options were raised. How would it be managed and respected if people were moving through? How could people be involved in activities such as gardening when they do not have a long-term commitment to a place? What if it becomes a default option for people who are really homeless or do not like where they live? What if it is overwhelmed by demand from people experiencing other serious factors such as domestic violence?

If a drop-in building-based option is created, it might also function as a base from which crisis outreach responses could be launched, including into hospital emergency departments. Crisis outreach teams would preferably be available 24/7, although some suggested a critical time period until 11.00 pm, and certainly over weekends. They would respond within a short time-frame and be highly responsive, with the capacity and capability to engage a person and work with them to understand the drivers for and solutions to their safe-space needs. From an outreach service, it was considered important that a person could be referred/transferred to hospital if needed, to safe-space beds/drop-in or for other elements to be put in motion as a result of the intervention, including seamless referral to existing support arrangements.

The questions often triggered stakeholder views on a gamut of system gaps, including the lack of ongoing intensive support for people who are

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⁸ This board was generated at the Caboolture workshop, however the need for extended/24-hour services was frequently highlighted in the consultation across other events and interviews.

⁹ The majority of responses highlighted the need for a location to be near to/accessible to hospitals but not within hospitals.
highly vulnerable whether they have a diagnosis or not. A safe-space solution will not function as a ‘cure-all’ and there is a risk that a safe-space alternative obscures the deeper system challenge of providing intensive, outreaching, ongoing support. Models such as assertive community treatments are operating in other jurisdictions and help to provide people with consistent, ongoing and intensive outreach support and treatment that have a positive impact on hospital stays and the prevention of crises. Preventative and early intervention options are worthy of further discussion, not least because various stakeholders raised a more enduring need to have direct support and treatment options available to people, working with them where they reside.

5.5 Staffing arrangements

In the creation of a safe-space option/alternative with outreach capacity, people most commonly saw staffing arrangements as including:

- a team-based approach
- staff who could move between centre-based support and outreach functions
- possibly with multidisciplinary inputs
- at least linkages to clinical staffing support/options which might include a mental health nurse on the team and options such as a support guarantee from the Acute Care Team, or some other medical resource when assessment is needed
- definite peer worker involvement (this was strongly supported by diverse stakeholders) with supportive recruitment, training and supervision and an articulated framework to optimise positive outcomes
- a potential role for volunteers drawn from the community
- visiting services and providers of activities
- collaboration, coordination and partnerships.

5.6 Addressing the risk of dependency: an acute sense of purpose

Several stakeholders are concerned that the dependency on emergency departments will be transferred to a new facility if it is created. This is a valid concern and one which stakeholders felt could be addressed through various measures such as:

- including time limits on any residential stays (including as a measure to differentiate this response from the planned Step Up Step Down response). Some people considered stays as being for up to two weeks; others considered a maximum period being two days. While arbitrary time periods may not be consistent with person-centred and individualised approaches, the time for residential stays could be the subject of targets while discretion is allowed in individual situations that require more flexibility
- ensuring that people are supported through the development of an individualised safety plan as part of a broader care or support plan. This may involve multiple strategies and actions depending on that person’s need. Some interviewees mentioned individual safety planning and that some organisations such as Roma House routinely work with people on safety planning that is documented using a specific tool/format. This should take into account the opportunities represented by decentralised access points, community-based settings and neighbourhood space (shops, coffee shops etc.) and create no barriers to active, effective, warm referrals with support if needed
- assertively linking people to ongoing support where needed, subject to their consent and choices about future safety planning
- achieving continuity of care where possible with existing support and/or care facilitation providers
ensuring a service delivery model that is highly purposeful about achieving ongoing, sustainable individual safety plans with adequate support where needed for implementation

• the option of planned residential stays or drop-in visits as part of a safety plan

• staff who are highly skilled in working effectively to reduce the risk of dependency, yet also in providing assertive, active, warm and persistent assistance where vulnerability is assessed as high or very high.

5.7 Location and regional differences

The region is so vast and varied that the stakeholders commonly highlighted the need for a decentralised approach. There was a preference to see viable alternatives accessible to all hospitals in the region. Some input suggested that one safe-space facility and outreach service was needed around the middle of Brisbane’s north side accessible to the Royal Brisbane and Women’s Hospital and the Prince Charles Hospital. The distance between Redcliffe to Caboolture and the lack of public transport options also highlighted the need for an option close to both these hospitals.

It was highlighted in the consultation that the Caboolture region is particularly disadvantaged in terms of socioeconomic indicators and should be prioritised if only one new facility/service is possible or piloted. However, it was also pointed out that presentations to hospital seem fewer in Redcliffe, although this may mask the lack of an acute mental health facility at this location. The extent of socioeconomic disadvantage is a very important factor, given that some of the identified psychosocial issues when people seek help at emergency departments are worsened and more complex because of poverty, poor physical health, low education levels, higher levels of unemployment, drug and alcohol use and minority status.

The regional differences add strength to the idea of augmenting a safe-space model with optimal use of existing, decentralised infrastructure that contributes to wellbeing. Some additional points collected during the consultation include:

• in some instances, placing a role/person in hospital emergency departments to respond to people seeking safety was suggested

• some ideas were flagged about where this could be within the hospital (existing or repurposed spaces) and how this role could be designed into new hospital developments (such as Caboolture)

• this could involve NGO partners with other support offerings and also engage peer workers

• host families also garnered some support—where private houses/households play a part with robust support from the mental health system.

Transport was considered another important resource, with some people making contact to emergency departments through calling emergency services. Having transport/vehicles is important, combined with flexible transport solutions where a person is particularly vulnerable and needs either brokerage to access public transport or taxis, or an actual pick up from their location.

5.8 Making best use of infrastructure

There was significant interest in making best use of existing infrastructure and services wherever possible. This included the under-utilised potential of community centres at night, for instance, and their decentralised locations, although they are not available in every neighbourhood. Some existing art groups were identified that need some marginal support. Some existing mental health services provide drop-in/safe-space options for people, usually during business hours. Locations such as libraries, shopping districts, GP surgeries, pharmacies, etc., were mentioned as playing their
part. Other services, including a specialist youth service, indicated that their building base could be adapted for after-hours drop in, subject to resources.

In the case of Caboolture, some existing spaces in the hospital complex were identified, as was a 24/7 super clinic that may be able to play a part. One consideration was that a mid-north side of Brisbane option could be to enhance the Step Up Step Down facility planned for the former Nundah House site. Other sites are distributed across various community centres and specialist mental health agencies which do have available space that is under-utilised after hours.

Overall, an important principle emerged in the consultation that, wherever possible, existing infrastructure should be strengthened and supported to play a part in a safe-space strategy. In one instance, it was highlighted that, while discussion of a specific and new facility might be important, some existing examples of initiatives required only minimal additional support to play an important role. However, while there is existing infrastructure, staffing capacity for after-hours needs additional resources.

