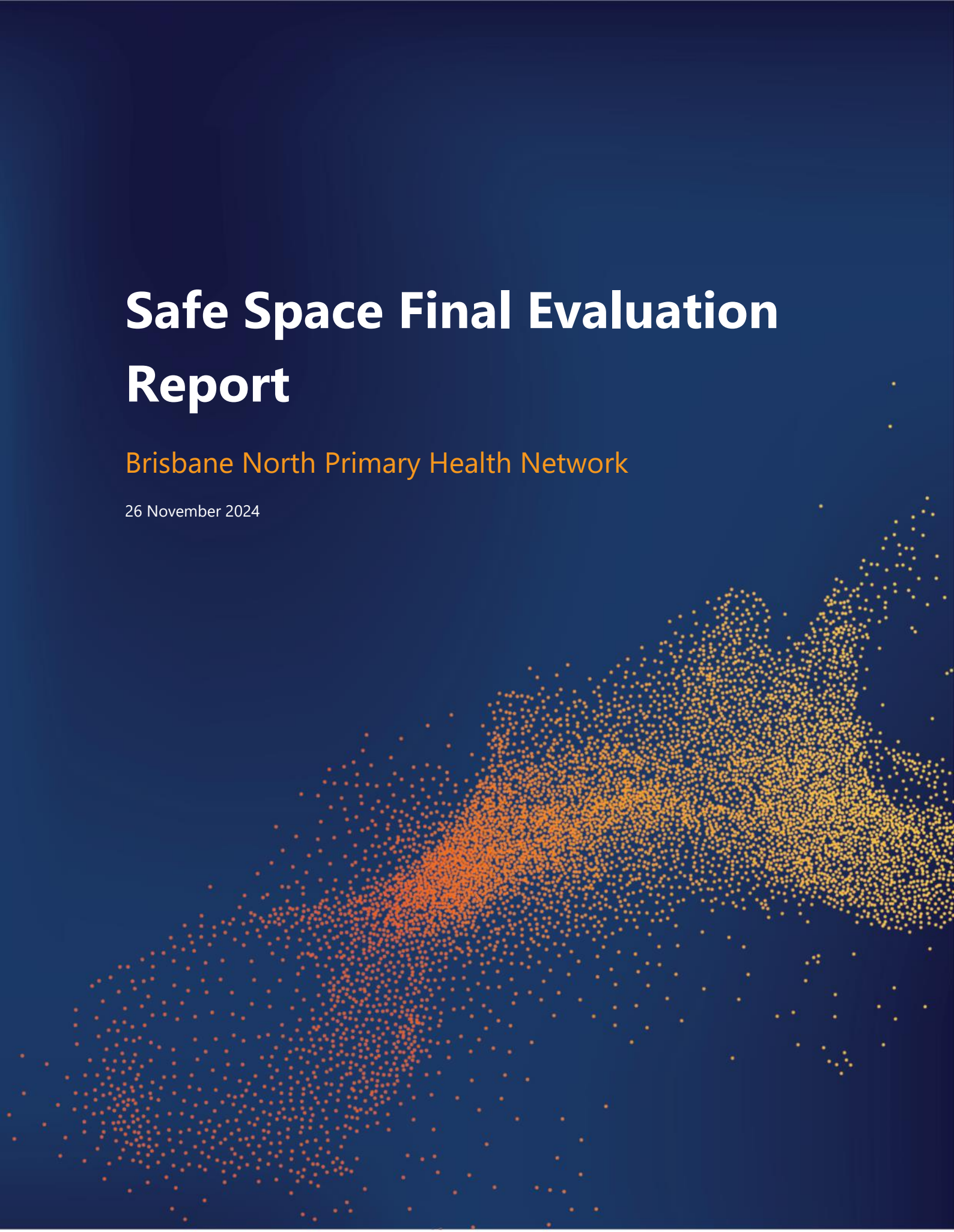
Safe Space Final Evaluation Report

Brisbane North Primary Health Network

26 November 2024



nous

Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

Contents

Glossary

Abbreviations

Abbreviation	Definition
ASIST	Applied Suicide Intervention Skills
CALD	Culturally and linguistically diverse
CBT	Cognitive Behavioural Therapy
CCHP	Commonwealth Government's Community Hospital and Health Program
CI	Confidence interval
CSU	Crisis Stabilisation Units
DBT	Dialectical Behaviour Therapy
ED	Emergency Department
GP	General practitioner
KLEs	Key Lines of Enquiry
LGBTQIA+	Lesbian, gay, bisexual, transgender, intersex, queer or questioning, and asexual (and other identities not included within the acronym)
MMHC	Medicare Mental Health Centre
PCYC	Police Citizens Youth Clubs
PHN	Primary Health Network
PiR	Partners in Recovery
PTSD	Post-traumatic stress disorder
QALY	Quality-adjusted life years
QPR	Question Persuade Refer
SUDS	Subjective Units of Distress Scale

Key terms

Term	Definition
Guest	People attending Safe Spaces are referred to as 'guests'
Contact	A 'contact' refers to any contact a person (e.g. a guest, their family member, friend or carer, or another service provider) has with a Safe Space, in-person or otherwise.

Term	Definition
Visit	A 'visit' refers to a contact in which a guest was physically accessed the Safe Space. Note that a guest can have multiple visits.
Compassionate Village	A group of interconnected organisations/businesses/people who offer support to vulnerable and distressed members of the community as either the primary or incidental function of their work. They include organisations that have made a commitment to participating in mutual investment in each other and the community by participating in educational workshops and offering resources they may have available to other members to support people in distress.
Community place	Any business, organisation, or community-led social group within the surrounding suburbs of each Safe Space that offer support to people in distress either as incidental to their usual function (e.g. library, cafe, salon, chemist etc.) or as part of the primary function (Safe Space or other support services).

1 Executive Summary

In July 2021, Brisbane North PHN received grant funding from the Commonwealth Government's Community Hospital and Health Program (CCHP) to design and pilot the Safe Space program as an after-hours, peer-led alternative to Emergency Departments (EDs) for people in distress. Following a co-design process, four Safe Spaces opened in April–August 2022 across Brisbane and Moreton Bay, supported by Compassionate Villages—networks of other places within the community facilitating better community responses to distress and referral pathways.

1.1 About the evaluation

Brisbane North PHN engaged Nous Group to evaluate Safe Spaces' design, effectiveness, and sustainability from 2022 to 2024. The evaluation used a mixed-methods approach (program data, surveys, interviews) to assess the design, implementation, effectiveness, and sustainability of the Safe Spaces model. This aimed to build the evidence base for Safe Spaces, identify what works and to identify key insights for future policy, funding, and program development, especially considering the upcoming Medicare Mental Health Centres (MMHCs).

Brisbane North PHN is currently in the process of commissioning MMHCs, which are designed to expand access to clinical mental health services by offering structured, diagnosis-driven support in a clinical setting. One of the functions of MMHCs is to provide walk-in crisis supports to those requiring urgent mental health assistance as an alternative to ED. However, the MMHC service model indicates that PHNs have the flexibility to adjust any service offering to ensure MMHC are complementing and not duplicating existing services in the region.

1.2 Key findings

Suitable after-hours alternatives to strained EDs are needed to support people in distress

EDs are often not suitable environments to support people in distress. While they remain an essential option for individuals requiring urgent medical attention—particularly when someone is harmed or there are serious concerns about their physical wellbeing—EDs are generally not equipped to support de-escalation or address the underlying causes of mental distress. Designed for acute medical emergencies, EDs are overstimulating environments lacking the calm, privacy, and time required to appropriately support people in emotional crises. People in distress frequently face longer wait times, inadequate or inappropriate treatment (including restrictive practices) and stigmatising interactions which can worsen their condition. This experience often retraumatises individuals, worsens their distress and leaves the root causes of their distress unresolved, leading to cycles of crisis and re-presentation and creating barriers to future health seeking. Mental health ED presentations exacerbate the strain on already overloaded EDs, which have experienced longer waiting times and increasing ambulance ramping issues.

In many parts of Australia, EDs are the only place people experiencing distress can receive in-person support after hours. Most mental health supports require an appointment, have out of pocket costs and/or are often not available after hours including private psychologists, general practitioners, psychosocial supports and other community-based services such as Headspace While mental health support and crisis helplines are available after hours as an initial point of contact, phone-based supports are limited in their ability to support people to de-escalate by not being able to provide a calming environment and sensory regulation activities and they typically refer people to ED if they disclose thoughts of self-harm. In some parts of the country crisis stabilisation units have been introduced which provide a calming environment for people experiencing acute mental health crisis; these require a referral and are led by clinicians. This

leaves a gap in after hour supports for people who need more support than a phone line can provide but do not meet the threshold for admission to a crisis stabilisation unit.

Safe Spaces are accessible, reaching cohorts underserved by existing services

The Safe Spaces have demonstrated significant reach, having supported nearly 2,500 individuals across a wide range of demographics and backgrounds between April 2022 and September 2024. Safe Spaces were particularly effective at reaching cohorts who are underserved by existing services including First Nations and LGBTQIA+ communities, people who have had negative or traumatic experiences with clinical services, people experiencing homelessness and financial insecurity, people who do not have a diagnosed mental health condition and people who feel stigma around mental health. The key factors which made the Safe Spaces accessible were:

- the ability to walk-in without an appointment
- their non-clinical nature and marketing, including their physical separation from clinical services
- their after-hours availability
- the convenient locations in communities near public transport and the transport services offered by some spaces and
- the inclusive, welcoming and non-judgemental approach from staff.

Safe Spaces are appropriate and effective at supporting guests to create safety, reduce distress, address the root causes of their distress across the stepped care continuum

Safe Spaces have proven effective in both reducing immediate distress with 86 per cent of guests reporting reductions in their distress levels after visiting Safe Space and 12 per cent of guests reporting no change in their distress levels and only 2 per cent showing increases in distress. The small number of guests who experienced heightened distress had a significantly lower median distress levels upon arrival, which could explain their subsequent increase in anxiety. Staff noted that these rises in distress were often tied to the need to leave Safe Spaces, which had become an important source of support for them.

Safe Spaces have supported guests to address the root causes of their distress by: i) equipping guests with the skills, confidence and self-efficacy to address challenges in their life and to unlearn harmful, internalised stigmas; ii) by providing holistic supports considering broader social, emotional and tangible needs to deliver practical solutions to the issues that were most important to guests like housing and employment; and iii) by providing a sense of connection, belonging and hope through relationship building with both peer workers and other guests – group sessions allow guests to support each other and learn how to reframe their own experience to help others.

Safe Spaces have played a key role in suicide prevention for many guests, who attribute the Safe Spaces with saving their lives and keeping them safe. Safe Spaces have supported the development of practical and effective safety plans for guests and attending Safe Spaces is a critical feature of many guests' safety plans. Disruptions to the delivery of Safe Spaces would create considerable safety risks for many guests.

Safe Spaces provide complementary supports to clinical services, filling a gap in supports

Safe Spaces have provided complementary care to existing clinical options. Some guests utilise Safe Spaces exclusively, finding them to be more effective than traditional clinical services or unable to access those services due to financial hardship, restrictive eligibility criteria, or challenges in attending during business hours. Other guests use Safe Spaces in conjunction with clinical services, appreciating the immediate, accessible support provided between appointments. This gap-filling role allows them to maintain stability and avoid crises when clinical support is unavailable.

For all guests, Safe Spaces were complimentary to traditional clinical supports due the unique non-clinical nature of the supports offered at Safe Spaces—characterised by social connection, hope, resilience, and empowerment and the holistic and flexible approach to supports. This helped guests make broader improvements in their life, not just their mental health symptoms.

The non-clinical approach is critical to the success of the model

The success of the Safe Spaces model is rooted in its non-clinical approach, where peer workers engage guests through empathetic, empowering, and non-hierarchical relationships. First, the mutual understanding based on shared lived experience fosters a unique connection; over 80 per cent of guests felt that staff genuinely "got" their situation. This made guests more receptive to support and reduced feeling of isolation and loneliness, which are key drivers of distress. Second, the strengths-based approach focuses on each guest's abilities rather than challenges, creating an environment that values personal growth and resilience. This improved guests' self-efficacy and confidence to enact often difficult changes required to improve their lives. Third, Safe Spaces offer guests flexibility, allowing them to choose from a range of holistic support options that best address their needs, from informal conversations to practical assistance with housing or employment. This choice empowers guests to take control of their own recovery, practicing decision-making skills to address the root causes of their distress—an essential step for creating sustainable, positive changes in their lives. Fourth, the unhurried, welcoming atmosphere lets guests take their time in processing emotions, which contributes to a comforting, effective setting for reducing distress and encouraging long-term solutions.

