Report: A Safe Spaces Narrative -

emerging outcomes of Safe Spaces co-design

Beacon Strategies

Roses in the Ocean
stemming the tide of suicide

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About these findings

The findings contained within this report have been collated based on the outputs of extensive co-design activities led by Roses in the Ocean in communities:

- across New South Wales, as part of the establishment of Safe Haven (Alternatives to Emergency Department Presentations) services
- in Queensland, as part of the establishment of Safe Spaces funded by the Brisbane North Primary Health Network.

These findings capture the broad perspectives of people with a lived experience of suicide (including direct experience of a suicidal crisis and/or attempt, and caring for a loved one through suicidal crisis), along with health professionals who have supported people through the process of seeking help in their professional role.

The findings are presented in the structure through which they were captured during the co-design processes led by Roses in the Ocean, which includes:

- needs of people seeking support when experiencing a suicidal crisis (or choosing not to access support)
- key components of a Safe Space model
- key outcomes of a Safe Space, including ways of responding to specific scenarios

There are also several additional areas for further exploration outlined at the end of this report.

These findings capture the perspectives of people with lived experience of suicide and health professionals from co-design activities for over twenty Safe Spaces being established in communities across urban, regional and rural parts of Queensland and New South Wales.

It is important to note that these findings are particularly shaped and constrained by the Statewide Requirements specified by the NSW Ministry of Health for the Safe Haven (Alternatives to EDs) services and being established by NSW Local Health Districts, and the contractual parameters of the Queensland Safe Space Hubs.

These findings can be helpful as a foundation and starting point to generalise for the broader development of Safe Space services, but can also be built on or challenged to meet the needs and aspirations of local communities or in other contexts.

Underlying needs

Needs of people with a lived experience of suicide

Informed by the reflections of people with a lived experience of suicide who accessed help through a hospital emergency department (ED), there are many needs that people experiencing these situations have that are often unmet by the ED environment.

In many cases, these needs, and the emotional distress and/or crisis people are experiencing are reportedly exacerbated by presentation to an ED.

These needs are expressed through the feelings and emotions that people experienced during each of these stages. Some of the most common feelings and emotions experienced by people accessing the ED at various touchpoints are outlined in Table 1.

Table 1: Feelings or emotions commonly reported by people with lived experience of suicide when accessing emergency department (ED)

Stage of journey through ED	Feelings and emotions	Description of experience — 'why were you feeling this way?'
Finding	Confused Desperate Embarrassed Fatigued Fearful Hopeless Overwhelmed Reluctant Sad Unsure	"Fear of the unknown—had never been to ED" "Choice and control were going to be taken away from me" "Worried about confidentiality in a small town" "By the time you got to ED, you have exhausted all of the help available in the community" "Didn't know where to turn"
Arrival and initial assessment	Alone Angry Blamed Confused Embarrassed Frustrated Guilty Ignored Powerless Relieved Resigned Safe Shameful Sick Uncomfortable	"When already not in a good frame of mind, the exposure was confronting" "That fear of being judged and less than them" "I expected that they would welcome me with open arms and I had that flipped on its face" "I was embarrassed about who else would see me when they were visiting ED" "There was no consideration of previous trauma" "Once you enter that building, you lose your rights and you lose your voice" "I knew the outcome would be that I would be sent home" "Didn't feel prioritised - despite it being a life and death situation" "Felt like I was taking time away from other patients because of something I was going through"

Stage of journey through ED	Feelings and emotions	Description of experience — 'why were you feeling this way?'
Waiting	Agitated Bored Cold Fearful Frustrated Hungry Impatient Invisible Numb Safe Sweating Uncertain Unsafe	"Had to wait what felt a really long time — literally 4 hours. Especially considering there were doctors and nurses around" "No communication about what's going to happen" "Nurse can't smile, seems cranky, makes you feel like a burden" "There was nothing there - I was just staring at the blank walls" "Racing thoughts — I haven't got anything to distract my mind" "You wonder why you've come here - you would be better off staying at home"
Treatment	Confused Depressed Disconnected Hopeless Misunderstood Numb Relief Shame Trapped Withdrawn	"It was only a few minutes of conversation. There really wasn't any actual support" "They didn't have the time or the care factor... they didn't see me as a human being" "Often people made decisions, it was about me, without my involvement" "Treated more like a criminal rather than a patient" "It's really hard to answer questions when you are tired and overwhelmed and you have been waiting for hours" "I felt guilty about taking up people's time and resources" "The psychiatrists see 100 people and they only have 5 minutes for you to ask you how your medication is going" "I only started to feel more connected when my people were there, and I could talk to them. Having a jovial, friendly nurse helped."
Leaving	Abandoned Angry Defeated Determined Disappointment Hopeful Relieved Scared Stupid Tired	"Didn't provide any support or guidance. Too busy to care" "Was given processes and next steps, but all just dry, clinical steps" "You get your freedom back" "Go from 24/7 watch to inadequate support" "Looking forward to a brighter future" "I went back to doing all of the things that got me there in the first place" "It was going to take a week before they were going to see me at Community Mental Health" "My sister had to agree to watch out for me, which I felt was a bit much to expect of her" "Clinician felt people with this diagnosis don't belong in hospital - turned away" "Relieved to be out of that space. There wasn't much choice in what follow up was offered"

Stage of journey through ED	Feelings and emotions	Description of experience — 'why were you feeling this way?'
Generally	Determined Disconnected Invalidated Irate Misunderstood Naive Shattered Vulnerable	"I just won't go there anymore when I have dark thoughts" "Felt better after having spoken to the peer support workers. It was lucky they were there." "I had to reach a crisis to get the help" "I don't know what we would do if it ever happened again"

There are also common experiences shared by people who didn't access an ED or who wouldn't access an ED when experiencing a suicidal crisis because of previous traumatic experiences with the system, which included:

- recognition that the help that is available isn't the 'right' help
- fear of judgement and consequences (including being referred to as a 'repeat offender', 'frequent flyer', 'attention seeker', 'manipulative')
- lack of empathy or shared understanding
- stigma of mental health presentations in hospitals compared to physical health
- lack of options other than a GP.