The consultation included the following perspectives and advice:

- various specialist mental health services, arts programs and community centres effectively offer space for drop in, coffee, activities, meals, information, referral etc.
- while not formally a safe space responding to mental health issues, constituents including people living with a mental health difficulty make use of these spaces
- these places play their part and form part of a decentralised, locality-based suite of options—closer to home, with opportunities to meet neighbours, take up other roles (volunteering, etc.). These may require additional support to scale up, make physical improvements or increase hours
- stakeholders felt that community centres, arts spaces etc., need to be part of the solution
- A strong principle to emerge was ‘use what we have, build on what we have’.

5.9 Vulnerability

The consultation highlighted the extent that people needing a safe-space response can experience significant vulnerability because of the combination of a mental health issue and other psycho/social/economic challenges. In the case of people who frequently present to emergency departments, it was considered important to understand that there is considerable vulnerability beyond a major mental illness or mental health issues. This is often in the form of multiple co-presenting issues, which may include combinations of using alcohol and other drugs, significant health issues including chronic disease/s, poverty, isolation, inadequate or no housing/homelessness, relationship breakdown, domestic violence, intellectual disability and acquired brain injury. One respondent reflected the possibility that intellectual disability was a factor that needed more consideration as something driving people to seek safety and structure in an environment such as a hospital.

It was considered important that a safe-space response emerges from a robust understanding of vulnerability caused by multiple complex factors. A model/response needs to link seamlessly to other support and assistance to address presenting issues, particularly where inadequate housing or a lack of housing is an issue. Referral processes and coordination need to be active and assertive where assessed as necessary, as well as persistent and protective in the case of extreme vulnerability where a person has reduced capacity for self-determination and planning.

There is also a concern about the risk of service

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10 In one such example, an art group in Redcliffe that included people living with mental health difficulties was seeking organisational support to access a key to a facility where the group operated.
exclusions where problematic behaviours are a factor. Some stakeholders identified the need to ensure outreach and building-based staff are skilled in de-escalation and for the model to be focussed on preventing exclusions wherever possible.

5.10 A reflective framework for recovery

The conceptual framework at the beginning of this report highlights the importance of recovery practices and principles, and the consultation phase certainly endorsed a recovery framework to guide the implementation of a safe-space response.

Some respondents also highlighted the need for a reflective approach to recovery in the context of high or extreme vulnerability. In one interview, it was clearly expressed as a need to ensure that people could access a safe-space response, even if they could not articulate their own recovery goals. It was suggested that the safe-space response should be guaranteed on the basis of needing/seeking safety and not require people to have recovery goals as a pre-requisite. Some respondents highlighted times in their own experience where the scope of their horizon was to be in a place that felt safe and to have someone to talk to/human contact, or even just to be somewhere that was safe where other people were around. Others highlighted that they have experienced times of being so unwell that making goals and plans was too great a challenge for that moment in time.

For others, it was important to adopt a view that a model/response and practice could all be guided by recovery principles even if a person was unable to think about their own situation in terms of recovery at that time. The very nature of a recovery model is that practitioners can hold a sense of the future, and that time is a resource which can change and develop a person’s own outlook and horizon. With time, a person can engage more in making new goals infused with greater hope and readiness to pursue opportunities and creative ways of coping.

One possible approach is to see a safe-space response as important in the recovery process, addressing very fundamental needs for human contact and safety as a platform for further progress at some time in the future, where possible.

Where extreme or high vulnerability is present, it was suggested that other frameworks are engaged to inform practices, including harm minimisation, that are driven by a greater focus on protective, persistent care. This might include where people are a risk to themselves or where their circumstances and physical condition are such that serious deterioration is likely. This does not translate to taking away people’s choices or their participation in planning/creating their own future. It does mean skilled assessments of vulnerability and planning for safety and support in such a way that there are robust responses to the factors driving vulnerability, and that the approach to support provision is respectful and participatory while also very active and persistent on the part of the support/key worker.

As respondents grappled with the role of recovery frameworks in a safe-space response, it was clear that some people were edging beyond a binary proposition that a model/response is either a recovery model or not. As frequent presenters have multiple, co-existing factors driving their vulnerability, there is an opportunity to integrate a recovery framework that is meaningful and practical in the face of considerable risk of harm to the person.

5.11 Connections to the broader mental health system

Respondents cautioned against a new initiative that has a poorly articulated relationship to the broader mental health system. Some interviews, focus groups and workshops grappled with the complexity of the system and how an additional response should be located and structured to leverage and complement other contributions and resources. Everything should

¹¹ It was also acknowledged that this can change over time and that practice needs to be responsive to these changing opportunities and have the scope to establish smaller, achievable goals that are meaningful to the person at that time, while a broader, longer-term plan is still being formulated.
be done to avoid duplication of existing services and it was considered essential to define the relationship of a safe-space response to other service elements. Even though exemplary work has been done to map mental health services in North Brisbane, people often responded to questions about a new model with more questions like:

- How does this fit with the new Step Up Step Down service?
- What role would the Acute Care Team play?
- How would an outreach service work with the Homeless Health Outreach Teams (HHOT) and other street outreach teams?
- Is there a role for the 1800 Mental Health number/call centre?
- How would other safe-space/drop-in services/options fit in?

While it was clear that there was a system gap in terms of a safe-space response, there was also an acute sense of importance that the relationship of this response to other key system elements is well defined. There was also a lot of input acknowledging how existing services throughout the region contribute to safe-space options.

Some responses in the consultation that differentiated a new facility included:

- a safe-space facility with beds should be for much shorter response times to Step Up Step Down
- the Acute Care Team could possibly provide outreach to a safe-space facility, subject to resources
- after-hours outreach could be planned and coordinated with other existing outreach services and be highly targeted to people requiring a safe-space alternative to hospital/emergency departments
- the 1800 Mental Health number could be one point of contact/referral/triage
- existing safe-space alternatives should be maintained and identified, reflecting the diverse needs of stakeholder groups.

Most importantly, a new response needs to be guided by the principle that it will be carefully defined in the broader context of mental health and other services. Practical measures will be needed to ensure that day-to-day practices and referral pathways are effective and facilitated through well-articulated agreements, protocols and procedures. Continuity of client care is also very important, and linking with existing support providers should be a core feature of the response.

5.12 Beyond competition

A number of respondents highlighted the competitive nature of service delivery as a barrier to an effective system’s response to safe-space needs. If the diversity of safe-space opportunities and needs is well-understood, then it was considered essential that agencies overcome competitive practices that manifest in limitations to service delivery and referral pathways. To achieve individualised safety plans, it is important to ensure that people have access to the full range of options that may exist in highly decentralised locations. A support and safety plan that addresses a person’s need must ensure that operational or strategic tensions caused by competition for resources or historical factors are actively overcome.

Another manifestation to competition for some stakeholders was the tension between government and community-based services, clinical and non-clinical inputs. Most respondents, and in particular consumers and peers, urged towards an approach that overcame these tensions to acknowledge the value of diverse inputs simply because people have diverse needs and need a system to be working seamlessly towards excellence in care.

**Safe-space needs among Aboriginal and Torres Strait Islander peoples**
Specialist input from an Aboriginal and Torres Strait Islander organisation highlighted the importance of culture, preventative approaches and working with people in their communities in preference to centralised hubs of services.