Safe Spaces are cost-effective

Safe Spaces contribute positively to the broader mental health system, proving to be a high-quality, cost-effective alternative to EDs and traditional clinical services. By diverting individuals from EDs and reducing repeat presentations, Safe Spaces have helped alleviate pressures on emergency services, generating between $16.2 million and $16.3 million in estimated cost savings from avoided ED presentations and subsequent acute admissions across the life of the pilot between late April 2022 and September 2024.

Annual projections indicate that Safe Spaces could prevent approximately 895 ED presentations (95 per cent CI, 785 and 1004) translating into $9.1 million in avoided cost per year. This figure ranges from a conservative lower bound estimate of $8.0 million to an upper bound estimate of $10.3 million, reflecting the variability in the number of avoided ED presentations from Safe Space visits and the proportion of people who are admitted to hospital following an ED for a mental health reason. Operating costs for the four Safe Space sites are $3.7 million per year, leading to a net annual saving of approximately $5.4 million.

Given operating costs for all four Safe Space sites are $3.7M per year, Safe Spaces produce a net saving of $5.4 million annually (lower = $4,264,074, upper = $6,588,588). This is an underestimate of the total economic benefits of Safe Spaces as this evaluation does not have the data to calculate the economic benefits associated with improvements in productivity and quality-adjusted life years.

Safe Spaces have improved integration of supports for guests across emergency services and hospitals, other health services as well as broader community services

Safe Spaces have effectively integrated with emergency services and hospitals, creating effective and efficient referral pathways to and from the Safe Spaces. This has ensured guests have received the care they need when they were not able to be safely supported at the Safe Spaces.

Safe Spaces have actively integrated with guests' other health and mental health care provides to ensure comprehensive assistance for ongoing health issues and to promote a more integrated pathway to recovery. By actively engaging with guests to understand their existing connections with mental health

specialists, general practitioners, and community services, peer workers tailor supports to fill gaps in their existing services and facilitate effective referrals.

The Compassionate Village has strengthened referral pathways by connecting guests with other community places such as gyms, cafes, libraries and social services by creating a network of support beyond Safe Spaces. This has supported better community-based responses to distress by upskilling staff in local communities to identify and respond to distress, and by creating opportunities for grassroots collaboration to harness community resources to support people in distress. For example, libraries and op shops have established relationships to offer essentials like clothing and toiletries and some gyms and pools are being better resourced to respond to growing distress in the community and making it more accessible for homeless people who can then access shower facilities, have opportunity for exercise and increased sense of belonging in the community.

Sustainable implementation of Safe Spaces requires separation from clinical services, fit-for-purpose and accessible infrastructure, a diverse and skilled peer-led workforce supported by parallel peer and clinical governance, strong community networks and ongoing improvement

The evaluation identified eight key lessons to ensure the sustainable and successful implementation of Safe Spaces.

1. **Separation from clinical services:** Safe Spaces should operate separately to clinical services. Incorporating Safe Spaces into clinical services like MMHC would be costly and likely compromise the features that have made them successful.
    a. Safe Spaces should operate independently of clinical services to preserve their non-clinical identity including distinct branding and physical separation. Incorporating clinical association with 'mental health' would likely reduce accessibility, deterring individuals with past medical trauma, mental health stigma, or non-medical life challenges from seeking support.
    b. Incorporating Safe Spaces into clinical services like MMHC would likely compromise the features that have made them successful. Integrating Safe Spaces into a clinical setting could undermine its successful peer-led, empathetic, flexible, and relational approach which has proven critical to their success in reducing distress and empowering guests to address the root causes of distress in their life. Successfully running a Safe Space model requires not just a peer-led approach but also a supportive organisational culture that values and upholds peer leadership and governance structures where lived experience and clinical governance systems run in parallel. Cultivating this culture and governance structure takes time, dedicated effort, and ongoing commitment. This could disrupt service quality and availability, creating safety risks for guests
    c. Effectively incorporating Safe Spaces would demand costly and duplicative infrastructure and staffing changes to clinical services, resulting in minimal efficiency gains. Additionally, this would diminish the return on substantial investments already made by current providers, including capital for dedicated spaces, development of supportive organisational culture, governance structures and workforce, community recognition, and established networks with other services.
    d. Safe Spaces should operate alongside MMHCs to provide complementary peer-led support. MMHC guidelines recognise the unique value of non-clinical peer-led crisis services. By establishing clear referral pathways and protocols, Safe Spaces can effectively complement MMHCs, without duplicating efforts or compromising their distinct service models. A similar integration has already been achieved between Safe Spaces and other Mental Health Service Hubs within Brisbane North PHN – this could be expanded or duplicated to include MMHCs.
2. **Fit-for-purpose infrastructure in an accessible location:** Safe Spaces are most effective when they provide a homely, non-clinical atmosphere and are in accessible areas. Facilities need to have group

and private individual spaces as well as options for sensory activities and kitchenette facilities for food and refreshments. Having homely, calming spaces with private rooms, sensory activities, and kitchenette facilities is essential to meet immediate needs of guests (such as hunger), reduce distress and create a safe, non-threatening environment. Accessible locations are vital to ensure that individuals, especially those without access to private transport, can reach Safe Spaces easily.

3. **Staffing levels and support requirements:** Organisations need to be ready to commit to ongoing investment in peer-led workforces. Staffing levels and supports are critical to ensure the safety of guests and workers, to minimise the risk of burnout and to support retention of staff. Safe Spaces need adequate staffing levels with a pool of at least 10 peer workers per site to cover weekly shifts with paid time before and after the shift to prepare and debrief. This number of staff allows Safe Spaces to maintain safe and reliable staffing levels (at least three or four workers per shift) and avoid burnout. All staff need access to training, and supports such as supervision, mentoring, debriefing, reflective practice and access to confidential mental health supports. Adequate staffing ensures that guests consistently receive quality care, while structured support, such as debriefing and mentorship, helps sustain peer workers' well-being, vital to delivering effective, empathetic care.
4. **Diverse and skilled peer workers:** Effective recruitment for Safe Spaces should prioritise hiring peer workers with diverse backgrounds and lived experiences who can apply their lived experiences to support guests. A diverse peer workforce brings a range of perspectives and skills, enhancing guest outcomes by enabling stronger, more relatable connections. A range of lived experiences in the workforce allows Safe Spaces to address the unique challenges of guests with varying backgrounds, helping them feel understood and fostering trust, which is essential for effective support. Effective hiring processes include lived experience input and are based on a clear understanding of the practical realities of the peer worker role – reflected in position descriptions and interview processes.
5. **Parallel lived experience and clinical governance**: For the peer-led model to function effectively, Safe Spaces requires parallel lived experience and clinical governance structures. Clinical Governance is used to ensure the safety and quality of services. This is done in partnership with, and alongside continued investment and development of lived experience governance. This ensures the peer-led nature of Safe Spaces while allowing for clinical safeguards when needed.
6. **Continuous improvement through monitoring, evaluation and collaboration:** Embedding continuous improvement practices into program governance is essential for adapting the Safe Spaces model over time. This includes ongoing PHN performance management, opportunities for cross-provider collaboration and sharing of resources and a monitoring and evaluation approach characterised by minimal regular data collection supplemented with periodic in-depth mixed methods evaluations. This approach will support Safe Spaces to remain responsive to evolving community needs and enhance service quality without excessive data collection burden on guests and staff which can compromise the non-clinical nature of the service.
7. **Building strong community networks**: Compassionate Villages support collaborations with local organisations to extend resources and integrate supports for guests. The partnerships improve referral pathways and provide practical resources ultimately strengthening community responses to distress.
8. **Certainty about ongoing funding arrangements:** Clarity around funding ensures that Safe Spaces are appropriately staffed and can plan effectively. It also provides the Network Coordinator with scope to effectively plan and manage relationships with community places, an essential aspect of effectively establishing Compassionate Villages.

1.3 Recommendations

This report provides 5 recommendations which are detailed in Chapter 7. These recommendations reflect the high quality and cost effectiveness of the current services.

- Recommendation 1: Continue funding Safe Spaces as a stand-alone, peer-led service
- Recommendation 2: Provide funding certainty to the Safe Spaces and the Compassionate Villages
- Recommendation 3: Ensure adequate staffing levels and workforce supports
- Recommendation 4: Continue to strengthen community networks and referral pathways
- Recommendation 5: Develop comprehensive service guidelines and embed continuous improvement mechanisms

2 Background and context

This chapter provides the background and key motivating context for the Safe Spaces pilot program (the Pilot). Brisbane North PHN received non-recurrent grant funding from the Commonwealth Government's Community Hospital and Health Program (CCHP) in July 2021 to design and implement the Pilot. Four Safe Spaces were opened between April 2022 and May 2022 in the North Brisbane and Moreton Bay region to provide peer-led, non-clinical supports for individuals in distress after hours, offering an alternative to EDs.

Brisbane North PHN engaged Nous to deliver this evaluation over the three-year period from January 2022 to January 2025 to evaluate the design, implementation, effectiveness, and sustainability of the Pilot. The evaluation aimed to build an evidence base of the efficacy of the Safe Space model, understand what works and to support continuous improvement throughout the pilot implementation. This final evaluation report intends to provide Brisbane North PHN with insights to guide future decision-making on policy, funding, commissioning and program arrangements for Safe Spaces, including highlight the features of Safe Spaces that are important to its effectiveness in the context of the planned introduction of MMHCs in the region.

Brisbane North PHN is currently in the process of commissioning MMHCs, which are designed to expand access to clinical mental health services by offering structured, diagnosis-driven support in a clinical setting. One of the functions of MMHCs is to provide walk-in crisis supports to those requiring urgent mental health assistance as an alternative to ED. However, the MMHC service model indicates that PHNs have the flexibility to adjust any service offering to ensure MMHC are complementing and not duplicating existing services in the region.

2.1 EDs are not always appropriate for people in distress

In many parts of Australia, EDs are the only place people experiencing distress can receive in-person support after hours. Although EDs are often not the most appropriate environment for addressing the underlying causes of mental distress, they remain an essential option for individuals who require urgent medical attention, particularly where someone is harmed or there are serious concerns about their physical wellbeing. While mental health support and crisis helplines are available as an initial point of contact, phone-based supports are limited in their ability to support people to de-escalate by not being able to provide a calming environment and sensory regulation activities and they typically refer people to ED if they disclose thoughts of self-harm.[1]

Hospital EDs are complex clinical environments and not always the most appropriate environment to assist distressed individuals. EDs have four main limitations in meeting the needs of people experiencing mental distress:

- The physical environment of EDs can be overstimulating, with bright lights, noise and a lack of privacy, particularly for individuals with autism spectrum disorder.[2]
- EDs focus on stabilising people and moving them on from the ED as soon as possible and are not equipped to address the underlying drivers of distress.[3]

[1] Suicide Prevention Australia, 2019, Submission to the Royal Commission into Victoria's Mental Health System.
[2] Child and Adolescent Psychiatric Clinics of North America. Management of Agitation in Individuals with Autism Spectrum Disorders in the Emergency Department [accessed 31 Oct 2024]. Available here: https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments#characteristics
[3] Health Direct. Hospital emergency departments [accessed 31 Oct. 2024]. Available here: https://www.healthdirect.gov.au/hospital-emergency-departments#:~:text=EDs%20have%20trained%20doctors%20and,start%20your%20care%20as%20needed.