When exploring the reasons why people experienced these emotions, the underlying needs that people had during those times emerged. These needs commonly span broad areas such as practical, emotional connection and information.

A list of the common needs identified by people with lived experience of suicide when experiencing a suicidal crisis include:

Practical or environmental needs

- Food, water and nourishment
- Warmth
- Safety
- Shelter
- Distraction, entertainment
- Help with arrangements at home (e.g. children, pets)
- Comfort (touch, sounds, sights, smells)
- Links to other services and supports
- Rest and relaxation
- Privacy
- Ability to keep own personal items
- Connection to outdoors/nature
- Assistance with transport

Emotional needs

- Being greeted and welcomed
- Company and companionship
- Validation
- Connection with other people
- Meaningful activities
- Empathy
- Eye contact
- Enquiry about what is going on for them without interrogation
- Respect and dignity
- Able to speak calmly with someone who can listen, even if about 'nothing'
- Frequent checking in, not being left alone
- Reassurance and validation that have done the right thing
- Understanding own needs and situation
- Involving family and carers if the person wishes
- Feel cared for and nurtured

Information needs

- Transparency and knowing what to expect
- Information on what the person is experiencing
- Skilled and knowledgeable supporters
- Answers to questions
- Strategies and skills for self-management
- Advocacy
- Information for person's support network (e.g. loved ones, GP)
- A plan for what to do next
- Range of opt-in services

Other needs

- Non-clinical environment
- Peers who have experienced crisis themselves
- Autonomy and choice
- Avenues for creativity and expression
- Immediate support, not left to wait
- Stopping painful emotions
- Able to go home
- Follow up after leaving
- Help after hours
- Continuity — can attend regularly without complacency

This highlights the broad range of underlying needs that a Safe Space service model should be focused on addressing to effectively support any person experiencing a suicidal crisis.

Needs of health professionals

The experiences of health professionals in supporting someone through the process of accessing ED in a suicidal crisis highlight common feelings and emotions reported from this perspective at each touchpoint.

Table 1: Feelings or emotions commonly reported by health professionals whilst supporting someone through the process of accessing emergency department (ED)

Stage of journey through ED	Feelings and emotions	Description of experience — 'why were you feeling this way?'
Finding	Frustrated Empowered Confused Anxious Guilty Responsible Shameful Sad Pressured	"Just happens that ED is open 24/7 and staffed — so it's the default' option" "I want to make sure they'll be safe and not sure if that will be the case" "We want to tell patients we are taking them to a safe space — but this may not always be true in a very busy environment where handover to ED staff is tricky" "People may be so triggered by how they're brought in that they may be in flight or fight" "ED is obvious for physical injury, but not mental"
Arrival and initial assessment	Awkward Helpful Concerned Disappointed Overwhelmed Satisfied	"It's terrible. Everyone can hear everything...others are looking on...people don't want to disclose that info in front of all those people" "Much of our time is taken up with administrative and procedural documentation" "ED staff have very variable capability in meeting the needs of suicidal patients" "It is very difficult to let someone tell their story given the busy, stressful and intense physical environment" "Suicidal thoughts aren't always taken as seriously as they should be" "Process makes person relive the experience...the process of asking people for their story can be extremely distressing for them"
Waiting	Annoyed Stressed Anxious Frustrated Unheard Concerned Sad	"Those who don't come with someone have little support while they're there" "Staff don't have time or capacity to provide the level of attention and support they need" "Patients are not sure what they're waiting for... they don't know what is going on" "To leave someone alone doesn't feel right" "People in suicidal distress can be required to wait in a secure area – which is essentially a room with a mattress on the floor" "ED is a very busy place, patients can experience a lack of privacy and confidentiality and are at risk of just getting up and leaving" "Action doesn't match seriousness of situation"

Stage of journey through ED	Feelings and emotions	Description of experience — 'why were you feeling this way?'
Treatment	Deflated Helpless Relieved Frustrated	"Resources might not be available (e.g. bed) but what's the alternative to ensure someone's safety?" "People don't always get to explain their narrative and articulate what they need" "We acknowledge that many people have had traumatic experiences with previous hospital admissions" "If people just sat down and gave a person more time they would pull a lot more out of them" "Clinical terminology and explanations can be overwhelming"
Leaving	Angry Disappointed Self-judgement Frustrated Guilty Confused Upset	"The time and energy it took to get them to ED wasn't worth it" "No holistic solutions… people are just prescribed medication and sent on their way" "Things aren't followed up on properly" "No consistency" "Ideally, our Peer Workers would be able to follow up each person after an admission and presentation" "You can be the scapegoat for family and friends…who are upset that their family member has been discharged or nothing done" "Too much pressure on family and friends to take responsibility" "We try to be realistic about what we can achieve — what we can do is provide someone with a safe environment" "Leaving can perpetuate aloneness"
Generally	Distressed Frustrated Unhappy Powerless	"ED is often viewed as only offering support for physical ailments" "Lack of awareness on how to receive the person" "It is not that we don't care it is just total frustration with the system we currently have" "It is an ongoing cycle that we don't seem to be addressing" "People have this perception that going to hospital will fix everything - but I know that's not the case"