The preference is ‘a home-based model—we put resources into building capacity in community—working with family and friends to see how they can support clients in community, not away from community. We avoid the over professionalisation of services. When interviewing new employees we look at personality, openness, language and those kinds of qualities’.

‘(I’m) not in favour of a community hub. We work preventatively before the acute stage’ (Indigenous Stakeholder comment).

It was highlighted that the most important elements of a safe-space response include:

- open access
- the right staff
- activities that engage people (including sport, for example).

It was also emphasised that a safe-space response needs to work to build the capacity of people and communities. An example was used to illustrate this approach in the context of family support being offered within homes at key times such as 6.30–8.00 am and 3.00–7.00 pm, to assist families with routines and other types of support over a period of a month while the family is working towards greater independence and capacity. This input also suggested creative ways of engaging people, such as through cafés and sport.

5.14 Culture, language and diversity

Specialist advice regarding LGBTI communities emphasised that safe space is different for everyone and that there needs to be capacity building and training across the various relevant sectors in how to ensure all space is safe space. There are training and capacity-building programs available to assist service providers with greater responsiveness to specific needs.

Cultural awareness will be an essential element of a new service and systems response. Practical measures to improve cultural awareness might include:

- employing bi-cultural/bi-lingual workers
- having designated positions
- ensuring robust partnerships with specialist agencies
- engaging mentors
- ensuring a culture-aware service model and action plan, including a reconciliation action plan
- leading practice in the active use of interpreters.

5.15 Workforce capability and planning: implications for procurement and recruitment

The scope of a safe-space response, combined with the critical importance of a response that is well located within the broader system, raises the challenge of workforce capability and planning. Some stakeholders highlighted the need for deliberately addressing the need for a well-trained workforce so that the service delivery model is implemented in ways that considerably improve the likelihood of successful outcomes. The role of skills and practice in good outcomes was very important to acknowledge for some respondents. Workforce capabilities considered important included:

- the need for excellence in assessment skills while also being able to facilitate a soft entry to a safe-space facility
- capabilities in actively creating the culture of a space/plan to be positive, welcoming and purposeful about the future
- capabilities and frameworks that demonstrate commitment to and skills in partnering, collaboration and facilitation of inputs from various sources
• capabilities in assessing and understanding vulnerability and capacity issues, with skills in adopting appropriate plans and interventions depending on the level of capacity for decisions and self-care

• capabilities and frameworks responsive to people with self-harming intentions

• openness to emergent practice/evidence and a commitment to continuously reflecting and learning

• a practical, solution-focussed approach to problem solving

• a capacity for systems thinking and participating in collaborative change and continuous improvements

• a capacity to work within recovery frameworks while also working with extreme vulnerability

• a capacity to work with diverse groups of service users

• making safe spaces accessible and welcoming to diverse communities, including Aboriginal and Torres Strait Islander cultures, people from diverse cultural and language backgrounds and LGBTI communities.

This range of capabilities has implications for the procurement of services to participate in providing a new response. Within that service, this range of capabilities should also help guide recruitment to ensure that the right capabilities, frameworks and skills are present, with a focus on successful and measurable outcomes.

5.16 Managing risks

Some respondents identified risks in the provision of after-hours and outreach services. Some highlighted that risks need to be understood in terms of diverse regions that are part of North Brisbane. Some identified risks included:

• outreach generally and particularly after hours. There was a perception in one interview that some locations would be inherently riskier than others

• the risk of suicide or self-harm, and that soft-entry approaches fail to adequately assess the risk and respond appropriately

• the risk of violence or aggression on site

• the risk of neighbour complaints, neighbourhood fatigue and loss of community support.

The question of safety was often raised, and for some people this meant the need for a robust risk management plan. There is also confidence among stakeholders that risks can be managed through planning and good management. There is recognition that outreach and after-hours services already occur, not least evidenced in the example models people were invited to review. While there are concerns about risk, there is also a commitment to exploring responses to those risks, based on considerable existing practices and models for providing outreach and building-based responses to vulnerable people. Some elements of risk management were also understood to involve robust relationships with partners such as visiting services, emergency services and community networks.

5.17 A creative approach to resolving tensions

Several tensions emerged during the consultation phase that highlight the degree of complexity involved in considering a safe-space option for vulnerable people:

• If only one location is possible for a new service, where should that be? In populous Brisbane or in a location like Caboolture where socioeconomic disadvantage is so high?

• Should the model be outreach-based or building-based?

• Should the service be hospital-based or community-based?

• Should there be clinical or non-clinical inputs?
Who is it for? Anyone in distress versus actual, identified frequent presenters to hospital?

Should there be a formal assessment or a soft-entry approach?

How can we apply a recovery model in the face of extreme vulnerability?

How can we manage risk and provide after-hours/outreach services?

How does it fit with other parts of the system, including the 1800 Mental Health number, HHOT, Acute Care Teams, community centres etc.?

Is it a crisis response versus longer-term, consistent, outreaching, assertive support?

These are outlined above to reflect the dilemmas and tensions people highlighted in their own thinking about safe-space options. They cannot necessarily be resolved once and for all, but in stages of solution/revision/resolution. The model will be working to address complex client circumstances, in distinctive sub-regions, in a complex mental health system. It is important that the capacity to openly and honestly grapple with tension is part of the capabilities demonstrated by the service provider and staff. More than anything, some respondents were earnest in their attempts to move beyond binary thinking and more towards a synthesis of options with a clear focus on flexible, individualised outcomes for vulnerable people.

5.18 Towards convergence: a discussion

The engagement process mostly converged around the need for diverse safe-space responses for diverse people depending on their needs. It was often suggested that the different service models could be complementary and co-exist. The interest in diverse, individualised responses with a strong preference to recognise and build on what already exists pointed more to a broader safe-space regional strategy than a single safe-space model for Brisbane North. The strength in a strategy is that existing safe responses could be identified and harnessed, service gaps identified and collaborative structural arrangements used to address those gaps through new innovations.

While there is a variety of existing responses and ways in which people achieve greater safety for themselves that are both dependent of the service system and the broader community, it was quite clear that people also considered that a safe-space alternative was needed with a building-base and outreach component. Given the diversity of responses in other jurisdictions, and based on obvious support for a broader strategy within which a building-based facility with outreach elements exists, the remainder of this report will:

- articulate the elements of a broader safe-space regional strategy for North Brisbane that harnesses existing opportunities and infrastructure, while locating a new safe-space facility in relation to other key service system elements
- articulate a model for a safe-space facility with building-based and outreach elements of service delivery as a way of addressing identified system gaps.
6. A North Brisbane regional safe space strategy

This section attempts to articulate the elements and actions involved in a broader regional safe-space strategy

It recognises:

- various initiatives and types of infrastructure already exist and play their part in providing decentralised safe-space options reflecting diverse, individual and regional needs
- some service system gaps definitely exist and require a collaborative and strategic response to advance new initiatives that respond to those gaps
- safe-space options need to provide choices and reflect the uniqueness of individuals. A strategy is a broader framework in which diverse options can be identified and harnessed in a person-centred approach
- a strategy is also a way to articulate system linkages and the relationship of safe-space options to other key features of the mental health system, thus safeguarding against duplication and isolation from other complementary services and resources needed by people in the process of achieving greater safety and wellness.