- People presenting to EDs with mental-health related conditions often wait longer than other presentations. In 2022-23, 90 per cent of ED patients were seen within 2 hours and 4 minutes[4] while 90 per cent of patients presenting with mental-health related conditions were seen within 2 hours and 26 minutes.[5]
- EDs can use restrictive practices, such as forced medication or physical restraints that can lead to psychological trauma from the incident with 10-20 per cent of trauma patients developing PTSD post-incident.[6]

People attending the ED for mental health reasons describe encountering negative attitudes and behaviours from ED staff, such as humiliation, discrimination, lack of empathy, and denial of routine care.[7,8,9] For many people, attending the ED reinforces cycles of shame, distress, and repeated self-harm.[10,11] When people do present to ED and leave without appropriate, timely and continuing support, it can increase the risk of greater acuity, recurrence of crises, escalation of distress, or disengagement from treatment and the linkages to support in the community that can help.[12] However, there is strong evidence that earlier intervention and providing connections into community-based supports is an effective way of avoiding both ED presentations and admissions.[13,14]

As a result, people presenting to the ED in mental distress can experience a 'double disadvantage' in which they can experience negative and even traumatising impacts of the ED, further compounding their distress. This can also translate to an avoidable admission to an acute ward, which can be counterproductive for the person's wellbeing. From a system perspective, this also drives higher costs and increased demand on acute inpatient services. In addition, a significant number of people who present to ED for mental health will re-present to the ED within 28 days (8 per cent) or 6 months (16 per cent).[15]

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[4] AIHW. Emergency department care (accessed 4 Nov. 2024). Available here: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

[5] AIHW. Mental health, presentations to emergency departments (accessed 4 Nov. 2024). Available here:
Australian Medical Association. *Mental health patients wait up to a day in EDs, new report finds* (accessed 4 Nov. 2024). Available here: https://www.ama.com.au/ama-rounds/1-november-2024/articles/mental-health-patients-wait-day-eds-new-report-finds#:~:text=The%20latest%20figures%20show%20the,day%2C%20before%20receiving%20a%20bed

[6] Greenwald A, Kelly A, Mathew T, Thomas L. Trauma-informed care in the emergency department: concepts and recommendations for integrating practices into emergency medicine. Medical Education Online. 2023 Dec 31;28(1):2178366.

[7] Owens C, Hansford L, Sharkey S, Ford T. Needs and fears of young people presenting at accident and emergency department following an act of self-harm: secondary analysis of qualitative data. The British Journal of Psychiatry. 2016 Mar;208(3):286-91.

[8] Banfield M, Fitzpatrick SJ, Lamb H, Giugni M, Calear AL, Stewart E, Pavloudis M, Ellen L, Sargent G, Skeat H, Edwards B. Co-creating safe spaces: Study protocol for translational research on innovative alternatives to the emergency department for people experiencing emotional distress and/or suicidal crisis. Plos one. 2022 Oct 3;17(10):e0272483.

[9] Taylor TL, Hawton K, Fortune S, Kapur N. Attitudes towards clinical services among people who self-harm: systematic review. The British Journal of Psychiatry. 2009 Feb;194(2):104-10.

[10] Pitman A, Osborn DP. Cross-cultural attitudes to help-seeking among individuals who are suicidal: New perspective for policy-makers. The British Journal of Psychiatry. 2011 Jul;199(1):8-10

[11] Owens C, Hansford L, Sharkey S, Ford T. Needs and fears of young people presenting at accident and emergency department following an act of self-harm: secondary analysis of qualitative data. The British Journal of Psychiatry. 2016 Mar;208(3):286-91.

[12] CSIRO. Improving patient care and reducing waiting times [accessed 31 Oct. 2024]. Available here: https://www.csiro.au/en/research/technology-space/data/patient-care

[13] Trépel D, Ruiz-Adame M, Cassarino M, Ahern E, Devlin C, Robinson K, O'Shaughnessy Í, McCarthy G, Corcoran C, Galvin R. The cost effectiveness of early assessment and intervention by a dedicated health and social care professional team for older adults in the emergency department compared to treatment-as-usual: Economic evaluation of the OPTI-MEND trial. PloS one. 2024 Jun 25;19(6):e0298162.

[14] O'Callaghan C. ED to Community Program: Pre-Intervention Assessment Study in Sydney Australia. International Journal of Integrated Care. 2021;22(S1):168.

[15] Chong S, Achat HM, Stubbs JM, Murphy M. Factors associated with mental health representations to the emergency department within six months. International Emergency Nursing. 2024 Aug 1;75:101480.
International Emergency Nursing.. [accessed 31 Oct. 2024]. Available here: https://www.sciencedirect.com/science/article/abs/pii/S1755599X24000752#:~:text=8%20%25%20of%20ED%20attendees%20with,day%20and%206%2Dmonth%20representations.

2.2 EDs are under strain

Australian EDs are under increasing strain with increases in waiting times and decreases in the percentage of patients seen on time

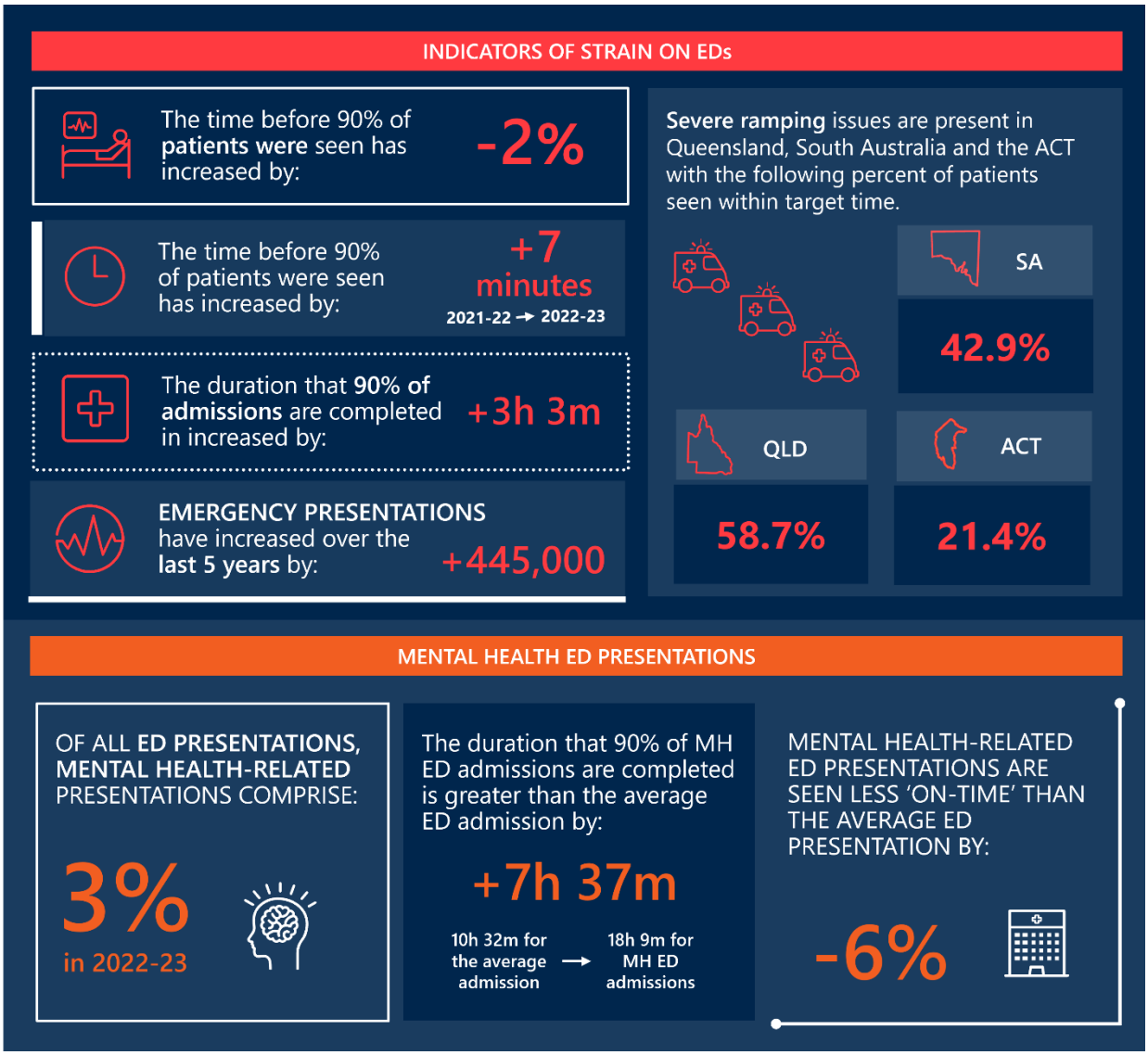
EDs are essential to Australia's health care system, providing urgent medical, surgical and other care to patients 24 hours a day. Demand for EDs is rising with ED presentations having increased by 1.3 per cent per year between 2018-19 and 2022-23.[16] EDs are struggling to meet rising demand as evidenced by increasing waiting times and reductions in proportions of people who are being seen on time for their triage category between 2018-29 and 2022-23 as shown in Figure 1.

Increases in the demand placed on EDs has exacerbated ambulance ramping issues. Ambulance ramping refers to delays in patient transfer to a hospital's ED due to, for example, availability of beds. This delay prevents the ambulance from completing its patient transfer on time, and by extension, increases the waiting times for subsequent patients. This remains a significant across Australia, with all states performing below their respective patient waiting time targets and three states deteriorating further between 2021-22 and 2022-23. Queensland, South Australia and the ACT suffer the most severe ramping issues, with 58.7, 42.9 and 21.4 per cent of patients reached within their state targets.[17]

[16] AIHW. Emergency department care activity [accessed 4 Nov. 2024]. Available here: https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed

[17] AMA. Ambulance Ramping Report Card 2023 [accessed 1 Nov. 2024]. Available here: https://www.ama.com.au/articles/2023-ambulance-ramping-report-card

Figure 1 | The state of mental illness and ED care in Australia in 2022-23[18,19]



ED are not well-equipped to handle mental illness, and these presentations exacerbate existing strain on the system

Mental health presentations add further strain on EDs across Australia. The trend in the rate of mental health ED presentations increased steadily between 2014-15 until 2019-20. Mental health ED presentations declined during the early stages of the COVID-19 pandemic between 2020-21 until 2021-22 due to changes in care patterns associated with public health restrictions and changes in care protocols to manage additional demand on hospitals.[20,21] Since the end of COVID-19 public health restrictions, mental health ED presentations have started to rebound in line with pre-pandemic trends in 2022-23 which have

[18] AIHW. Emergency department care. Available here: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

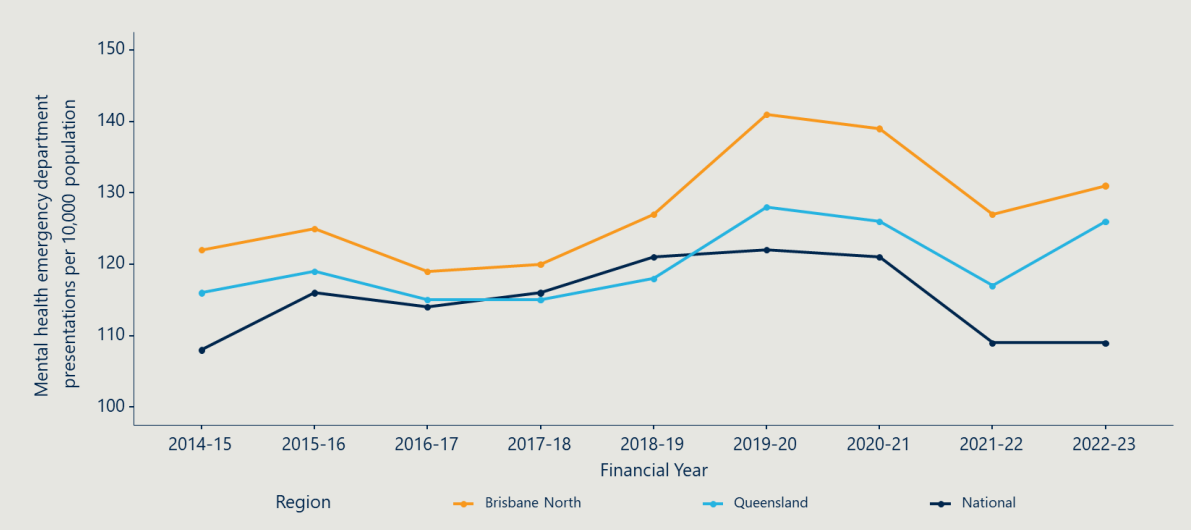
[19] AIHW. Mental Health, Presentations to emergency departments. Available here: https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments

[20] Newberry-Dupé J, Chu W, Craig S, Borschmann R, O'Reilly G, Yates P, Melvin G, King K, Hiscock H. Adult Mental Health Presentations to Emergency Departments in Victoria, Australia between January 2018 and October 2020: Changes Associated with COVID-19 Pandemic Public Health Restrictions. Psychiatric Quarterly. 2024 Mar;95(1):33-52.