Health professionals identified what's missing within the services and supports available for people experiencing a suicidal crisis within their community, which can help to highlight what needs an ideal Safe Space could meet. Common gaps in existing services identified by health professionals include:

- Community-based crisis support — other places to take people than ED
- Services that involve peer workers and clinicians
- Consistent after-hours support
- Culturally appropriate support for First Nations people
- Human interaction with supportive people
- Holistic models of care to meet broad needs of people experiencing suicidal crisis
- Communication and protocols with ambulance and other services
- Safe and secure spaces where people are welcomed
- Coordinated responses that connect people

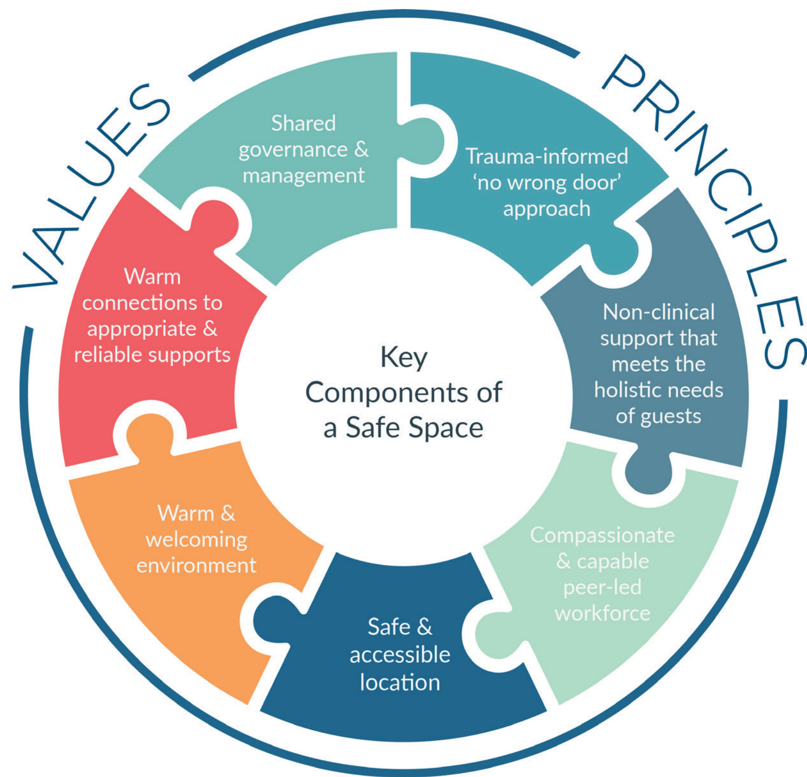
- Supports for carers and families
- Prevention-focused support

Similarly, there are several factors that health professionals commonly identified that they need to feel comfortable when supporting someone to access a Safe Space:

- Endorsement from hospital and health services
- Strong relationships with service
- Staff trained in trauma-informed practice
- Processes that outline how risks will be managed
- Workforce who are trained, supported and have access to resources
- Policies and procedures
- Trust that the system will support the person
- A place that solves immediate crisis
- Peer-led with access to clinical support if requested
- Undaunting location to access
- Coverage after hours
- That a guest can talk to someone right away
- A space where people are listened to and validated
- Separating children and youth from adults
- No set time frame for people to leave
- In close proximity to hospital EDs but not within view
- Safe and secure space where people aren't exposed to further harm
- Understanding of Safe Space model of care and services offered
- Clear and transparent 'escalation' pathways and processes

Key components of a Safe Space

Overview of a Safe Space



VALUES

Values are the things that people with lived experience of suicide identify as representing what a Safe Space should be and underpin all that happens within a Safe Space. They provide the internal compass and the place from which all scenarios are 'sense checked'. Some of the common values that should guide the delivery of a Safe Space identified by people with a lived experience include:

- Compassion
- Hope
- Respect
- Dignity
- Inclusion
- Choice
- Acceptance
- Autonomy
- Transparency
- Integrity
- Empathy
- Authenticity
- Equity
- Trust
- Safety (expressed holistically in terms of emotional, psychological and cultural safety)

PRINCIPLES

Principles are those rules or beliefs that govern the actions of people within the Safe Space, including staff, volunteers and guests. Some of the most common principles that should guide the delivery of a Safe Space identified by people with a lived experience include:

- Person-centred
- Tolerant of risk
- Strengths-focused
- Collaborative and integrated
- Evidence-based and professional
- Lived experience-led
- Walking together with people
- Valuing each person's experience and expertise
- Promoting autonomy, self-determination and 'choice and control' for guests
- Supporting people to get what they need
- Valuing each person's lived experience and expertise
- Maintaining confidentiality of what happens in Safe Space
- Respectful of diversity

COMPONENT 1:
A trauma-informed 'no wrong door' approach

Well-established, warm connections within local communities are an important factor in connecting people experiencing a suicidal crisis with the support of a Safe Space.