The potential benefits of a broader safe-space regional strategy are:

- existing safe-space options and contributions can be identified, supported, harnessed and leveraged
- there will be diverse options for diverse people supporting choice and individual solutions
- a community of practice may emerge that supports innovation and improvements to collaboration and service delivery
- there is scope to ensure that new initiatives are well-located within the broader service system
- there is a framework for holding together the range of contributions necessary to safe-space solutions, particularly across such a vast region
- sector leaders are engaged to contribute to a broader safe-space strategy, including new initiatives and innovations.

Some emerging elements of a strategy are suggested to include (Figure 11):

- effective governance arrangements
- individual safety plans
- identifying and harnessing existing safe-space options
- offering a support guarantee to existing frequent presenters
- initiating decentralised safe-space hubs for North Brisbane including scope for outreach
- creating the scope for innovation
- developing workforce capacity and capability
- ensuring robust evaluation.

¹² If a safe-space regional strategy is agreed to and progressed, there would need to be a phase where a strategy is reviewed and refined by key stakeholders, particularly because the scope of this project was mostly focussed on asking people about a single preferred model. More suggestions and data might have been generated if the broader questions from the start were to generate ideas for a safe-space strategy. The emergence and suggestion of a broader strategy is in recognition that stakeholders overwhelmingly thought that diverse options were needed by diverse individuals. It was also highlighted that a range of initiatives (mental health sector and more broadly) already contribute to safe-space options and may be even more beneficial if leveraged against other inputs and resources.
The elements of a safe-space strategy are further explored in Table 8.

Table 8: Brisbane North Regional Safe-Space Strategy plan

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Actions</th>
<th>Outputs and measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop governance arrangements to support the refinement and implementation of a safe-space strategy</td>
<td>Terms of reference Strategy Operational Plan Progress reports Communications strategy</td>
</tr>
<tr>
<td></td>
<td>1.1 Consider whether the Collaboration in Mind consortium could serve as a governance structure overseeing the refinement and implementation of a Brisbane North Regional Safe-Space Strategy (BNRSSS)</td>
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<td></td>
<td>1.2 If this structure is not appropriate then develop a governance structure to oversee the strategy to include key representatives from Queensland Health, community services, mental health services and consumer and carer representatives</td>
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<td>1.3 Develop/enhance terms of reference</td>
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<td>1.4 Refine a strategy plan</td>
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<td>1.5 Develop an operational plan and annual priorities including allocation of responsibilities across key agencies (mental health and broader)</td>
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<tr>
<td>Strategy</td>
<td>Actions</td>
<td>Outputs and measures</td>
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<td></td>
<td>1.6 Include measures and indicators as a basis for evaluation</td>
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<td>1.7 Establish an engagement and communication strategy with the broader mental health sector</td>
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<td>1.8 Provide strategy support through a safe-space hub (see project role in point 5)</td>
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<td>1.9 Review and report progress every six months</td>
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<td>2</td>
<td>Adopt the routine development of individual safety plans as part of support plans that stay within the person</td>
<td>Agreed tool Number of safety plans developed Measurement of change for individuals, aggregated and reported</td>
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<tr>
<td></td>
<td>2.1 Review options and tools for safety plans as part of support plans</td>
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<td></td>
<td>2.2 Adopt a tool agreed to by multiple agencies</td>
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<td>2.3 Identify and agree trial sites</td>
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<td></td>
<td>2.4 Implement the safety planning tool and use in conjunction with the Subjective Units of Distress Tool and Outcomes Star to provide some metrics regarding individual changes as well as improvements measured through reduction in emergency department presentations</td>
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<td>3</td>
<td>Identify and harness existing safe-space options, provide support where needed, build their profile and promote them to vulnerable people and the service sector</td>
<td>Calendar/map options</td>
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<tr>
<td></td>
<td>3.1 Identify existing safe-space options including art spaces, community centres, coffee shops, drop-in spaces, libraries etc. Include places like Stepping Stones, Brook Red, Pearl, ARAFMI respite houses, MIFQ, specialist youth services, GP Super Clinics etc.</td>
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<td>3.2 Identify potential safe-space resources and spaces that are part of, or connected to, other resources such as hospitals, GP clinics, community centres, arts programs etc.</td>
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<td></td>
<td>3.3 Develop these into an identifiable network and publish an overview and regional map/calendar of options accessible to consumers, carers and the service system</td>
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<td>3.4 Consider the relative merits of branding safe-space alternatives as a way of identifying them in localised settings and raising their profile in a non-stigmatising way. If considered helpful, then develop a brand and apply it to a network of spaces (using non-mental health-specific language)</td>
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<td>3.5 Provide some capacity-building support to decentralised locations through a project worker role. This could include trouble shooting, design improvements, workforce learning and development and incubating new ideas/projects, including a home family placement option</td>
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<td></td>
<td>3.6 Develop a kit to support safe-space locations/networks to add/enhance/improve safe-space responses across a decentralised network of locations/activities</td>
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<tr>
<td>Strategy</td>
<td>Actions</td>
<td>Outputs and measures</td>
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<td>4</td>
<td>Offer a support guarantee to frequent presenters to emergency departments</td>
<td>Increase in availability of direct and ongoing support to frequent presenters</td>
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<tr>
<td>4.1</td>
<td>Consider small capital grants for physical enhancements to support minimalist, localised safe-space alternatives (including exploring whether the Gambling Community Benefit Fund could consider a mental health safe-space stream similar to previous solar system grants)</td>
<td>Number of support arrangements</td>
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<tr>
<td>4.2</td>
<td>Ensure that ongoing support options are available to people who frequently present to emergency departments</td>
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<td>4.3</td>
<td>Where support is already part of a person’s ongoing recovery, then ensure sufficient coordination and collaboration between hospital and key support providers reflected in a collaborative safety plan</td>
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<td>4.4</td>
<td>Maintain continuity of care where support already exists and improve coordination if needed</td>
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<td>4.5</td>
<td>Where necessary enhance the availability of resources to ensure a support guarantee can be achieved</td>
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<tr>
<td>5</td>
<td>Initiate three safe-space hubs in Brisbane North Region</td>
<td>Calendar/map options</td>
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<tr>
<td>5.1</td>
<td>Trial three sites for a designated 24/7, after-hours safe-space hub with drop-in options, some crisis beds and mobile outreach roles</td>
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<tr>
<td>5.2</td>
<td>Operate the building base as a hub including:</td>
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<td>• drop-in options</td>
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<td>• activity options</td>
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<td>• access to support</td>
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<td>• access to peer support</td>
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<td></td>
<td>• base for and referral point to a mobile outreach team, which would be available to visit ED, other key locations and visit people at home/in situ</td>
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<td>• flexible in-reach by other services</td>
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<td>• sensory modulation options</td>
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<td>• volunteer programs involving the broader community</td>
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<td></td>
<td>• a capacity builder/project role to develop new initiatives such as:</td>
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<td></td>
<td>° a volunteer program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° a Home Placement network of families/households supported by hub staff to expand safe-space options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° capacity-building services and support to the broader network of safe spaces identified as part of points 3 and 7</td>
<td></td>
</tr>
<tr>
<td>Strategy</td>
<td>Actions</td>
<td>Outputs and measures</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td></td>
<td>° supporting collaborative responses to safe-space provision across the region</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° providing support to the broader safe-space strategy</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Hub sites could include mid-north Brisbane (the Chermside-Nundah corridor); Caboolture, given the level of socioeconomic disadvantage; and Redcliffe</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Hub sites would include after-hours mobile outreach teams to provide outreach to people at home and in situ</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>Provide hubs through an NGO with clinical support from Queensland Health (guided by protocols and a support guarantee) or alternatively include clinical staff with clinical governance arrangements in place. In either scenario, a partnership and protocol with Queensland Health is essential</td>
<td></td>
</tr>
<tr>
<td>5.6</td>
<td>Have in place protocols with other key parts of the mental health system and clear definitions as part of the continuum of care (ACT, Step Up Step Down, HHOT, other street outreach programs, Mental Health phone line)</td>
<td></td>
</tr>
<tr>
<td>5.7</td>
<td>Staffing should include mental health professionals, peers, volunteers, clinical support (internal or external)</td>
<td></td>
</tr>
<tr>
<td>5.8</td>
<td>Have in place a range of inputs including sensory, soft entry, formal assessment, activities</td>
<td></td>
</tr>
<tr>
<td>5.9</td>
<td>People can walk in, attend as part of a planned response, be referred, be transferred from hospital: multiple pathways</td>
<td></td>
</tr>
<tr>
<td>5.10</td>
<td>Robust risk management yet an enabling approach to outreach and building-based services</td>
<td></td>
</tr>
<tr>
<td>5.11</td>
<td>Enabling approach to minimal/no exclusions from service</td>
<td></td>
</tr>
<tr>
<td>5.12</td>
<td>Excellence in a data framework, data capture, reporting and evaluation</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Continue to explore and develop safe-space alternatives</td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Monitor new models, leading practice, research and innovation</td>
<td>New initiatives</td>
</tr>
<tr>
<td>6.2</td>
<td>Consider pursuing assertive community treatment teams for Brisbane North</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Explore and incubate innovation and new ideas</td>
<td></td>
</tr>
<tr>
<td>6.4</td>
<td>Family/home placement programs</td>
<td></td>
</tr>
<tr>
<td>Strategy</td>
<td>Actions</td>
<td>Outputs and measures</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| 7        | 7.1 Identify workforce development opportunities and needs regarding mental health, related topics and safe-space provision  
7.2 Share workforce development opportunities across and between agencies  
7.3 Consider the facilitation of a ‘community of practice’ across agencies involved in implementing the safe-space strategy  
7.4 Provide joint training opportunities involving Queensland Health and community sector staff  
7.5 Provide a clearing house facility for initiatives and innovations, continuing to capture and understand ways of working in other jurisdictions  
7.6 Capture data on learning and progress from participants and agencies | Workforce development events and activities  
Attendances  
Subjective evaluations of events by participants |
| 8        | 8.1 Using the strategy and operational plan, ensure a data framework, measurement and reporting that drives an open and transparent approach to evaluation for the strategy  
8.2 Ensure data capture is supported by participating agencies  
8.3 Include formative elements that drive continuous and timely improvements to the strategy  
8.4 Include summative elements that report on outcomes, benefits and key indicators such as a reduction in emergency department presentations and increased wellbeing reported by vulnerable people | Data framework  
Data collection tools  
Data reports  
Outcomes reports |
7. Safe-space hubs for North Brisbane