[21] Sweeny AL, Keijzers G, Marshall A, Hall EJ, Ranse J, Zhang P, Grant G, Huang YL, Palipana D, Teng YD, Gerhardy B. Emergency department presentations during the COVID-19 pandemic in Queensland (to June 2021): interrupted time series analysis. Medical journal of Australia. 2023 Feb 20;218(3):120-5.

been particularly pronounced in Queensland and Brisbane North. Mental Health ED presentations also experience a longer period of treatment in the ED. While 90 per cent of all patients left EDs within 10 hours and 32 minutes across all emergency presentations, this figure was 18 hours and 9 minutes for people presenting with acute mental health crises in 2022-23.[22] The length of stay exceeded this time for 10 per cent of these mental health presentations, further worsening the mental health condition of these patients.[23]

Figure 2 | Brisbane North compared to Queensland and National total – Mental health ED presentations[24,25]



2.3 Peer-led support models have been implemented nationally and internationally to support people in distress

Peer-led models in Australia and internationally have been successfully implemented. Figure 3 contains a timeline of some similar models that have been implemented, and it demonstrates that there are different ways to implement a peer-led model. For example, some of the models are located within hospitals, others in the community and one is a mobile coffee van. Likewise, some target those with mild to moderate levels of distress while others aim to help those in suicidal distress.

These models have been successful at reducing distress and avoiding ED presentations. Key successes from these models include:

- The Safe Haven Cafés in the UK have reported reducing mental health hospital admissions by one third.[26]

[22] AIHW. Mental health. Presentations to emergency departments [accessed 4 Nov. 2024]. Available here: https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments#keypoints

[23] Mithell Institute and Victoria university. *Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments* (accessed 2 Nov. 2024). Available here: https://www.vu.edu.au/sites/default/files/nowhere-else-to-go-people-mental-illness-stuck-emergency-departments-report-mitchell-institute.pdf

[24] Nous analysis of AIHW, Mental health, State and territory ED presentations data tables (accessed 4 Nov. 2024). Available here: https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments

[25] Nous analysis of AIHW, Mental health, presentations to emergency departments (accessed 4 Nov. 2024). Available here: https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments

[26] NHS England, Safe Haven Café in Aldershot, n.d. (accessed 25 October 2024), https://www.england.nhs.uk/mental-health/case-studies/crisis-mental-health-case-studies/aldershot/

- The Living Room diverted 675 ED presentations in one year.[27]
- The Brisbane North Sensory Safe Space Pilot achieved significant decreases in distress among 120 guests, both immediately after visiting the space and by a follow-up 72 hours later. The Pilot also equipped guests with the ability to self-recognise symptoms and implement management plans.[28]
- Reduction in presentations at the St Vincent's Hospital Melbourne's ED.[29]
- 64 per cent of guests attending the Gold Coast's After-Hours Safe Space indicated that they would have gone to the ED if it did not exist.
- 98 per cent of guests at a New South Wales Safe Haven would prefer to access the Safe Haven then go to the ED when experiencing distress or suicidality.[30]

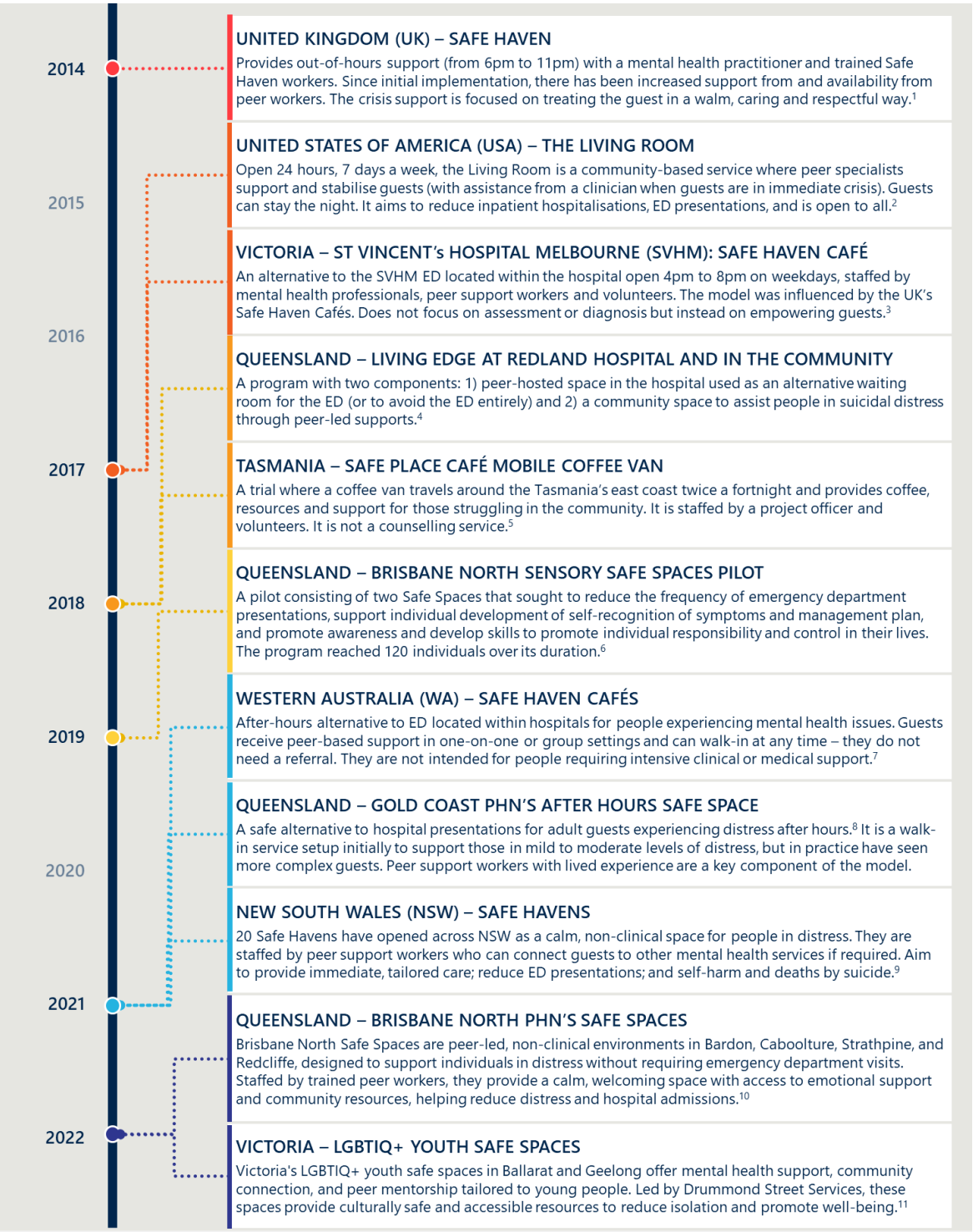
[27] Scattergood Foundation, The Living Room, n.d. (accessed 1 November 2024), https://www.scattergoodfoundation.org/award_submission/the-living-room/

[28] Metro North Hospital and Health Service. Project Post Implementation Review [Brisbane North Sensory Safe Space Pilot] (accessed 4 Nov. 2024).

[29] Safer Care Victoria, An alternative safe space for those seeking mental health support, 16 October 2020 (accessed 25 October 2024), https://www.safercare.vic.gov.au/sites/default/files/2020-12/PROJECT%20SUMMARY%20Safe%20Haven%20Cafe.docx

[30] NSW Legislative Council Portfolio Committee No. 2 – Health, Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales, 4 June 2024 (accessed 25 October 2024), https://www.parliament.nsw.gov.au/lcdocs/inquiries/2973/Report%20No.%2064%20-%20PC2%20-%20Equity.%20accessibility%20and%20appropriate%20delivery%20of%20outpatient%20and%20community%20mental%20health%20care%20in%20NSW.pdf

Figure 3 | Timeline of introduction of non-clinical, peer models similar to Safe Spaces



[1] Surrey and Borders Partnership NHS Foundation Trust, Safe Havens, (accessed 25 October 2024), https://www.sabp.nhs.uk/our-services/mental-health/safe-havens
[2] Scattergood Foundation, The Living Room, n.d. (accessed 1 November 2024), https://www.scattergoodfoundation.org/award_submission/the-living-room/
[3] Safer Care Victoria, AN ALTERNATIVE SAFE SPACE FOR THOSE SEEKING MENTAL HEALTH SUPPORT, 16 October 2020 (accessed 25 October 2024), https://www.safercare.vic.gov.au/sites/default/files/2020-12/PROJECT%20SUMMARY%20Safe%20Haven%20Cafe.docx
[4] Queensland Mental Health Commission, ED alternative: trial underway, 17 April 2019 (accessed 1 November 2024), https://www.qmhc.qld.gov.au/media-events/news/ed-alternative-trial-underway
[5] Primary Health Tasmania, Taking a Safe Place on the road in Break O'Day, 21 May 2019 (accessed 1 November 2024), https://www.primaryhealthtas.com.au/2019/05/taking-a-safe-place-on-the-road-in-break-oday/
[6] Metro North Hospital and Health Service. Project Post Implementation Review [Brisbane North Sensory Safe Space Pilot]. Available here: https://nousgroup.sharepoint.com/:b:/r/sites/TS14325/Shared%20Documents/General/E.%20Research%20and%20analysis/Project%20Post%20Implementation%20Report%20-%20Brisbane%20North%20Safe%20Space%20Pilot.pdf?csf=1&web=1&e=WGoB1z
[7] Government of Western Australia Mental Health Commission, Safe Haven Cafes, 30 January 2024 (accessed 31 October 2024), https://www.mhc.wa.gov.au/getting-help/hospital-mental-health-alcohol-and-other-drug-services/safe-haven-cafes/
[8] Gold Coast PHN, After Hours Safe Space, 30 September 2024 (accessed 25 October 2024), https://gcphn.org.au/commissionedservices/after-hours-safe-space/
[9] NSW Health, Safe Haven, 7 August 2024 (accessed 25 October 2024), https://www.health.nsw.gov.au/towardszerosuicides/Pages/safe-haven.aspx
[10] Brisbane North PHN. *Safe Spaces open across North Brisbane and Moreton Bay* (accessed 3 November 2024). Available here: https://brisbanenorthphn.org.au/news/safe-spaces-open-across-north-brisbane-and-moreton-bay
[11] VIC.GOV.AU. LGBTIQ+ youth safe spaces grant (accessed 2 November 2024). Available here: https://www.vic.gov.au/lgbtiq-youth-safe-spaces-grant

2.4 The Safe Spaces Pilot represents an opportunity to provide after-hours supports for people in distress

The need for an after-hours service to support people experiencing emotional distress emerged from the research undertaken by the Partners in Recovery (PiR) program in 2016-17 and following Safe Space trials conducted in the region in 2018-19 through Metro North Health LINK funding. Based on this trial project, Brisbane North PHN, in collaboration with local mental health services and Metro North Health, applied for and received CHHP funding to develop and implement Safe Spaces in 2019.

Brisbane North PHN partnered with Roses in the Ocean to undertake a co-design of a Safe Space model. This co-design process incorporated the voices and perspectives of those had experienced emotional distress and suicidal crisis, people who care for them, health professionals and other relevant community representatives. Four Safe Spaces were opened in each hospital catchment in Brisbane North PHN:

- **Bardon** Safe Space, ran by Communify and opened in May 2022[31]
- **Caboolture** Safe Space, ran by Stride and opened in May 2022[32]
- **Strathpine** Safe Space, ran by Neami National and opened in April 2022[33]
- **Redcliffe** Safe Space, ran by Redcliffe Youth Space and opened in August 2022.[34]

Compassionate Villages, networks of supportive community places including health and other social services, were formed around each Safe Space site to support better community responses to distress and facilitate referral pathways for people in distress.

The Safe Space model is described in further detail in Chapter 4.

[31] Private communication with Brisbane North PHN in April 2022.
[32] Ibid.
[33] Ibid.
[34] Ibid.

3 Overview of the evaluation

This chapter provides an overview of the evaluation including its aims and key evaluation questions (Chapter 3.1), key activities (Chapter 3.2), data collection and analysis approach (Chapter 3.3) and

3.1 Aims and key evaluation questions

The evaluation aimed to build an evidence base of the efficacy of the Safe Space model, understand what works and to support continuous improvement throughout the pilot implementation. This final evaluation report intends to provide Brisbane North PHN with insights to guide future decision-making on policy, funding, commissioning and program arrangements for Safe Spaces, including highlight the features of Safe Spaces that are important to its effectiveness. The key lines of enquiry that informed this evaluation are outlined below in Table 1.