People with lived experience and health professionals commonly described these pathways to connect to the support offered within a Safe Space as:

- people being free to visit the Safe Space whenever they need to
- awareness and acceptance of the Safe Space within the local community
- other service providers and health professionals acknowledging and accepting the role of a non-clinical safe space
- assistance with or information about transport options
- clear information about what people can expect when arriving at the Safe Space
- linkage with hospital emergency departments (EDs), where people can be warmly connected to the Safe Space by ED staff when presenting there

An important principle of a Safe Space is a 'no wrong door' approach, which aims to ensure all guests are welcomed and able to access support within the space. It was considered rare that a capable workforce and holistic support offered by a Safe Space would not be able to meet the needs of a guest arriving at a Safe Space. The role of Safe Space is to welcome, listen, understand a person's needs.

People with lived experience and health professionals felt strongly about the need for a Safe Space to welcome and work compassionately with guests whose distress may present as agitation or aggression, and to provide practical comforts to people who may be experiencing distress alongside other circumstances such as using drugs or alcohol or experiencing homelessness. Importantly, a 'no wrong door' approach means the Safe Space would not have the exclusion criteria often present in other clinical services.

In some instances, Safe Space staff may identify that a person might be better supported by another type of support, such as linking a child aged under 16 years with a youth-focused service, connecting someone in need of medical treatment with a clinical service, or assisting people who present for reasons other than suicidal crisis or emotional distress (e.g. shelter) with appropriate services. This would be done in accordance with the guests wishes and alongside the person being made welcome and supported whilst additional connections and supports are organised.

People with lived experience of suicide and health professionals recognised the importance of 'first impressions' upon their connection to and arrival at a Safe Space. Upon arrival, guests must be warmly greeted by a peer worker with a lived experience of suicide who starts building trust and rapport and helps the guest to feel safe and welcome. It was noted often that the power of connection that occurs between people with a shared lived experience expediates this process. Other aspects of a positive experience include:

- reassurance that the guest has come to the right place
- not having to undergo a formal assessment or triage process
- a suicide prevention peer worker sensitively inquiring to understand what a person might be needing from the Safe Space
- guests feeling comfortable and in control with when and how they share their experience with a suicide prevention peer worker
- the guest having the ability to define the role or presence of their carers or loved ones in the space
- clear information about what the Safe Space involves, including what support is available (and what isn't), managing capacity (including any waiting times), staff roles and the expectations of guests

COMPONENT 2: Non-clinical support that meets the holistic needs of guests

A Safe Space involves provision of non-clinical support that aims to respond to the needs of people experiencing emotional distress or suicidal thoughts and behaviours, and to reduce their distress in a safe environment.

Reflecting the principles of a Safe Space, guests have the autonomy to identify their needs at their own pace and to engage in activities that they determine, with the support of a suicide prevention peer worker.

The role of peer workers within the Safe Space is to introduce guests to the broad range of non-clinical supports that might be relevant to their needs and work together to develop a plan for 'what next' to ensure guests leave with a sense of hope and empowerment.

Non-clinical support aims to respond to the holistic needs of each guest, which can span emotional support (e.g. talking and listening), practical support (e.g. self-care, nourishment), and information support (e.g. resources, onward connection). This includes working to involve and support a guest's carer, family or friends who attend with them, but in a way that is directed by the guest's preferences.

Examples of the type of support identified by people with lived experience of suicide and health professionals that can be provided within a Safe Space includes:

- supportive conversations or sitting together with a suicide prevention peer worker
- activities that provide distraction or creative expression (e.g. art, games, support animals)
- information tools and resources (e.g. guides, fact sheets, apps), without being overwhelming
- individual time to rest and relax
- connection to other people in the space (e.g. support groups, activities, walks)
- information for family and friends
- discussing 'staying safe for now;, longer term safety and support strategies
- assistance to access other services or supports

COMPONENT 3: A compassionate and capable peer-led workforce

A compassionate and capable peer workforce comprising people with their own lived experience of suicide is fundamental to the Safe Space model. This includes considering who the staff will be that provide support to guests within the Safe Space, as well as the systems and processes that support these staff.

Considerations for the staffing mix within a Safe Space include the nature of someone's lived experience, the values and attributes they hold, as well as their cultural diversity. It was identified consistently that Safe Space roles should be filled by suicide prevention peer workers who:

- have their own direct lived experience of suicidal crisis and/or attempt
- are comfortable to share their lived experience purposefully in a peer work approach
- have a deep understanding of local services and community supports
- are authentic and approachable
- dress casually but are still identifiable within the Safe Space
- work in a team-based environment

The workforce should aim to reflect the diversity of guests who attend the Safe Space. This includes representation of staff from culturally diverse backgrounds, First Nations people, LGBTIQ+ communities and young people. This not only creates cultural safety and meaningful connection for guests, but also contributes to a more diverse and inclusive working environment that enables matching peer workers with guests. Diversity was also identified as including Suicide Prevention Carer Peer Workers who have a lived experience of supporting a loved one through crisis to offer peer support specifically for carers who attend the Safe Space.

An adequate level of staffing to ensure coverage across operating hours and avoid burnout or fatigue within the workforce was also identified as an important factor.