While it is recommended that a broader strategy is adopted for the North Brisbane region, the draft strategy does take into account the need for safe-space hubs that include:

- a base where people can drop in
- outreach/in-reach capacity to people at home/in situ and to key facilities including emergency departments
- a homely, welcoming environment with attention to furnishings, sensory approaches, activity options and community/individual spaces
- a project development role that allows for strategy support, volunteer engagement and innovation (such as through facilitating home placements, identifying and promoting existing safe-space options)
- transport/brokerage component for people referred and mobile capacity for outreach teams
- robust and seamless connections to the broader service system to enable ongoing support, treatment and other inputs
- a continuity of care approach to individual safety plans as part of broader support planning, maintaining involvement of existing supports
- well-located in relation to hospitals with a suggestion of mid-north Brisbane, Caboolture and Redcliffe
- an active approach to preventing dependencies and achieving sustainable solutions.

The following table outlines suggested elements of a service delivery model for a hub/s (Table 9).

<table>
<thead>
<tr>
<th>Service delivery model element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>People can access safe-space alternatives that are connected and enabling</td>
</tr>
<tr>
<td>Objectives</td>
<td>To provide a safe-space alternative to emergency department presentations</td>
</tr>
<tr>
<td></td>
<td>To operate as a hub of centre-based, outreach and project services</td>
</tr>
<tr>
<td></td>
<td>To harness regional contributions to safe-space outcomes for diverse people</td>
</tr>
<tr>
<td></td>
<td>To pursue innovation and excellence in safe-space provision</td>
</tr>
<tr>
<td>Principles</td>
<td>A safe-space hub is guided by the following principles and guidelines:</td>
</tr>
<tr>
<td></td>
<td>• clarity of purpose and strategy</td>
</tr>
<tr>
<td></td>
<td>• best use of existing infrastructure</td>
</tr>
<tr>
<td></td>
<td>• respect for and responsiveness to diverse and individual needs</td>
</tr>
<tr>
<td></td>
<td>• working preventatively</td>
</tr>
<tr>
<td>Service delivery model element</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **Vision**                    | • working to avoid dependency  
                              | • working on the underlying issues and drivers  
                              | • working within a recovery model while not requiring people to have articulated recovery goals  
                              | • inclusion and active prevention of exclusion  
                              | • openness to innovation, creativity and varied methods of cultivating safe space (such as community connections, arts programs, sensory methods etc.)  
                              | • linking well with other key parts of the system  
                              | • team approaches  
                              | • investing in staff and sector capabilities for innovation, collaboration and continuous improvements |
| **Staffing arrangements (per hub)**  | • team leader  
                              | • two centre-based roles  
                              | • two outreach roles (to homes, key locations including ED)  
                              | • one project-based role  
                              | • peer support workers  
                              | • volunteers  
                              | • visiting services  
| Skills: mix of clinical, non-clinical and peer inputs. Clinical inputs could either be through partnerships and protocols with Queensland Health or through internal staffing including a clinical role. There could be a role for visiting GPs as well. Include specialist cultural roles and links/engage specialist mentors |
| Staff capabilities will need to include: | • evidence-based understanding of mental illness/mental health issues  
                              | • a systems view of safe-space responses  
                              | • high-level capabilities in working collaboratively  
                              | • high-level capabilities in soft entry and formal assessment  
                              | • high-level capabilities in active referral  
                              | • capabilities in providing space to diverse people and helping to manage that space collaboratively with service users  
                              | • capabilities in de-escalation  
                              | • frameworks that support partnering and removing barriers to accessing other services, in the interests of clients  
                              | • openness to learning and continuous improvements  
                              | • key support work experience in a mental health or related context |
**Service delivery model element** | **Description**
---|---
**Hours** | Extended hours including over weekends, and outreach staff concentrated across hours of 3.00–11.00 pm. Some stakeholders indicated the need for services to operate 24/7