Table 1 | High-level key evaluation questions and key lines of enquiry

Key lines of enquiry (KLEs)	Key evaluation questions
1. Implementation and Context *How well was the Safe Spaces program implemented and in what contexts?*	1.1 What are the similarities and differences in the models for each catchment? 1.2 How effective was the implementation of the Safe Spaces and Network? 1.3 What are enablers, barriers and lessons learned from the implementation of Safe Spaces?
2. Appropriateness and Design *To what extent was the service design and delivery for the Safe Space program appropriate?*	2.1 How appropriate is the service design and delivery given the local needs as well as the service and policy context? 2.2 To what extent does the service design and delivery support quality and safety for guests and staff in-line with evidence and best available practice in the literature? 2.3 To what extent does the service design and delivery provide an accessible and welcoming service for guests?
3. Outcomes and Impacts *What were the outcomes and impacts of the Safe Spaces program for guests, service providers and staff and the broader system?*	3.1 What were the outcomes and impact of Safe Spaces across cohorts and their contexts? 3.2 What were the outcomes and impact of Safe spaces across staff and service provider groups and their contexts? 3.3 What were the system outcomes and impacts across contexts?
4. Improvement and Sustainability *How can Safe Spaces be improved and sustained over time?*	4.1 What worked well and what could be adapted or improved? For whom and in what circumstances? 4.2 What is needed to support the ongoing sustainability of the Safe Spaces model in Brisbane North PHN?

3.2 Overview of key activities

The evaluation timeline commenced January 2022 and finished December 2024 across three stages consisting of planning, conducting the evaluation and delivering this final report. These stages and associated activities and deliverables are outlined below in Figure 4.

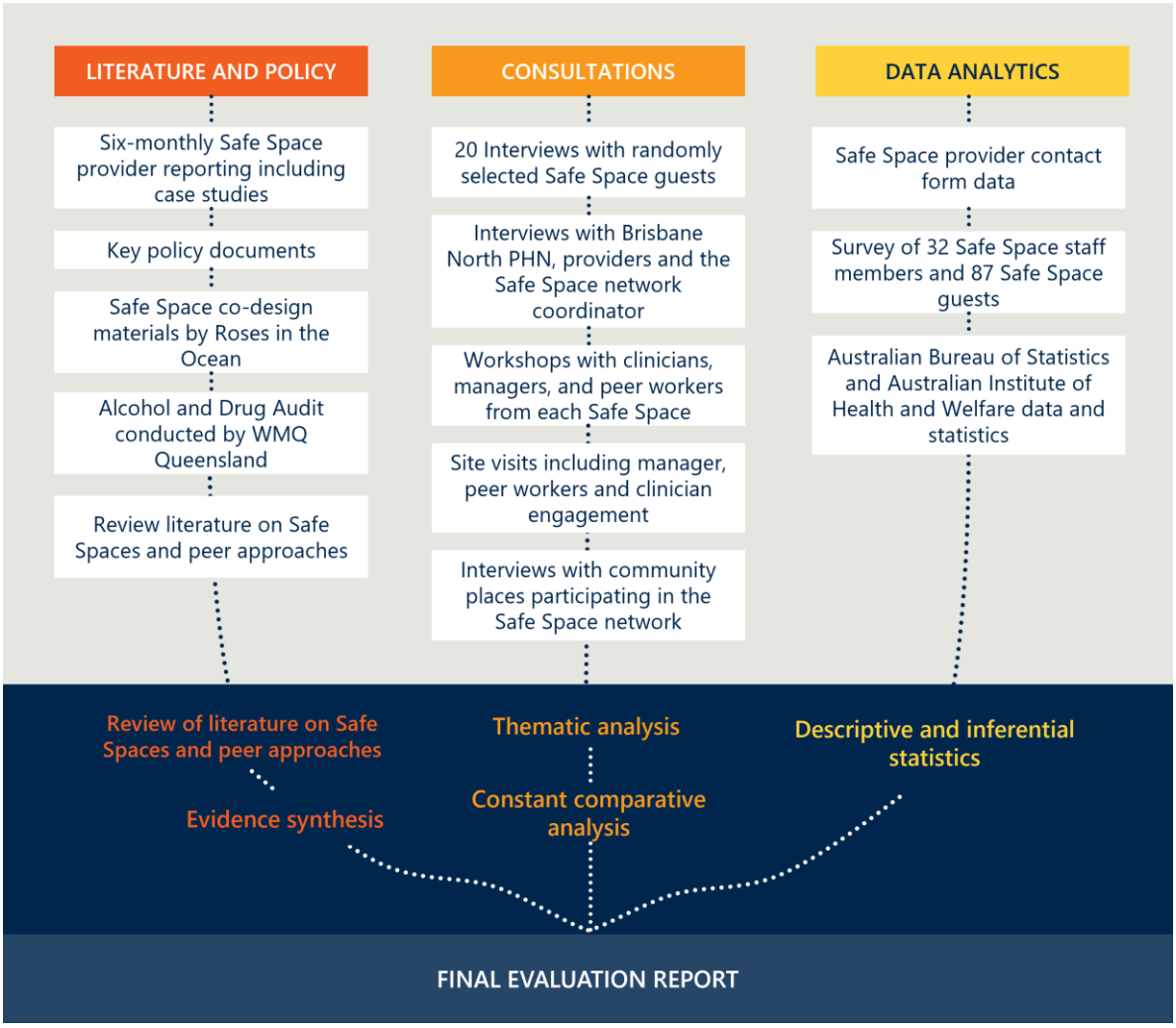
Figure 4 | Evaluation timeline and activities

STAGE 1	STAGE 2	STAGE 3
Plan and design the evaluation framework	Conduct the evaluation and build capacity	Deliver the final report
18 January – 30 September 2022	1 October 2022 – 29 February 2024	March 2024 – December 2024
DELIVERABLES		
Activity Plan (February 2022) Evaluation Framework (June 2022) Data Check (September 2022)	Progress report (March 2023) Interim Report (October 2023)	Final report (December 2024)
KEY ACTIVITIES		
Set up the project for success • Initiate project and establish engagement structures • Develop and deliver initial Activity Plan which outlines the proposed methodology, outputs, and timelines for each aspect of the evaluation • Complete desktop and literature review. **Plan for stakeholder engagement** • Develop detailed stakeholder engagement and capacity building plan, including work with the PHN and Roses in the Ocean to define engagement approach for people with lived experience • Commence ethics approval process. **Co-design the Evaluation Framework** • Conduct interviews/focus groups with key stakeholders including consumer, family and carer representatives, Brisbane North PHN staff, service providers and other stakeholders from each of the four local catchment areas to understand the program and relevant context. • Hold workshops with key stakeholders to co-design the Framework, including evaluation purpose, methodology, and data collection plan. • Draft Evaluation Framework including data collection tools. • Conduct Data Check to ensure local catchments are providing consistent data for the evaluation.	**Conduct rolling data collection, analysis and continuous improvement cycles** • Collect and analyse quantitative program data • Distribute survey and analyse data • Conduct stakeholder consultation and engagement • Engage PHN, service providers and community stakeholders in workshops to identify opportunities for continuous improvement, share key lessons and emerging insights • Deliver a Progress Report and an Interim Report to support continuous improvement.	**Engage in interviews with Safe Space coordinator and community places** • Complete interviews with the Safe Space Network Coordinator • Complete interviews with community places involved in Compassionate Village **Test and refine evaluation insights and findings** • Complete outstanding interviews and quantitative data analysis • Refresh literature review for updated evidence • Bring together findings from across stages • Test summative insights and findings with key stakeholders **Finalise report and communicate findings** • Deliver final evaluation report to inform future decision-making
---Conduct monthly progress meetings and quarterly insights and community of practice sessions---		

3.3 Data collection and analysis approach

Data for the evaluation was collected under the three streams: Literature and policy, Consultations and Data and analytics. These data have been analysed and triangulated to respond to the key lines of enquiry as illustrated in Figure 5 below. For interviews and surveys with guests, ethics approval was received from Bellberry (NMHRC code A/ EC00372 - application number 2023-06-676).

Figure 5 | Summary of data collection and analysis approach



Primary quantitative data collected through the evaluation are provided in Table 2.

Table 2 | Primary quantitative data collected through the evaluation

Data inputs	Description
Contact form data (up until September 2023)	• Administrative data collected by Safe Space providers with deidentified data on contacts, visits and guests. • Covered information such as visit details around visit time and duration, demographic information outlining the guests age, gender and various diversity identifier, and the guests experience at the Safe Space measured through the Subjective Units of Distress Scale (SUDS) distress scores gathered at the start and end of visits.

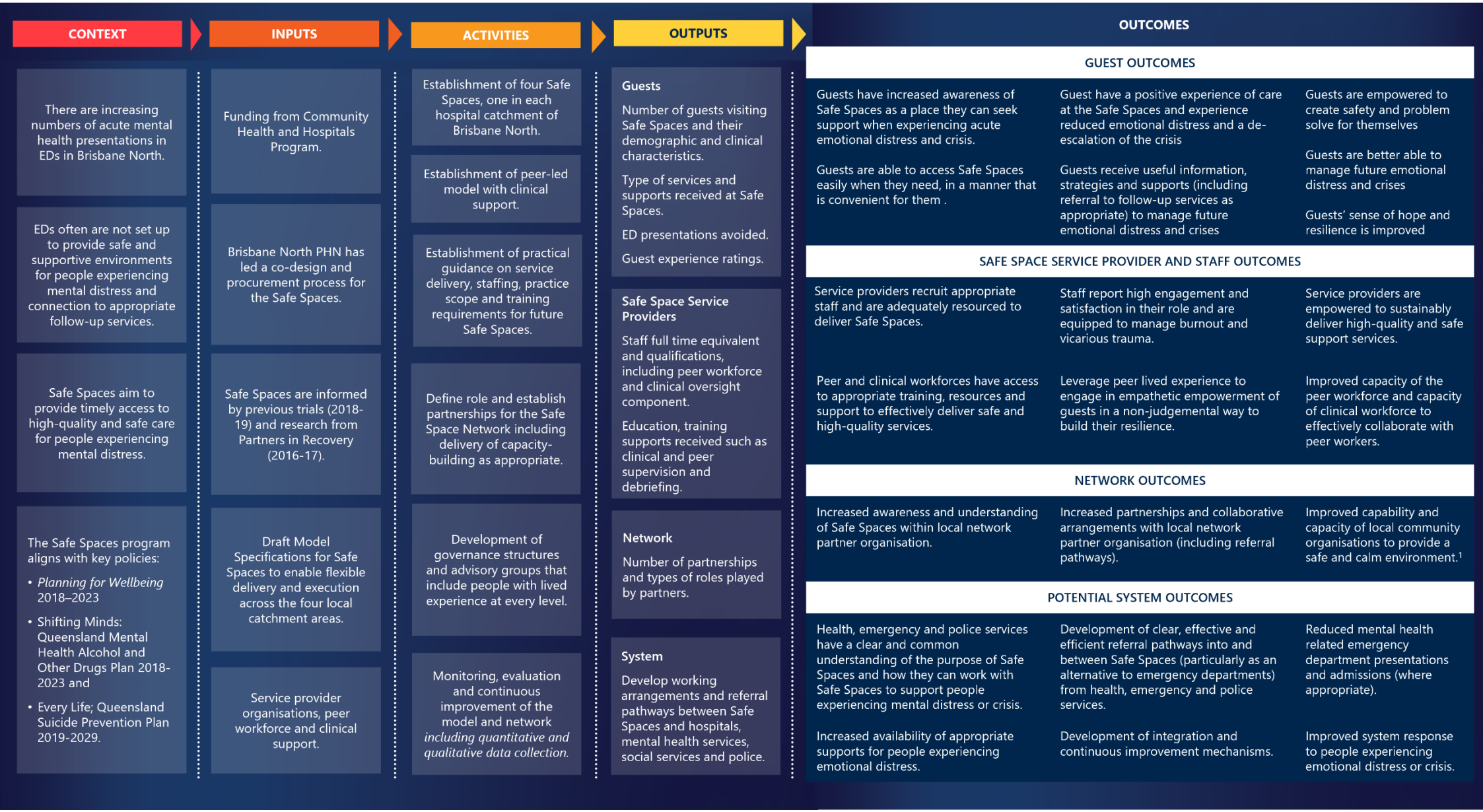
Data inputs	Description
Staff survey	• A survey of 37 peer workers, clinical staff, and managers seeking to understand their experience providing care to guests and their understanding of the effectiveness of the Spaces, along with perspectives on improvement opportunities.
Guest survey	• A semi-convenience sample of 87 Safe Space guests across sites which are representative of the number of guests across sites. A random sample of guests were selected from contact data to participate in the survey. To recruit additional guests to participate in the survey QR codes placed at Safe Spaces, staff at the Safe Space encouraged guests to participate in the survey and the primary investigator attended Safe Spaces during opening hours to support guests to fill in surveys. • The survey sought to understand guest experiences at the Safe Space to inform how the Safe Space was helping guests, if it was attracting specific cohorts and potential improvement opportunities.