Considerations relating to workforce development and support include the initial and ongoing training provided to or required by staff, along with the supervision and support made available to staff to help strengthen their capability and to maintain their own wellbeing over time. This includes:

- completion of a certain level of training by peer workers, particularly areas such as:
- trauma-informed practice
- cultural capability
- peer worker training (including specific focus on the suicide prevention context)
- effective management role to develop systems and supervise staff
- strong relationships between SP peer workers and clinicians that enable connection of a guest to clinical support if they request it
- meaningful collaboration between peer workers and clinicians, outside of the safe space
- opportunities for supervision, debriefing, individual mentoring and group co-reflection
- mentoring and networking with suicide prevention peer workers in other services/areas

COMPONENT 4: A safe and accessible location

Selecting the right location is critical in ensuring the safety and accessibility of a Safe Space for members of the community who may attend the Safe Space or promote it to others.

Location includes the physical building or venue itself, as well as other factors such as geographical location and proximity to other services, opening days/hours, and historical context of the building or site in how it has been used previously. These factors may present as barriers (real or perceived) to how safe or accessible the location is for various guests or may present as supporting factors that create safety and make it more accessible. Discrete access was highlighted as particularly important for confidentiality reasons.

People with lived experience of suicide and health professionals commonly described the ideal location of a Safe Space as:

- a building that resembles a regular home, cafe or lounge
- located off hospital grounds, but in close proximity to an emergency department and/or other services
- a permanent space, rather than a temporary or makeshift structure
- centrally located and easily accessed within a community (e.g. parking, public transport)
- safe to access at all times of day
- accessible for people of all abilities

The importance of selecting a location that prevents re-traumatisation of people who may have had negative experiences of professional services in the past was commonly identified. The principle of selecting a location that was non-clinical in nature and different from traditional health service environments was important, while some more specific examples of locations that were not appropriate for a Safe Space were sites that are known in communities as being associated with involuntary treatment of people in suicidal crisis or experiencing mental health issues (such as existing mental health service premises).

While the constraints of any service were acknowledged, it was commonly noted that the aspiration was for a Safe Space that was always open (i.e. 24 hours a day, 7days a week) or had as much coverage as possible. Where this wasn't possible, it was recommended that opening hours reflected the best availability when other services and supports were less likely to be accessible, such as in the evenings or on weekends. Many people acknowledged that the nature of suicidal crises are not always aligned to a particular time of day. Guests can stay for as little or as long as they wish within the opening times of the Safe Space.

It was also noted that for the many people for who their distress and/or suicidal crisis is not related to mental illness, accessing mental health services during the day is not considered an option, and therefore the Safe Spaces needed to be open during regular hours to accommodate this cohort of people.

COMPONENT 5: A warm and welcome environment

A warm and welcoming physical environment within a Safe Space is fundamental to the experience of guests.

This relates to the configuration and layout of the physical environment, aesthetic and sensory experiences, facilities and amenities, and the inclusiveness of the environment to people from diverse backgrounds, cultures, genders, ages and abilities.

There is a general acceptance amongst people with lived experience of suicide and health professionals that the physical environment of a Safe Space should comprise a mix of private and open spaces. This enables guests to find an environment that meets their needs, which may change during their time within the space.

The ideal environment is immediately welcoming upon entry, without the need to enter via a reception area or complete any paperwork, and no barriers that exist between staff and guests.

Private spaces enable guests to have private conversations with a peer worker, or to simply rest and recuperate in a safe and comforting environment. Open spaces enable guests to connect and talk with other people (including other guests) and to engage in supportive activities in a self-directed way. The flexibility of the physical environment should also accommodate family, friends and carers in a way that aligns with the guest's wishes. Outdoor spaces are important for those wishing to connect with nature, those seeking fresh air, and others wishing to have a cigarette.

Supportive activities will vary from guest to guest depending on their needs and what they find helpful in managing their distress. Some guests will have a

well-developed sense of activities or strategies that help to manage their distress, while other guests may want to learn about and try new strategies. Supportive activities may aim to support a person's emotional, information, practical or sensory needs, and are outlined in more detail under component 5 below. The physical environment needed to support these needs includes:

- lounges and comfortable furniture, arranged in a variety of seating combinations
- food, water and tea/coffee
- soft lighting, calm music, warm colours and decor/imagery
- bathrooms (including shower)
- outdoor areas with plants and greenery
- designated smoking area
- access to WiFi, computers and phone chargers
- sensory objects and/or sensory modulation spaces
- visibly safe and inclusive environment for First Nations people, culturally diverse communities and LGBTIQ+ people
- provision for young children who may visit the safe space with an adult in distress

COMPONENT 6: Warm connections to other appropriate and reliable supports

A key component of a Safe Space commonly identified by people with lived experience of suicide and health professionals is connecting guests to other services and supports within their community relevant to their needs, and providing follow-up upon leaving the space. This recognises the principle that a Safe Space is available for people to take their time and attend as often as they need, while also being a source of appropriate and reliable support.

The focus on onward connection and follow-up starts within the space, working with the guest to develop a plan for what to do next. Suicide prevention peer workers can connect guests with relevant services and supports that may involve:

- connecting back with family, friends and other social supports
- addressing stressors and underlying causes of distress
- meeting material needs (e.g. financial, legal, housing, relationships, employment)
- suggestions on 'next step' supports, which may involve connecting guests with a range of supports addressing relationship, housing, financial needs or to clinical or acute services, such as the hospital ED, should they wish to do so
- support or advice for carers, friends and family

Staff within the Safe Space will have strong relationships and networks with services across the local community, enabling them to understand what might help to meet a person's needs and to connect them effectively.