**Drop in** | Drop-in facilities including communal and individual spaces

**Infrastructure and design** | • home-like
• house in the community
• if not a house, then a facility that blends well in the neighbourhood and is positively branded to avoid any stigma
• comfortable, soft furnishings and use of fabric/texture
• comfortable chairs and beanbags
• activities, computers, etc.
• place to make food
• outdoor space with interactive garden (including gardening activities)
• group space
• sensory options (auditory, olfactory, visual, tactile etc.)
• attention to culture of the space
• use of an existing facility if one is appropriate (could help to consolidate with other services and reduce capital/running costs)

**Location and access** | • consider one each in Nundah-Chermside corridor, one in Caboolture and one in Redcliffe
• close to transport
• mobile/transport solutions including taxis, brokerage, etc.
• use existing buildings/locations if possible to consolidate and leverage other contributions.¹

**Programs and services offered** | • building-based and outreach support service
• direct support and active linkages with existing support providers
• supportive chat/soft entry
• peer support roles
• visiting services/activities
• art/culture programs
• individual safety planning (linked to support plans)
• sensory programs
• group recovery options
• residential/crisis option

¹ Several locations were suggested, including GP Super Clinics, community centres, existing drop-in centres, underused spaces in some health facilities, etc.
<table>
<thead>
<tr>
<th>Service delivery model element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• include intoxicated people: space to recover</td>
<td></td>
</tr>
<tr>
<td>• clinical inputs/links including through partnership with Queensland Health and possibly with ACT, GPs, etc.</td>
<td></td>
</tr>
<tr>
<td>• specialist support linkages (young people, older people, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) people, etc.)</td>
<td></td>
</tr>
<tr>
<td>• outreach roles to provide enabling assessment in situ and work with the client to consider options including management at home, transfer to building base, active referral, transfer to hospital depending on need. Outreach roles with definite access to clinical support where needed</td>
<td></td>
</tr>
<tr>
<td>• project role to assist with volunteer participation, home placements network and mapping/engaging other safe-space options and promoting these to service users</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Governance arrangements</th>
<th>• make best use of existing governance arrangements such as Collaboration in Mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>• if the hubs are progressed, governance could either be as part of a broader safe-space strategy or, if the strategy is not in place, specific to the hubs but structured as part of Collaboration in Mind</td>
<td></td>
</tr>
<tr>
<td>• subordinate structures could include a project reference group on more day-to-day aspects of the operations and to ensure seamless linkages at the operational level, as well as peer, consumer and carer input</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management and procurement</th>
<th>• consider NGO providers with excellent linkages to the broader sector and protocols involving Queensland Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• establish a rigorous procurement process requiring demonstration of capabilities in true service integration and partnering (focussed on individual needs rather than agency preferences/politics). Include reference checks</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to broader elements of sector</th>
<th>• protocols with Queensland Health, ACT, EDs, HHOT, Emergency Services and Step Up Step Down, Mental Health phone line.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• clearly defined referral pathways including:</td>
<td></td>
</tr>
<tr>
<td>° referral to and from agencies</td>
<td></td>
</tr>
<tr>
<td>° referral/transfer from Queensland Health and hospital</td>
<td></td>
</tr>
<tr>
<td>° Referral from mental health phone line</td>
<td></td>
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<tr>
<td>° referral from emergency services</td>
<td></td>
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<tr>
<td>° self-referral</td>
<td></td>
</tr>
<tr>
<td>° drop in</td>
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<tr>
<td>° planned attendance (as part of a safety plan)</td>
<td></td>
</tr>
<tr>
<td>• use collaborative support and safety plans, case coordination and other mechanisms such as PiR support facilitation where assessed as needed</td>
<td></td>
</tr>
<tr>
<td>• ensure continuity of care with existing care providers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes measurements and evaluation</th>
<th>• data on presentations, stays, services used, outreach events</th>
</tr>
</thead>
<tbody>
<tr>
<td>• data on projects and innovations</td>
<td></td>
</tr>
<tr>
<td>• develop an evaluation framework from initiation</td>
<td></td>
</tr>
<tr>
<td>• put in place data management and client management systems</td>
<td></td>
</tr>
<tr>
<td>Service delivery model element</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>• establish clear framework of reports</td>
<td></td>
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<tr>
<td>• ensure cumulative data analysis as a basis for continuous monitoring and improvements</td>
<td></td>
</tr>
<tr>
<td>• use tools such as the Subjective Units of Distress scale and Outcomes Star to measure changes in a person’s wellbeing</td>
<td></td>
</tr>
<tr>
<td>• use other wellbeing tools to establish change over time</td>
<td></td>
</tr>
<tr>
<td>• measure referrals/number of referrals, etc.</td>
<td></td>
</tr>
<tr>
<td>• measure reduction of hospital presentations and hospital stays for individuals over time</td>
<td></td>
</tr>
<tr>
<td>• partner-independent evaluator</td>
<td></td>
</tr>
</tbody>
</table>

The consideration of a safe-space hub model is somewhat informed by particular models identified in the literature review including:

- Bristol Greenway Centre
- Bristol Sanctuary
- Banner Psychiatric Centre (Arizona)
- The Living Room (Illinois)
- Mental Health Safe Houses (New York).

Crisis Response Teams as described within the UK context play a considerable role in responding to crises and preventing automatic presentation to emergency departments. The Victoria-based HARP model also includes outreach underpinned by considerable service integration and a leased bed if it is needed.

This report includes suggestions about the inclusion/attachment of crisis outreach teams to safe-space hubs that are loosely based on this model. It will be important to continue discussions about the identified merits of crisis-outreach responses by skilled teams as well as assertive community treatment models that are not only focussed on crisis responses but ongoing and assertive care, support and treatment. The broader challenge of not having enough follow-up support to people living with mental health issues is well known as a system issue and gap, and one which a safe-space strategy cannot fully address. One opportunity is for a safe-space strategy to be a basis for continued discussion about the need for ongoing, intensive support for people who need it as a core resource in the reduction of emergency department presentations, and in the achievement of improved safety and wellbeing for people in a state of distress.
8. Conclusions and recommendations

The scope of this project was to identify safe-space models (hopefully one preferred one) through research and engagement.

This project examined various models from different locations. The engagement component consulted a range of stakeholders about needs, issues, and opportunities and possible solutions.

The report concludes by refocussing on the core principle that safe-space solutions are unique to individuals and that people need different things at different times. The project consulted consumers of mental health services who had found an interlocking and creative range of ways to manage their own need for safety, which can fluctuate and change over time and circumstance.