3.4 Program logic

A theory of change describes, at a high level, how program activities will lead to intended outcomes. In the case of the Safe Space pilot Program, the theory of change is that peer-support and community-centred support will reduce distress and assist individuals to manage their own distress, while simultaneously easing the burden faced by EDs.

The program logic provides more detail to the theory of change, and represents visually the links between activities, outputs, and outcomes. The program logic for the Program (Figure 6) will help to identify and shape output and outcome measures and inform data collection.

Figure 6 | Safe Space evaluation Program Logic



4 The Safe Space model and its place in the system

This chapter intends to explain the design of the Safe Space model of care, its supporting evidence base and where it fits in the broader health system. It provides a description of the Safe Space model of care including the Compassionate Villages that sit around the Safe Spaces (Chapter 4.1), explains the similarities and differences between Safe Spaces and other more clinical service types and the gap in the service system that Safe Spaces fills (Chapter 4.2), provides an overview of the evidence-base which informs the design and service delivery features of the Safe Spaces (Chapter 4.3) and highlights how Safe Spaces are complimentary to clinical services (Chapter 4.4).

4.1 Safe Spaces provide peer-led after-hours support for people experiencing distress

Aim: Safe Spaces are non-clinical, peer-led alternative to EDs and hospitals designed to provide a safe environment for individuals experiencing distress. The goal is to support guests through distress and to empower guests to address the root causes of distress.

Location: Safe Spaces are based in community in areas where there are high levels of need and distress and that are readily accessible through public transport. The buildings for Safe Spaces are designed to be welcoming, and homely - a space that feels safe. They include private rooms, as well as common areas, sensory rooms, and an option for people to be outside. These include comfortable seating, refreshments offered (tea and coffee and a snack) and Wi-Fi available. The locations are designed to be non-clinical in look and feel and located away from the grounds of clinical services like hospitals (but within 5-10 kilometres of an ED so that guests can be transferred if required).

Opening hours The Safe Spaces are walk-in services open after hours (5:00pm to 9:00pm Monday to Friday, with staggered opening hours from 9:00am to 7:00pm across the four sites on Saturday and Sunday).

Accessibility and guest profile: The Safe Spaces takes a no wrong door approach to accessibility.

- Safe Spaces are open to anyone. There are no age restriction or access criteria.
- Safe Spaces are a walk in service. As such guests have a wide range of support needs ranging from low and moderate through to acute crisis.
- Marketing and communications deliberately avoid framing Safe Spaces as 'mental health' services and emphasise their non-clinical nature.
- Staff will communicate to guests what to expect on arrival, time frames for waiting, information on how to get there and where to park, and what they will do for follow up after their visit. Guests may call ahead to ensure space is open and there is capacity to be seen.

Supports provided: Supports at Safe Spaces are led by peer-workers with support from clinicians where appropriate. Peer support is the basis of all supports provided which involves peer workers providing empathetic and validating responses to guest distress drawing on their lived experience expertise of overcoming similar challenges. Peer workers connect with guests in a non-judgemental and non-hierarchical way so that guests feel that they are understood, supported and hopeful. The five support types of peer support provided by Safe Spaces are:

- **Distress management:** Techniques and strategies aimed at helping guests reduce immediate emotional distress and regain a sense of calm. This support may include practices such as grounding exercises, mindfulness, and sensory tools, which help individuals reconnect with the present moment

and manage overwhelming emotions. The goal is to provide immediate relief while equipping guests with skills they can use outside of the Safe Space.

- **Safety planning:** Collaborative development of personalised safety plans that outline strategies, activities, and resources available to guests to cope during challenging times.
- **Capacity building and problem solving:** Information, skills, and knowledge to enhance guests' ability to manage future crises and support to solve current problems. This may include practical supports and warm connections to other resources and supports to address the underlying causes of distress (such as housing, food and employment).
- **Brief structured intervention:** Time-limited, goal-oriented therapeutic sessions delivered by clinicians to address immediate needs and build coping skills drawing on clinical approaches such as Cognitive Behavioural Therapy (CBT) or Dialectical Behaviour Therapy (DBT).
- **Follow up contact:** Within 72 hours of the visit to a Safe Space, staff will call guests to check in about their wellbeing and any additional follow up supports.

Modes of delivery: These supports can be delivered one-on-one or in a group setting (except for brief structured interventions, which are delivered one-on-one). Supports will predominately be provided face-to-face but phone and online supports are offered.

Staffing: 3-4 peer workers with a Certificate IV in Mental Health Peer Work or equivalent qualification and a clinician.[35] Staff display the qualities of compassion, empathy, good communication and listening skills, understanding, and the ability to acknowledge and support the guest to ensure self-determination.

Role of Safe Spaces in safety plans: Safe Spaces have become a key feature of many guests care and safety plans as they are the only non-clinical and free service available after hours.

Intended outcomes of the Safe Spaces: Guests should leave the Safe Space feeling safe, welcomed, listened to and understood. Intended outcomes of the Safe Spaces include:

- **Reduced immediate distress** refers to the immediate and ongoing reduction of distress among guests. This is achieved by learning and practicing strategies to recognise and reduce distress, taught and informed by the lived experience of peer workers.
- **Equipped with the skills to create safety and manage future distress** refers to supporting guests to create practical safety plans to keep them safe when in crisis and to help guest gain skills to better manage distress in the future.
- **Addressing the needs and root causes of distress**. Safe Spaces aimed to help guests to identify and address the root causes of their distress by providing supports for first four levels of Maslow's hierarchy of needs.[36] The *physiological needs* of guests are realised directly by the space where food and drinks are available along with referral options for further support. Peer workers then support guests to achieve *safety and security* through assistance to acquire stable employment, housing and support. The Safe Spaces offer guests the opportunity to establish relationships and social engagement opportunities assisting them to fulfil *love and belonging* and *self-esteem*.
- **Improved sense of hope, connection and resilience** are achieved alongside the first two outcomes as guests gain the skills to manage their distress and find new reasons to have hope in their lives. Peer workers provide ongoing support through encouragement and strategies tailored to the specific point on each guest's recovery journey.

[35] While a Safe Spaces may be able to open occasionally with three staff, this should be avoided on a regular basis as with current demand levels this is unsustainable for peer workers and requires turning away guests.
[36] A. H. Maslow. Maslow's Hierarchy of Needs, 1943.

Service principles: The Safe Space model of care is underpinned by six principles:

1. **Self-determination:** Guests have agency to make decisions about their own care and what will best work for them; peer workers support guests to ensure they feel empowered to control their lives going forward.
2. **Relational:** Peer workers spend time building rapport with guests to ensure they feel comfortable sharing their experiences in their own time with someone who 'gets' their situation.
3. **Trauma-informed:** Peer workers understand the prevalence and impact of past trauma and recognise the variety of ways trauma responses can manifest. Peer workers provide supports that prioritise safety and do not harm, exacerbate or judge trauma-responses.
4. **Recovery-focussed:** Safe Spaces focus on personal recovery: being able to create and live a meaningful and contributing life in a community of choice. Peer workers focus on helping identify what personal recovery looks might like for guests, providing hope that recovery is possible and practical supports to work towards recovery.
5. **Strengths-based:** Peer workers focus on building on guest's strengths, highlighting what they can do and achieve and not their weaknesses or issues.
6. **Culturally responsive:** Peer workers are cognisant of cultural differences and how these differences may have an impact on how a guest will respond to types of care and the potential stigmas they might have relating to mental health.

Service values: The model is also governed by six core values that guide the care given to guests. They are:

1. **Choice:** Guests have agency to make decisions for themselves and have control over their own recovery.
2. **Mutuality:** Peer workers and guests build relationships which minimise power imbalances and promote connection and trust. There is shared understanding and acknowledgement of each other's experiences, leading to a deeper connection and empathy.
3. **Hope:** Peer workers aim to instil a sense of hope and resilience within guests, with a focus on an optimistic future.
4. **Belonging:** Everyone is welcome to Safe Spaces, including those from diverse backgrounds – differences are celebrated and valued.
5. **Interconnected:** Safe Spaces promote connections between guests within group sessions and with the greater community through the Compassionate Village.
6. **Justice:** Safe Spaces focuses on social justice, fairness and respect for people's rights informed by an understanding power imbalance.

The Safe Space model is presented visually overleaf.

Safe Space model of care

ACCESSING SAFE SPACES:

- Open after-hours: 5pm – 9pm weekdays and at varied times on the weekend.
- Walk-in service open to anyone – there is no age restriction or access criteria.
- Advertised as a distress support, not a not a mental health service.
- Spaces have a homely look and feel located in the community.

AFTER YOUR VISIT:

Follow up within 72 hours

Welcome to **return at any time**

Referrals to other supports

SAFE SPACES PROVIDE ONE-ON-ONE AND GROUP PEER SUPPORTS

Safe Spaces outcomes:

1. Reduced immediate distress
2. Addressed needs and root causes of distress
3. Equipped with skills to create safety & manage future distress
4. Improved sense of hope, connection and resilience

SERVICE PRINCIPLES: Self-determination | Relational | Trauma-informed | Recovery-focussed | Strengths-based | Culturally responsive

SERVICE VALUES: Choice | Mutuality | Hope | Belonging | Interconnected | Justice

4.1.1 Safe Spaces are supported by a network of health and other community services called Compassionate Villages

The Compassionate Villages are group of interconnected organisations and people who offer support to vulnerable and distressed members of the community

Each Safe Space site sits within an informal network of health services and other places in the community called 'Compassionate Villages'. A Compassionate Village Coordinator from Wesley Mission Queensland has worked across the communities at each of the four Safe Space sites to establish relationships with a range of community places such as neighbourhood centres, libraries, gyms and local health and social services.

Community places can encounter people in distress as part of their intended function (such as health services) or incidentally due to their location in the public/community (such as cafes or libraries). Many community places who incidentally encounter people with distress expressed initially not knowing how to effectively recognise and respond to individuals in distress. This at times could lead to unhelpful responses which further escalations of distress.

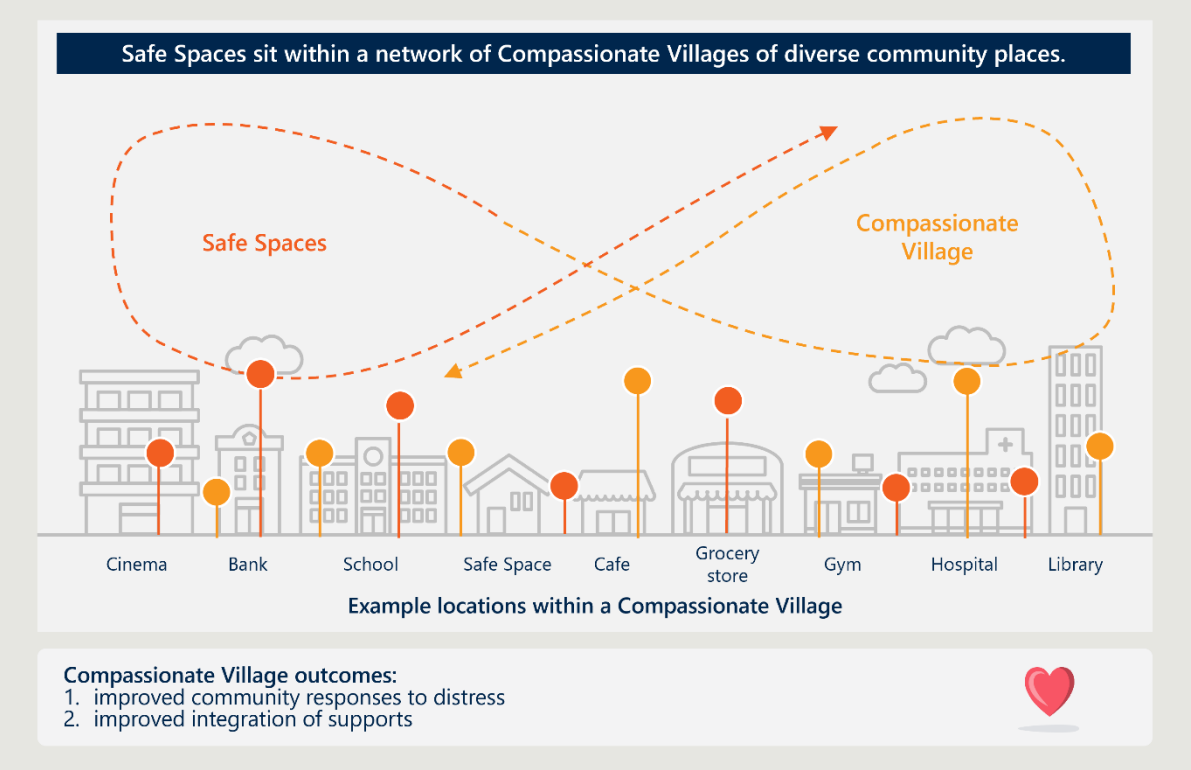
The Compassionate Villages aim to connect community places in order to:

- build community resilience and improve community responses to distress
- improve integration of supports.