The importance of supporting a guest experiencing significant levels of distress and helping them to remain safe, while maintaining the principles of risk tolerance and choice and control for guests was generally recognised by people with lived experience and health professionals.

People with lived experience of suicide and health professionals identified the importance of a Safe Space offering each guest an opportunity to follow up with them in the days following a visit to the space, as well as emphasising the ability to attend as much as needed as a supportive strategy in times of distress.

COMPONENT 7: Shared governance and management

The final component of a Safe Space model is governing the service jointly with people with lived experience of suicide. It also involves managing the space in a way that ensures the safety, quality and effectiveness of the support provided, while honouring the values and principles identified by people with lived experience.

Key areas of governance and management of a Safe Space identified include:

- maintaining the commitment to a non-clinical approach to the Safe Space while integrating with existing clinical and operational governance mechanisms of the organisation or system if the Safe Space sits within one
- documented policies and procedures that support Safe Space staff to work consistently
- governance and oversight mechanisms (e.g. steering groups) that involve generoud and

appropriate representation from people with lived experience

- systems and processes relating to informed consent of collecting personal information from guests, while maintaining privacy and confidentiality. Personal information is only to be collected for the purpose of further supporting the guest.
- determining critical incident or emergency processes (e.g. duress alarms) that align with the values and principles of the Safe Space
- capturing voluntary feedback from guests about their experiences and outcomes of using the Safe Space in a meaningful and appropriate way
- ensuring the safety of children and young people within the Safe Space, while applying the 'no wrong door' approach

People with lived experience and health professionals consistently identified that governance and management systems and protocols should be developed locally with the organisation responsible for delivering the service, and aligned to overarching organisational policies where appropriate and while honouring the values and principles of a safe space.

Where there is inconsistency or incompatibility between the principles or priority components of a Safe Space model with organisational policies or procedures, joint decisions can be facilitated through the exploration of hypothetical scenarios that aim to consider key issues from various perspectives. The findings from a set of common hypothetical scenarios explored with people with lived experience and health professionals are outlined in the following section.

Key outcomes of a Safe Space

Aims and objectives

The overall aim of a Safe Space is to provide a peer-led alternative to a hospital emergency department (ED) for people experiencing emotional distress and suicidal crisis.

For the findings presented in this report that were primarily captured as part of the co-design of Safe Space services funded by the NSW Government as part of the Towards Zero Suicide Initiative, these objectives were to:

- reduce deaths by suicide, suicide attempts and self-harm
- provide immediate, person-centred and compassionate care to people at risk of suicide
- connect people to support services to address the underlying factors contributing to their distress when they wish to be
- reduce pressure on emergency departments and provide a genuine alternative to traditional clinical services

While an emerging evidence base shows the positive impact of Safe Spaces, the specific outcomes that a Safe Space aims to achieve should be:

- meaningful, as defined by the people a Safe Space aims to support
- relevant, to local community needs and aspirations, and program/policy context

Therefore, the outcomes of a Safe Space should be determined and agreed collaboratively with people using these services through effective co-design.

Scenarios

The following scenarios describe the outcomes of a Safe Space in responding to situations and circumstances that might be expected to emerge, based on the insight and expertise shared by people with lived experience of suicide and health professionals in co-design.

Facilitation of these scenarios aimed to explore how the values, principles and components of the Safe Space would be reflected in the experience of a hypothetical guest visiting the space under circumstances that can be reasonably generalised.

A set of five scenarios were used consistently throughout each co-design process. While some local variation was observed, there was generally alignment within and across local communities in how a Safe Space would respond to each scenario, with these common points described below.

SCENARIO 1: Chantelle

The purpose of this scenario is to explore:

- how people aged under 18 will be supported when seeking help through a Safe Space
- how a Safe Space will manage supporting guests within organisational constraints such as limited opening hours
- what the scope and nature of support is to guests beyond direct support within a Safe Space.

Responding to Chantelle's scenario: Co-design participants generally agreed that the following approaches were important in responding effectively to what Chantelle might need in this scenario:

Providing non-clinical support to someone seeking help for the first time

- Ensure Chantelle's initial experience is a positive one, recognising that the first time Chantelle is accessing support is a critical moment
- Match a peer worker with Chantelle around her age, gender and culture where possible
- Recognise that a Safe Space with well-trained suicide prevention peer workers can make a difference in a short space of time
- Provide space for Chantelle to talk with a peer worker about what she is experiencing and underlying cause of her distress
- Explore what family, friend and other support networks Chantelle has outside of formal services — connecting with these natural supports with Chantelle's wishes
- Develop a plan to stay safe, together with Chantelle, in a conversational and non-clinical way
- Offer information and education around what other services and supports might be relevant

Meeting the needs of a young person aged under 18 years

- A 'no wrong door' approach means that Chantelle is welcomed into the Safe Space — her age is not a barrier
- Additional considerations for ensuring Chantelle's safety, obtaining informed consent and/or connecting with other age-appropriate services might exist if Chantelle was aged under 16 years
- All peer workers should be knowledgeable in working with children and young people, with diversity in the age of the workforce providing opportunities for matching young people with younger peer workers
- If a peer worker is required to contact Chantelle's caregiver, Chantelle should have choice and control over how that is done

SCENARIO 1: Chantelle (continued)

The purpose of this scenario is to explore:

- how people aged under 18 will be supported when seeking help through a Safe Space
- how a Safe Space will manage supporting guests within organisational constraints such as limited opening hours
- what the scope and nature of support is to guests beyond direct support within a Safe Space.