With this core idea in mind, and working from various demonstrated models, it is suggested that the lens be widened to develop and advance a North Brisbane Regional Safe Space Strategy. This allows for best use of existing safe-space initiatives and infrastructure, addresses system gaps through safe-space hubs, and works to build system and workforce capacity through combining leadership and governance towards effective implementation.

A number of cited examples addressed the question of evaluation, lamenting the lack of rigorous measurement of outcomes across some safe-space alternatives. As this strategy involves using what exists combined with innovation, workforce development and collaborative partnerships, it is suggested that a strategy should include scope for rigorous and independent evaluation.

While a safe-space strategy is proposed, the engagement process highlighted concerns about broader system gaps, such as a lack of support available to people who are vulnerable and may or may not have a formal mental health diagnosis. There is a risk that safe-space solutions are piecemeal, and a reaction to other key service system challenges to provide assertive, outreaching support to assist people at home and in their community. Not everyone has access to individualised plans that provide unique and responsive solutions reflecting a person’s uniqueness.

This project tentatively suggests a broader safe-space strategy while also suggesting a building base with hub functions as part of that strategy. This needs robust discussion, as there are several important considerations and safeguards needed. If a hub is advanced through to implementation, it will be critical for the roles and functions to include individualised safety planning, a support guarantee for vulnerable people, and broader system capacity building. Decentralised safe-space options will contribute to a regionally sensitive approach.

The recommendations from this report are as follows:

1. That North Brisbane Partners in Recovery develops a North Brisbane Regional Safe Space Strategy (NBRSSS) to promote existing safe-space contributions and create innovative new models such as safe-space hubs.
2. That an NBRSSS is governed by Collaboration in Mind to harness leadership, expertise and support towards implementation.
3. That an NBRSSS seek funding and multi-agency contributions to provide decentralised North Brisbane hubs with extended opening hours. The hub model should include capacity for:
   • centre-based support including clinical, non-clinical and peer contributions
   • outreach staff who provide interventions in situ and at key locations such as emergency departments
• scope for volunteer/community involvement
• transport options and brokerage funds
• activities, arts and sensory options
• a project worker role to support the strategy’s implementation and governance group, include community involvement and home placements, build capacity in generalist organisations and generate a calendar and map of other safe-space alternatives
• active approaches to working with extreme vulnerability and preventing the need for service exclusions.

4. That an NBRSSS include mapping and documenting existing safe-space groups, community centres, drop-in options, activities and arts centres. Consideration could be given to a safe-space network brand that unites these alternatives and raises their profile to the sector and to service users in a non-stigmatising way.

5. That individualised safety planning is more widely adopted by support providers using shared tools that are part of collaborative and coordinated support plans; and a shared support planning platform is implemented that seeks client consent for a highly coordinated approach.

6. That resources are harnessed and where necessary increased to achieve a support guarantee for people who are vulnerable and who frequently present at emergency departments.

7. That an NBRSSS is a basis for building a ‘community of practice’ and providing workforce development opportunities to enhance skills, capabilities and capacities in achieving safe-space options within individual support and safety plans and at the organisational and systems levels. Workforce capacity and capabilities are needed in working with recovery models of practice while also responding to the impact of extreme vulnerability.

8. That a culture of innovation and creativity is facilitated as part of the provision of decentralised, community and place-based safe spaces that are accessed by the broader community and accessible to people living with mental health difficulties. This could include scope to develop home placement options for example.

9. That a process is put into place whereby an NBRSSS includes culturally aware and competent approaches, and is responsive to the needs of specific community groups with identified needs. This should be achieved through organisational development, mentoring, staff from diverse backgrounds, and workforce capability development.

10. That the strategy is rigorously and independently evaluated.
9. References


smbcpkrjm.


Johnson, S. 2015. Crisis resolution and home treatment in England, where are we now? Division of Psychiatry UCL. Presentation.


Psych Central, (2016). For psychiatric crises, alternatives to ERs have their advantages, PsychCentral website. Editorial.
SANDBAG. (2014). Shining a light. SANDBAG, Griffith University, Community Living Association and Deception Bay Neighbourhood Centre.
West End Community House. (2011). Strengthening people and places: the role of value of community and neighbourhood centres. WECH.
Appendix 1: Interview questions

1. What is your name?
2. What is your organisation?
3. What is your role?
4. What is the need for a safe space in Brisbane’s North region?
5. Who would be the target group?
6. What model do you think is most beneficial for Brisbane’s North?
7. Why do you think this would be the best model for North Brisbane?
8. Are there any current services that could be strengthened or changed to complement or provide a safe-space model?
9. Is there a location where you think it could be best placed?
10. What would the staffing model be?
11. What would the safe space be like? How would it look? How would it feel? What would you make sure is included?
12. Does your organisation operate a safe space or provide space for dropping in?
13. What are the three most critical elements for a safe-space model?
14. Is there any other advice that you have for a safe space for Brisbane?
15. What is your email address?
16. Is there anyone else we should make sure is invited to participate?
## Appendix 2: Agenda and flyer for regional workshops

<table>
<thead>
<tr>
<th>Time</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30 am</td>
<td>Coffee and refreshments</td>
</tr>
<tr>
<td></td>
<td>Warm Up</td>
</tr>
<tr>
<td>10.10 am</td>
<td>Exploring who is here and what we bring</td>
</tr>
<tr>
<td>10.30 am</td>
<td>Listening to the story of safe space</td>
</tr>
<tr>
<td>11.10 am</td>
<td>Providing overview of models</td>
</tr>
<tr>
<td>11:30 am</td>
<td>Coffee stop</td>
</tr>
<tr>
<td>11:40 am</td>
<td>Exploring how the models could look and feel</td>
</tr>
<tr>
<td>12:30 pm</td>
<td>Feedback from each table</td>
</tr>
<tr>
<td>1.00 pm</td>
<td>Collating key elements</td>
</tr>
<tr>
<td>1.30 pm</td>
<td>Lunch, close and next steps</td>
</tr>
</tbody>
</table>
SAFE SPACE PROJECT WORKSHOPS

You are invited to attend a safe space project workshop which will explore options and suggestions for the best approach to providing a safe space for people living with a mental health issue in Brisbane North Region. It is intended that a safe space would function as an alternative to going to hospital.

Stakeholders are invited to attend a local workshop in addition to one culminating workshop. Local workshops will provide a brief overview of different models operating in Australia and overseas and engage people in hands-on design activities and discussions to consider, develop and refine ideas for the best approach. There are four workshops in different geographical areas designed to work intensively with about 20 people. These workshops will culminate in a larger event on Wednesday 25 May, where participants will review ideas and further refine a service delivery model for inclusion in a final report.

The project has been funded by North Brisbane Partners in Recovery Program. The project team consists of Neal Price, Jen Barrkman and Fiona Caniglia with Wesley Mission Brisbane. You can contact Fiona Caniglia for more information on 0400 1964 92 or at Fiona.caniglia@gmail.com.