Currently Compassionate Villages include 53 community places around the Safe Spaces localities, with growing interest and momentum in Compassionate Villages. This complements the strong relationships Safe Spaces have with local police, ambulance and hospital staff and other health services. Figure 8 presents the integrated nature of Safe Spaces and the Compassionate Villages within the community.

Further details on the activities for the Compassionate Villages are found in the next section below.

Figure 8 | The integration of Safe Spaces and Compassionate Villages.



The Compassionate Village Coordinator has taken a community development approach to establishing Compassionate Villages

The development of each Compassionate Village has an iterative process, that required dedicated time and effort from the Compassionate Village Coordinator using a community development approach outlined in Figure 9.

Figure 9 | Development process of the Compassionate Villages.

These steps bring together a diverse range of community places that value the Compassionate Village vision. These Compassionate Villages are designed to improve the collective, community response to distress through a range of mechanisms, including:

- Upskilling people in community places in how to best respond to distress. To date this has taken place through workshops on distress such as 'what can distress look like for different people' and 'helpful versus unhelpful responses to distress from a lived experience perspective'.
- Holding round-table discussions on local strengths, trends that community places are observing, challenges they may have and priorities in their Compassionate Village.
- Fostering connections between organisations and Safe Spaces to increase awareness of local assets and strengths and to be a forum for developing grassroots responses to better supporting people in distress in line with local priorities.
- Creating additional points of connection in the community for people who attend Safe Spaces. The Compassionate Villages can provide an avenue for Safe Space guests to remain connected with the community outside of the Safe Spaces, which helps reduce loneliness – a key driver of distress.
- Creating informal pathways into Safe Spaces. Staff who work in these community places can let people know about Safe Spaces as a support option and provide a warm referral.

4.2 The Safe Space model is different to other available services and fills a gap within Australia's mental health ecosystem

4.2.1 Safe Spaces fill a gap for people who need after-hours support for distress

There are a range of support options for people experiencing distress aside from Safe Spaces. These include acute services such as EDs, hospitals and Crisis Stabilisation Units (CSUs), private practitioners such as psychologists and general practitioners, crisis support lines (including Lifeline, 13Yarn, yourtown's Kids Helpline and Beyond Blue Support Service) as well as other community-based services including Medicare Mental Health Centres, headspace, PHN-funded low intensity mental health services, and PHN funded psychosocial supports.

However, Safe Spaces fill a gap in these support services by being highly accessible, available after hours and a non-clinical, peer-led services as summarised in Figure 10. Compared to other services, Safe Spaces are designed to be highly accessible providing free, after-hours and in-person support for anybody in distress, without access criteria or age restrictions. Safe Spaces are walk-in services, with no need to book in advance. As shown in Figure 10 many other services are not reliably available after hours or have out of pocket fees (such as GPs, Psychologists, Medicare Mental Health Centres and other community-based supports). Services that are free and available after hours either require a referral (CSUs), are not available in-person (crisis support hotlines) or are often inappropriate for people experiencing distress (EDs).

The importance of a non-clinical approach is discussed in further detail in Chapters 4.2.2 and 4.3. A detailed comparison of Safe Spaces and other support services can be found in Appendix A with community-based services in Table 10 and other services in Table 11.

Figure 10 | Support options for distress in Australia, highlighting Safe Space's unique position

4.2.2 Safe Spaces are non-clinical services, led by peers which operate differently to clinical services

Safe Spaces are expressly non-clinical services, which is reflected in a different design and service delivery approach compared to clinical services as shown in Table 3. These differences are a result an extensive co-design process in which people with a lived experience of emotional distress and/or suicidal crisis were

engaged alongside health professionals in a series of focus groups, feedback loops and surveys. This co-design process focused on ensuring the Safe Spaces were complementary to and operated differently to clinical services. This intended to overcome limitations of the clinical approach in reducing distress and supporting long-term recovery for some people.

Table 3 | Key differences in the design and service delivery approach of Safe Spaces and clinical services

	Safe Spaces	Clinical services
Key focus and goal	• Focus on a person's strengths, recovery to reduce distress • Emphasise ensuring guests feel heard and validated and that hope and recovery is possible. • Aim to empower people to understand and address the root causes of distress.	• Focuses on diagnosis treatment and management of mental health symptoms and conditions (deficit-focused) • Emphasise assessing symptoms, understanding their severity, and developing treatment plans to reduce the impact of symptoms.
Physical design	• Designed to be welcoming, cosy and calm which is important to supporting guests to reduce distress • Have designated spaces for sensory activities, group and one on one activities, outdoor areas and facilities for refreshments • Not located with clinical services.	• Typically, less cosy and welcoming environments • May be overstimulating • Do not usually have fit-for-purpose infrastructure to support distress reduction.
Marketing	• Advertised as support for distress or crisis.	• Advertised as clinical services which support people with mental health conditions.
Guest experience on arrival	• Guests and any carer or support person from a peer worker are warmly greeted by a peer worker • Peer workers inquire about what (both) their needs are, and offer refreshments, a place to sit and the range of supports and spaces available at that time • Typically, no waiting time to enter and start receiving supports • Guests are not required to fill out forms and can remain anonymous.	• Typically need to go to a reception • Guests go through structured clinical intake and assessment process and are often required to fill out forms • Typically, you need to wait to see a clinician and get support (or have an appointment).
Relationship dynamics	• Non-hierarchical and mutual relationship between peer workers and guests • Use a relational approach to build trust and connection through shared common understanding and experience.	• Hierarchical relationship where the clinician holds a position of authority and expertise over patients • More formal relationship with boundaries to maintain professional distance.
Time pressure	• Staff have time to develop rapport with guests are not rushed to process their feelings or solve a problem.	• Staff focus on efficiency and working through procedures– it can feel transactional • Staff are often time-poor.

Flexibility and decision making on supports received	• Supports are highly flexible and tailored based on a person's needs and preferences • Guests are empowered to make informed decisions about the supports they need or want. This aims to help build skills and capacity to manage future distress • Supports are holistic, considering the broader social, emotional and tangible needs of guests to deliver practical solutions to the issues that are most important to guests.	• Supports focussed on mental health symptoms such as medications and talk-therapies such as Cognitive Behavioural Therapy. • Clinicians lead decision making on the appropriate supports. While clinicians may seek input from patients, this often does not occur. • Some clinical services (such as EDs) may impose involuntary treatments such as seclusion and restraints

4.3 The differences in design and service delivery of Safe Spaces are evidence-based and intended to improve their accessibility and effectiveness

This section outlines the evidence-base which supports the key differences in the design and service delivery of Safe Spaces compared to clinical services. It highlights that these differences are based on evidence-based approaches to support improvements in access to supports for underserved cohorts, short-term distress reduction and long-term sustained improvements in people's lives.

4.3.1 The design of Safe Spaces draws on evidence-based approaches to improve access for groups that are underserved by clinical services

The non-clinical nature of Safe Spaces intends to make Safe Spaces accessible for groups who are underserved by clinical services. Generally, evidence suggests that peer-led models of support, such as Safe Spaces have significantly higher rates of uptake in hardly reached cohorts including due to cultural and linguistic diversity, sexual orientation, socioeconomic status, history of incarceration, substance use or lack of social network as noted in a 2016 systematic review.[37] The review suggests that peer-led support programs are better able to access such cohorts because they operate on the principles of trust and mutual respect, flexibility, user involvement and empowerment and community partnerships.

There is more specific evidence that highlights non-clinical services improve access to supports for people with prior medical trauma, people who feel stigma towards mental health and people without a mental health diagnosis. The evidence for these three cohorts is outlined below.

People with prior medical trauma find it easier to access non-clinical services due to a lack of triggering clinical cues

A range of studies highlight the benefits of non-clinical supports for individuals with medical trauma by providing safe, non-triggering support environments. This encourages help seeking and supports more consistent access to needed support.

- Udden et al. 2024 explore how non-clinical support settings foster better accessibility for trauma-affected individuals who self-harm or attempt suicide through a systematic review. The study

[37] Sokol R, Fisher E. Peer support for the hardly reached: a systematic review. American journal of public health. 2016 Jul;106(7):e1-8.

highlights how attending non-clinical services and avoiding clinical settings helps reduce the psychological barriers for individuals dealing with trauma-related distress. [38]

- Macdonald et al., 2020 highlights that people who have been to the ED following self-harm often experience stigma from staff which is traumatising. Non-clinical, peer-supported environments are shown to help these individuals feel more comfortable, facilitating access without the fear associated with clinical settings[39]
- Auth et al, 2022 shows that non-clinical, peer-based support enables emergency service staff with medical trauma individuals to access care without the pressure of medicalised environments, supporting a more comfortable approach to help-seeking. [40]
- McGill et al. (2022) evaluates the effectiveness of a non-clinical aftercare program for individuals discharged from hospital following self-harm episodes. The study found that the non-clinical nature of the program helped participants feel less stigmatised and more likely to access ongoing support, highlighting the importance of non-clinical interventions in post-crisis care. [41]

Individuals who have stigma around mental health are more likely to seek support from non-clinical services

For those affected by stigma around mental health, the non-clinical branding of Safe Spaces makes seeking support more approachable. By positioning itself outside of traditional mental health services, Safe Spaces avoids the labels that might otherwise prevent these individuals from accessing needed support. Studies highlight that non-clinical supports are especially helpful at improving access in CALD who have higher levels of mental health related stigma in general.

Studies in the general population

- Udden et al. 2024 evaluates attitudes toward clinical vs. non-clinical support services among individuals who self-harm through a systematic review. The review highlights how non-clinical settings help mitigate stigma, showing that individuals are more receptive to seeking help when traditional medicalised labels are avoided, supporting increased access [42]
- Dare et al., 2021 uses a mixed-methods approach to show how non-clinical settings such as Safe Space increase access to mental health support. The study finds that individuals respond positively to environments without clinical markers, where they feel less labelled and stigmatised, facilitating a sense of belonging and increasing support accessibility.[43]

[38] Uddin T, Pitman A, Benson G, Kamal Z, Hawton K, Rowe S. Attitudes toward and experiences of clinical and non-clinical services among individuals who self-harm or attempt suicide: a systematic review. Psychological medicine. 2024 Jan;54(1):13-31.
[39] MacDonald S, Sampson C, Turley R, Biddle L, Ring N, Begley R, Evans R. Patients' experiences of emergency hospital care following self-harm: systematic review and thematic synthesis of qualitative research. Qualitative Health Research. 2020 Feb;30(3):471-85.
[40] Auth NM, Booker MJ, Wild J, Riley R. Mental health and help seeking among trauma-exposed emergency service staff: a qualitative evidence synthesis. BMJ open. 2022 Feb 1;12(2):e047814.
[41] McGill K, Whyte IM, Sawyer L, Adams D, Delamothe K, Lewin TJ, Robinson J, Kay-Lambkin FJ, Carter GL. Effectiveness of the Hunter Way Back Support Service: An historical controlled trial of a brief non-clinical after-care program for hospital-treated deliberate self-poisoning. Suicide and Life-Threatening Behavior. 2022 Jun;52(3):500-14.
[42] Uddin T, Pitman A, Benson G, Kamal Z, Hawton K, Rowe S. Attitudes toward and experiences of clinical and non-clinical services among individuals who self-harm or attempt suicide: a systematic review. Psychological medicine. 2024 Jan;54(1):13-31.
[43] Dare J, Seiver H, Andrew L, Coall DA, Karthigesu S, Sim M, Boxall K. Co-creating visual representations of safe spaces with mental health service users using photovoice and zoom. Methods in Psychology. 2021 Dec 1;5:100059.