Responding to Chantelle's scenario: Co-design participants generally agreed that the following approaches were important in responding effectively to what Chantelle might need in this scenario:

Supporting someone seeking help nearing closing time or outside of opening hours

- If the safe space must have a closing time, this should be determined by local needs. Latest time of entry should be advertised with information on other 'after hours' supports available
- Roster peer workers for a minimum of one hour after closing time such that guests who arrive close to closing time are not hurried to leave
- Be upfront with guests about closing times to set expectations about what can be provided
- Work together with Chantelle on a plan for what to do next, which might mean Chantelle coming back the next day
- Peer worker to follow up with Chantelle via phone or text
- Processes for 'closing time' that balance flexibility to meet the needs of guests still in the Safe Space while protecting peer workers with defined finish times and/or remunerated overtime.
- Not directing Chantelle straight to ED because it's the only service open at that time — build relationships with other services that might be available after hours
- Should Chantelle wish to go to the ED, the Safe Space can inform the ED that she is coming, advocate for her and assist her in getting to the ED

SCENARIO 2: Leanne

The purpose of Leanne's scenario is to explore:

- how a Safe Space will work with guests who appear to be intoxicated
- how a Safe Space will work with guests whose distress may express itself as aggression
- ways the peer workers will manage the competing needs of guests.

Responding to Leannes's scenario: Co-design participants generally agreed that the following approaches were important in responding effectively to what Leanne might need in this scenario:

Supporting someone who attends the Safe Space regularly

- Acknowledge that previous peer worker is not available but ask about what she found trusting or helpful about that person
- Ask Leanne what brought her to the Safe Space, and what she needs to feel calm and comfortable
- Recognise that people may need to visit the Safe Space regularly — empower them to find what works for them, and encourage them to use the space as often as they need, while also working on developing other supports
- Be proactive about providing information about the principles of the Safe Space, including expectations of guests, at a suitable time during an initial visit
- Ask Leanne if she is comfortable with information about her visit being recorded to help peer workers next time she attends

Supporting someone who may be agitated or aggressive

- Avoid assumptions that Leanne is intoxicated, or that she isn't able to benefit from the Safe Space if she is intoxicated
- Apply 'no wrong door' principle to welcoming Leanne — provide opportunity for Leanne to calm and reduce agitation
- Ensure Leanne does not feel judged or stigmatised in her interactions with peer workers or other guests
- Clear guidelines for peer workers about managing guests' expectations, training in managing aggression and conflict, working as part of a team-based approach

Managing safety of all guests and staff

- Design physical layout of Safe Space with mix of private/open spaces (including outdoors) to manage sometimes competing needs of guests
- Peer workers monitor how guests are experiencing other guests around them
- Invite people to move around the various areas of the space to best suit their needs at that time — which could include talking with someone who is agitated in a private area, being outdoors or being able to walk/pace around
- Develop mechanisms for peer workers to obtain additional support and respond to any incidents

SCENARIO 3: Jason

The purpose of Jason's scenario is to explore:

- how a Safe Space will support carers/natural supports of people in crisis
- how to identify and honour the wishes of the guest regarding the role of their carers/natural in their crisis support
- what other potential supports could be offered to carers/natural supports.

Responding to Jason's scenario: Co-design participants generally agreed that the following approaches were important in responding effectively to what Jason might need in this scenario:

Understanding the needs of Jason and honouring his wishes

- Warmly greet Jason, make him feel comfortable and sensitively enquire what brought him to the Safe Space
- Recognise it may take some time for Jason to share
- Prioritise Jason's wellbeing, confidentiality and 'choice and control' for how his sister is involved
- Provide consistent support and communication to Jason during his time within the space, acknowledging his needs might change over this time
- Recognise presence of family member could be positive but may also make situation difficult if related to Jason's distress
- Ensure peer workers are knowledgeable about and sensitive to issues around family violence and coercive control

Supporting Jason's sister as a carer or natural support person

- Recognise importance of including and involving Jason's sister in a way that respects his wishes, and explaining this to her
- Work as a team with a second peer worker to talk with Jason's sister to share roles and maintain confidentiality
- Provide relevant information to Jason's sister about what he is experiencing and what role a natural support person can provide after leaving the Safe Space
- Offer Jason's sister the opportunity to rest and feel comfortable within the Safe Space
- Connect Jason's sister with relevant carer/family support networks or services to provide own type of peer support and prevent burnout.

SCENARIO 4: David

The purpose of David's scenario is to explore:

- how a Safe Space approaches the support of guests who have been identified as having a 'serious mental illness'
- how a Safe Space supports guests who identify as experiencing suicidal distress as a direct result of what clinicians would understand as 'symptoms' associated with 'psychosis'
- what non-clinical support looks like in the context of supporting guests with a diagnosis of 'serious mental illness'.