Choose one local workshop

Tuesday 26th April
At the Merthyr Uniting Church,
52 Merthyr Rd New Farm.
9.30am-1.00pm
Morning tea provided

Wednesday 4 May
at Lagoon Creek Café
and Function Room
1/11 Toovey St Caboolture
10.00-1.30pm
Coffee on arrival and lunch provided

Friday 6th May
The Old Fire Station
Volunteer Hub
395 Oxley Ave Redcliffe
10.00am-1.30pm
Coffee on arrival and lunch provided

Wednesday 11th May
Nundah Neighbourhood Centre
14 Station Rd Nundah
9.30am-1.00pm
Morning tea provided

Final workshop

Wednesday 25th May
Kedron Wavell Services Club
21 Kittyhawk Dr Chermside
9.30am-11.30am
Ideas will be presented and refined into a service delivery model involving participants.

Morning tea provided.
## Appendix 3: Culminating workshop agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.15 am</td>
<td>Registration</td>
</tr>
<tr>
<td>9.30 am</td>
<td>Welcome and introductions</td>
</tr>
<tr>
<td>9.40 am</td>
<td>Presentation</td>
</tr>
<tr>
<td></td>
<td>Directions and options</td>
</tr>
<tr>
<td>10.00 am</td>
<td>Discussion and questions</td>
</tr>
<tr>
<td>10.10 am</td>
<td>Small groups (facilitated):</td>
</tr>
<tr>
<td></td>
<td>• Who should a safe space be for?</td>
</tr>
<tr>
<td></td>
<td>• What should it be like?</td>
</tr>
<tr>
<td></td>
<td>• Where should it be?</td>
</tr>
<tr>
<td></td>
<td>• What opportunities already exist?</td>
</tr>
<tr>
<td></td>
<td>• Prioritise leading ideas</td>
</tr>
<tr>
<td>11.00 am</td>
<td>Feedback of priorities</td>
</tr>
<tr>
<td>11.20 am</td>
<td>What is the most important thing to you about a safe-space response for North Brisbane?</td>
</tr>
<tr>
<td></td>
<td>Individual reflection</td>
</tr>
<tr>
<td>11.30 am</td>
<td>Thanks and close</td>
</tr>
</tbody>
</table>
Appendix 4: Online survey questions

1. What is your name?
2. What is your organisation?
3. What best describes your role?
   - Carer
   - Consumer
   - Peer support worker
   - Service provider—non-clinical
   - Service provider—clinical
   - Manager
   - Community member
   - Policy role
   - Other
4. What is the need for a safe space in Brisbane’s North region?
5. Looking at the outline of models provided to you, what approach do you think is most beneficial for Brisbane’s North?
6. Why do you think this would be the best model for North Brisbane?
7. Is there a location where you think it could be best placed?
8. What would the safe space be like? How would it look? How would it feel? What would you make sure is included? What staff would be there?
9. What are the three most critical elements for a safe-space model?
10. Do you know of any models or examples of safe spaces that already exist that should be considered?
11. Is there any other advice that you have for a safe space for Brisbane?
12. What is your email address so we can say thank you?
Appendix 5: Workshop process for peer focus group

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.30 am</td>
<td>Welcome, introductions and warm up</td>
</tr>
<tr>
<td>10.40 am</td>
<td>Project presentation: ideas and options so far</td>
</tr>
<tr>
<td>10.50 am</td>
<td>Small groups:</td>
</tr>
<tr>
<td></td>
<td>• Who should a safe-space response be for?</td>
</tr>
<tr>
<td></td>
<td>• Where should it be?</td>
</tr>
<tr>
<td></td>
<td>• What should it be like?</td>
</tr>
<tr>
<td></td>
<td>• Favourite ideas (3 dots)</td>
</tr>
<tr>
<td>11.35 am</td>
<td>Feedback</td>
</tr>
<tr>
<td>11.50 am</td>
<td>Prioritisation</td>
</tr>
<tr>
<td>12 noon</td>
<td>Close and thanks</td>
</tr>
</tbody>
</table>
## Appendix 6: Three homes model

<table>
<thead>
<tr>
<th>Type of home</th>
<th>Description</th>
<th>Implications for a safe-space model</th>
</tr>
</thead>
</table>
| First home   | Is a person’s primary home or the self. It is our very being and identity. The fundamentals of this first home are physical, mental, emotional, social and spiritual in nature. Among the things we need to maintain in our ‘first home’ are nurturing, emotional support, time for reflection, a sense of purpose and meaning. Kraybill notes the greatness and depth of people’s capacities, yet acknowledges that people are also vulnerable and fragile. This inherent risk can drive the need for nurturing and caring responses, which may include the knowledgeable care and support of others at times. | Raises the question of:  
  - What care and support do people need when their own mental and emotional state is fragile?  
  - What responses can help to address challenges to first home?  
  - Who, what, where, how? |
| Second home  | The place we live, our housing. It refers to the physical structure in which we live and also to the kind of living environment created within it. This home offers a place of welcome, familiarity and stability. It should be a place for renewal of energy and purpose. This second home provides the necessary context for meeting the needs of the first home and an important foundation and link to the third home. | Are there elements of second home that drive the need for safe-space/safe places?  
  Are some living environments more likely to drive people to seek out alternative safe space?  
  Are there interventions involving ‘second home’ that can increase the sense of being safe? Can home be a safer space and contribute more to overall wellbeing? |
| Third home   | This is the larger community in which a person is located. “Here our interdependence with other people and organisations is fully evident … There are numerous opportunities for participation and resources in this third home that permit us to meet the needs of our first home and second homes.” | Are there broader community interventions that contribute to a sense of being in a safe place/safe space?  
  What places at a local level can contribute to safe space/a feeling of being safe? |

Adapted from Kraybill, 2012
Appendix 7: Acknowledgement and participating agencies

The project team with Wesley Mission Queensland would like to thank participating agencies and individuals for their time, insights and enthusiasm for safe-space solutions in North Brisbane. The following agencies participated with contributions to the report:

- Aftercare
- Brisbane North PHN
- Burnie Brae
- Centacare
- Churches of Christ Care
- Clinic 30 Queensland AIDS Council
- Community
- Footprints Inc.
- Group 61 Inc.
- Mental Illness Fellowship Queensland
- Mission Australia
- Neami National
- Open Minds
- QPASTT
- Queensland Alliance for Mental Health Inc
- Queensland Health
- Richmond Fellowship Queensland
- Under 1 Roof
- Wesley Mission Queensland

Other participants were individuals with experiences as peers and carers as well as a consultant in the private sector. It should be noted that there were multiple participants from many of the organisations listed above. Contributions included ideas, suggestions and artwork.

In particular we would like to acknowledge the project reference group consisting of Tina Pentland, Nicola Bristed, Elle Patterson, Trish Kane and Angela Taylor. The project team would also like to thank Natasha Malmstrom, Cameron Harris, Debbie Head, Kris Athanasiov Daniel Baddiley, Tony Stevenson, Keryn Fenton, Donna Bowman and Kris Sargeant for their contributions to the video. Thank you to Brisbane North PHN and North Brisbane PIR for initiating and resourcing the project, for providing day-to-day project leadership and for their assistance in accessing data and other information. Our apologies if any contribution has been omitted. Every contribution was very helpful.