Responding to David's scenario: Co-design participants generally agreed that the following approaches were important in responding effectively to what David might need in this scenario:

Welcoming David and making him comfortable

- Build rapport with David and allow him to tell his story
- Offer compassion and empathy without judgement
- Provide support in same way as someone else — able to enjoy others' company, tell his story, feel comfortable and safe
- Provide a range of sensory opportunities that might work for David in lowering his distress (e.g. talk with a peer worker or other guest, distraction activities, physical comfort)
- Be mindful of anything in the environment that might make David feel uncomfortable
- Give David the time he needs within the space, with a peer worker available and regularly checking back

Focusing on David's emotions and suicidal thoughts, not the mental illness

- Acknowledge the purpose of the Safe Space is to focus on suicidal distress
- Validate the emotions that David is experiencing as real without disputing what he has experienced
- Sensitively enquire with David about what other supports he might be linked with and how they are working
- Take a strengths-based approach and identify what strategies David has found helpful
- Avoid assumptions that the Safe Space can't be of benefit to David because of his mental illness
- Provide training for peer workers to confidently support David while working within scope of peer work

Connecting David with other appropriate and ongoing supports

- Recognise that David was connected by a clinical service, so may not benefit from connection with additional clinical supports
- Enquire with David if he is comfortable for the peer worker to inform his clinical worker that he came to the Safe Space
- If David's distress increases and he is not able to safely return home, work with him to identify other support options, which may include a clinical service
- Ensure other services understand the role of the Safe Space and provide correct information to people they are supporting

SCENARIO 5: Amanda

The purpose of Amanda's scenario is to explore:

- how a Safe Space will respond to guests who are characterised as at imminent risk of suicide
- how peer workers will support guests who are highly suicidal to ensure their safety
- what peer workers will need to support guests who are highly suicidal in an effective way.

Responding to Amanda's scenario: Co-design participants generally agreed that the following approaches were important in responding effectively to what Amanda might need in this scenario:

Offering non-clinical support as a genuine alternative to attending a hospital ED

- Recognise that Amanda coming to the Safe Space is a positive decision and that she has come to the right place
- Introduce peer support, acknowledging that clinical supports haven't worked for her in the past
- Welcome Amanda, make her feel comfortable and safe, listen and provide space to discuss what she is experiencing, and provide a hopeful perspective
- Explain that peer workers are comfortable to sit with her in her distress
- Avoid any formal or perceived 'assessment' or 'triage' process upon Amanda arriving at the space
- Give Amanda time to share her experiences and if any event has occurred that is causing her distress
- Provide non-clinical support that Amanda might not have accessed before (e.g. talking with a peer worker, sensory modulation, distraction activities, physical comfort)
- Peer workers to access pre-determined pathways to obtain advice or phone support from other professionals (e.g. clinical staff; emergency services) where requested — relationships needed between Safe Space staff, ED clinicians and emergency services
- Encourage Amanda to come back to the Safe Space as often as she needs to keep herself safe

Ensuring Amanda's safety and dignity

- Develop service guidelines and protocols to support peer workers to provide consistent response to managing safety while ensuring dignity of risk
- Have a conversation with Amanda about the nature of the means she has access to
- Involve Amanda's parents, family or friends in line with her wishes and provide information to them about how they can support
- Acknowledge that clinical support may be needed or somewhere with 24-hour support available if Amanda feels she is not able to keep herself safe upon leaving
- Recognise potential negative impact of connecting Amanda with ED or emergency services due to previous experience
- Peer worker may be able to re-frame experience of accessing clinical supports and restore trust as a suitable option if safe space has strong connection to a reliable, person centred clinical support option
- Warmly connect Amanda with and/or accompany her to clinical support if it's determined together with Amanda that clinical support might be more appropriate for her — ideally through a pathway that doesn't require Amanda to re-tell her story and/or wait in a hospital ED.

SCENARIO 5: Amanda (continued)

The purpose of Amanda's scenario is to explore:

- how a Safe Space will respond to guests who are characterised as at imminent risk of suicide
- how peer workers will support guests who are highly suicidal to ensure their safety
- what peer workers will need to support guests who are highly suicidal in an effective way.

Responding to Amanda's scenario: Co-design participants generally agreed that the following approaches were important in responding effectively to what Amanda might need in this scenario:

Supporting the peer workforce

- Ensure peer workers have required knowledge and training in active listening and knowing how/ when to share their own experience
- Provide regular, structured support for peer workers to prevent distress and vicarious trauma associated with nature of work

Areas for further exploration

The findings presented above present an initial summary of the insights captured through co-design activities completed over an approximate 18-month period with 500+ people with lived experience of suicide and other stakeholders including health professionals. As with any co-design process, these findings represent only a snapshot in time, are limited to the perspectives of participants and are influenced by the constraints of programs and funding that these co-design processes relate to.

Several key areas requiring deeper exploration, refinement and reflection emerged throughout these co-design processes. These included:

- finding appropriate opportunities for volunteers alongside paid suicide prevention peer work roles
- connection pathways to 'clinical' supports, including emergency departments
- culturally appropriate support and environments to meet the diverse needs of communities
- the role of carers and supporters within the Safe Space
- staying true to the principles of a 'no wrong door' approach and being risk tolerant while maintaining the safety of staff and other guests
- collecting meaningful data to offer continuity and evaluate outcomes while maintaining a guest's right to privacy and/or desire for anonymity.

Importantly, co-design participants generally agreed that these areas can be explored through ongoing and iterative co-design as services are established, and through monitoring and evaluation that is led by people with lived experience of suicide and includes the direct feedback from guests of the services and the suicide prevention peer workers working to support them.

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