- Staples et al. 2024 evaluate the accessibility of crisis cafés in the UK and find that non-clinical environments effectively reduce stigma, making individuals who avoid clinical mental health services due to negative perceptions feel more inclined to access support [44]

Studies on culturally and linguistically diverse communities

- Posselt et al., 2017 conduct a study in South Australia on improving supports to young refugees. The study highlights that mental health stigma is a problem in the general population but is reported to be greater in CALD communities and that shame and stigma were associated with experiencing mental health and alcohol and other drug problems was a frequently reported barrier to accessing services. Findings emphasise that community-based, non-clinical spaces enhance comfort and reduce stigma, which leads to a higher likelihood of service utilisation among these populations. [45]

Studies in men

- Tang et al., 2023 study explores barriers to mental health services among Australian men experiencing suicidal thoughts. The study indicates that men have lower contact with formal mental health services, in part due to stigma around not wanting to be labelled or self-identify as having a mental health disorder and the fact that they feel less in control of the supports. The research indicates that non-clinical services, such as men's sheds and informal community support groups, have higher uptake than traditional clinical settings with men reported feeling more comfortable not needing to identify with as having a mental health condition.[46]

People who are not diagnosed with a medical condition

These studies collectively illustrate that non-clinical supports are effective in reaching individuals who lack a formal diagnosis, making mental health support more accessible to a broader audience without the barriers that often accompany clinical care. Evidence suggest that this is particularly relevant for those who do not want to identify with having a mental health condition (particularly men), people with financial barriers to accessing care to receive a diagnosis, people with clinical symptoms below the threshold required to receive mental health support.

Studies in the general population

- Harris et al., 2022 focus on individuals without a clinical mental health diagnosis who hear voices. Findings show that non-clinical supports help these individuals manage distress without the formal diagnosis often required in clinical settings, promoting accessibility and reducing self-stigma.[47] T
- Tomczyk et al., 2017 examines the impact of mental health literacy on help seeking. The study finds that non-clinical environments are particularly beneficial for undiagnosed individuals experiencing symptoms of depression. Their result indicate that lower depression literacy related to a higher probability of seeking informal help (adjusted odds ratio 3.03, 95 per cent CI 1.19-7.69).[48] These

[44] Staples H, Cadorna G, Nyikavaranda P, Maconick L, Lloyd-Evans B, Johnson S. A qualitative investigation of crisis cafes in England: their role, implementation, and accessibility. medRxiv. 2024:2024-05.
[45] Posselt M, McDonald K, Procter N, de Crespigny C, Galletly C. Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: addressing the barriers. BMC public health. 2017 Dec;17:1-7.
[46] Tang S, Reily NM, Batterham PJ, Draper B, Shand F, Han J, Aadam B, Christensen H. Correlates of non-receipt of formal mental health services among Australian men experiencing thoughts of suicide. Journal of Affective Disorders Reports. 2023 Jan 1;11:100455.
[47] Harris O, Andrews C, Broome MR, Kustner C, Jacobsen P. Epistemic injustice amongst clinical and non-clinical voice-hearers: a qualitative thematic analysis study. British Journal of Clinical Psychology. 2022 Nov;61(4):947-63.
[48] Note the study reported the adjusted odds ratio focussing on comparing people with high depression literacy to people with low depression literacy Adjusted Odds Ratio 0.33 (95%CI 0.13, 0.84). The figure presented above is the equivalent odds ratio reversed to focus on comparing people with low depression literacy to people with high depression literacy calculated by 1 / odds ratio.

settings improve help-seeking behaviours by offering support in a less stigmatising environment, which is especially valuable for those not formally diagnosed. [49]

Studies in people with subthreshold symptoms & with financial barriers to accessing care

- Simo et al. (2018) analysed factors affecting service use among individuals with subthreshold mental health disorders, finding that financial and structural barriers often deter formal service utilisation. Non-clinical approaches, like community support, can address these gaps. [50] The study indicated unemployed people were less likely to seek clinical mental health support with an adjusted odds ratio of 0.586 (95 per cent CI 0.37 to 0.92).[51]

Studies in people whose issues stem from the social determinants of health rather than clinical mental health issues

- Whitman et al. (2022) noted that individuals facing social challenges, such as inadequate housing and unemployment, often engage more with non-clinical services that directly address these issues rather than clinical mental health services. This report underlines the importance of non-clinical, holistic approaches in addressing underlying socio-economic stressors.[52]
- Hassan et al., (2020) examined the Life Rooms model, a social prescribing initiative that provides mental health users with non-clinical support for housing and employment challenges. They found that people facing socio-economic issues are more inclined to use these services to address practical needs that influence mental well-being. [53]

4.3.2 The non-clinical features of Safe Spaces are based on evidence on how healthcare services can support distress reduction

Research on supportive design indicates that healthcare services can support distress reduction by ensuring the service fosters control and privacy, promotes social support and provides access to positive distractions.[54,55] The Safe Spaces are designed in line with this evidence base by providing a calming and private physical environment, in which:

- Guests have control over the supports they receive and are empowered to make informed decisions.
- The service delivery approach focuses on providing social support. Peer workers provide social support using a relational approach to build trust and connection through common shared experiences. There are also opportunities for social support through interactions other guests through relaxed group settings.

[49] Tomczyk S, Muehlan H, Freitag S, Stolzenburg S, Schomerus G, Schmidt S. Is knowledge "half the battle"? The role of depression literacy in help-seeking among a non-clinical sample of adults with currently untreated mental health problems. Journal of affective disorders. 2018 Oct 1;238:289-96.
[50] Simo B, Bamvita JM, Caron J, Fleury MJ. Predictors of mental health service use among individuals with high psychological distress and mental disorders. Psychiatry Research. 2018 Dec 1;270:1122-30.
[51] Note the study reported the adjusted odds ratio focussing on comparing people with employed people with unemployed people Adjusted Odds Ratio 1.706 (95%CI 1.086, 2.681). The figure presented above is the equivalent odds ratio reversed to focus on comparing unemployed people to employed people calculated by 1 / odds ratio.
[52] Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers BD. Addressing social determinants of health: Examples of successful evidence-based strategies and current federal efforts. Off Heal Policy. 2022 Apr 1;1:1-30.
[53] Hassan SM, Giebel C, Morasae EK, Rotheram C, Mathieson V, Ward D, Reynolds V, Price A, Bristow K, Kullu C. Social prescribing for people with mental health needs living in disadvantaged communities: the life rooms model. BMC health services research. 2020 Dec;20:1-9.
[54] Andrade CC, Devlin AS, Pereira CR, Lima ML. Do the hospital rooms make a difference for patients' stress? A multilevel analysis of the role of perceived control, positive distraction, and social support. Journal of environmental psychology. 2017 Nov 1;53:63-72.
[55] Marcheschi E, Sigurjónsson Á, Ulrich RS, Elf M. The physical environment and its effect on health outcomes–A systematic review. InARCH19 June 12–13, 2019–Trondheim, Norway. Proceedings from the 4th Conference on Architecture Research Care & Health 2021. SINTEF Academic Press.

- There are opportunities for positive distractions through sensory activities or positive interactions with peer workers or other guests.

4.3.3 The design and delivery approach of Safe Spaces is grounded in evidence-based approaches to support long-term improvements in a person's life

By promoting social connection and empowering people with the skills, information and resources to address the root causes of distress, Safe Spaces are designed to support long-term improvements in a person's life including a better ability to respond to distress and crises in the future. Evidence from a 2024 review including over 400 studies indicated that peer support can have a significant beneficial effect on quality of life, depressive symptoms, suicidal ideation, and recovery from mental health conditions.[56] Key driver of the improvements in outcomes are that peer approaches boost self-efficacy (which refers to a person's ability to take action to achieve a goal), social support as well as feelings of hope and empowerment.[57] Social support is an important driver of long-term distress reduction[58,59,60] and recovery.[61] Self-efficacy is also an important driver of long-term distress reduction[62,63,64,65] mediates the relationships between social support and recovery.[66] Practically this means that services which focus on combining social support and self-efficacy are likely to be more effective at promoting recovery over the long term.

Safe Spaces are designed to have considerable flexibility in the supports provided so that the social determinants of health can be addressed. For examples, peer workers can provide practical support in finding housing and employment or connecting guests with services that can improve these factors. There is considerable evidence that improving the social determinants of health is critical to long term sustained improvements in distress and mental health.[67,68]

[56] Cooper RE, Saunders KR, Greenburgh A, Shah P, Appleton R, Machin K, Jeynes T, Barnett P, Allan SM, Griffiths J, Stuart R. The effectiveness, implementation, and experiences of peer support approaches for mental health: a systematic umbrella review. BMC medicine. 2024 Feb 29;22(1):72.
[57] Ibid
[58] Wang HH, Wu SZ, Liu YY. Association between social support and health outcomes: a meta-analysis. The Kaohsiung journal of medical sciences. 2003 Jul;19(7):345-50.
[59] Benight CC, Harper ML. Coping self-efficacy perceptions as a mediator between acute stress response and long-term distress following natural disasters. Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies. 2002 Jun;15(3):177-86.
[60] Smith AJ, Benight CC, Cieslak R. Social support and postdeployment coping self-efficacy as predictors of distress among combat veterans. Military Psychology. 2013 Sep 30;25(5):452-61.
[61] Thomas EC, Muralidharan A, Medoff D, Drapalski AL. Self-efficacy as a mediator of the relationship between social support and recovery in serious mental illness. Psychiatric rehabilitation journal. 2016 Dec;39(4):352.
[62] Gallagher MW, Long LJ, Phillips CA. Hope, optimism, self-efficacy, and posttraumatic stress disorder: A meta-analytic review of the protective effects of positive expectancies. Journal of clinical psychology. 2020 Mar;76(3):329-55.
[63] Smith AJ, Benight CC, Cieslak R. Social support and postdeployment coping self-efficacy as predictors of distress among combat veterans. Military Psychology. 2013 Sep 30;25(5):452-61.
[64] Jackson T, Wang Y, Wang Y, Fan H. Self-efficacy and chronic pain outcomes: a meta-analytic review. The journal of pain. 2014 Aug 1;15(8):800-14.
[65] Chirico A, Lucidi F, Merluzzi T, Alivernini F, De Laurentiis M, Botti G, Giordano A. A meta-analytic review of the relationship of cancer coping self-efficacy with distress and quality of life. Oncotarget. 2017 May 5;8(22):36800.
[66] Thomas EC, Muralidharan A, Medoff D, Drapalski AL. Self-efficacy as a mediator of the relationship between social support and recovery in serious mental illness. Psychiatric rehabilitation journal. 2016 Dec;39(4):352.
[67] Curl A, Kearns A, Mason P, Egan M, Tannahill C, Ellaway A. Physical and mental health outcomes following housing improvements: evidence from the GoWell study. J Epidemiol Community Health. 2015 Jan 1;69(1):12-9.
[68] Hill S, Francis S, Robinson Z. Mental health, employment and housing. InMental Health Services Today and Tomorrow 2018 Apr 19 (pp. 121-135). CRC Press.

Critiques of clinical models of mental health care indicate they do not have a strong focus on promoting self-efficacy and social support, and help people to gain the necessary skills to keep themselves well.[69,70,71] Evidence suggest that clinicians have different priorities to service users about what are important outcomes: clinicians tend to focus on symptom reduction and "Although [patients] desire freedom from debilitating symptoms, they typically place at least as much emphasis on the importance of decent lives: safe, pleasant and affordable housing, well-paying and fulfilling jobs, friends… to be treated with dignity and respect, to have control over their lives and to have genuine choice".

This is result of key design features of clinical services as shown in Table 3:

- **Features of clinical models that are not conducive to promoting self-efficacy:** i) the expert status of the clinician in a hierarchical relationship ii) less opportunities for patients to be empowered to choose their supports (as these decisions are typically led by clinicians in line with clinical guidelines) and iii) a focus on a person's deficits (e.g. symptoms and issues) rather than their strengths.[72]
- **Features of clinical models that are not conducive to promoting social support:** i) hierarchical relationships and professional boundaries designed to maintain social distance ii) the emphasis on assessing symptoms, understanding their severity and making diagnoses (rather than being listened to and understood) iii) depersonalised administrative processes (e.g. filling out forms).

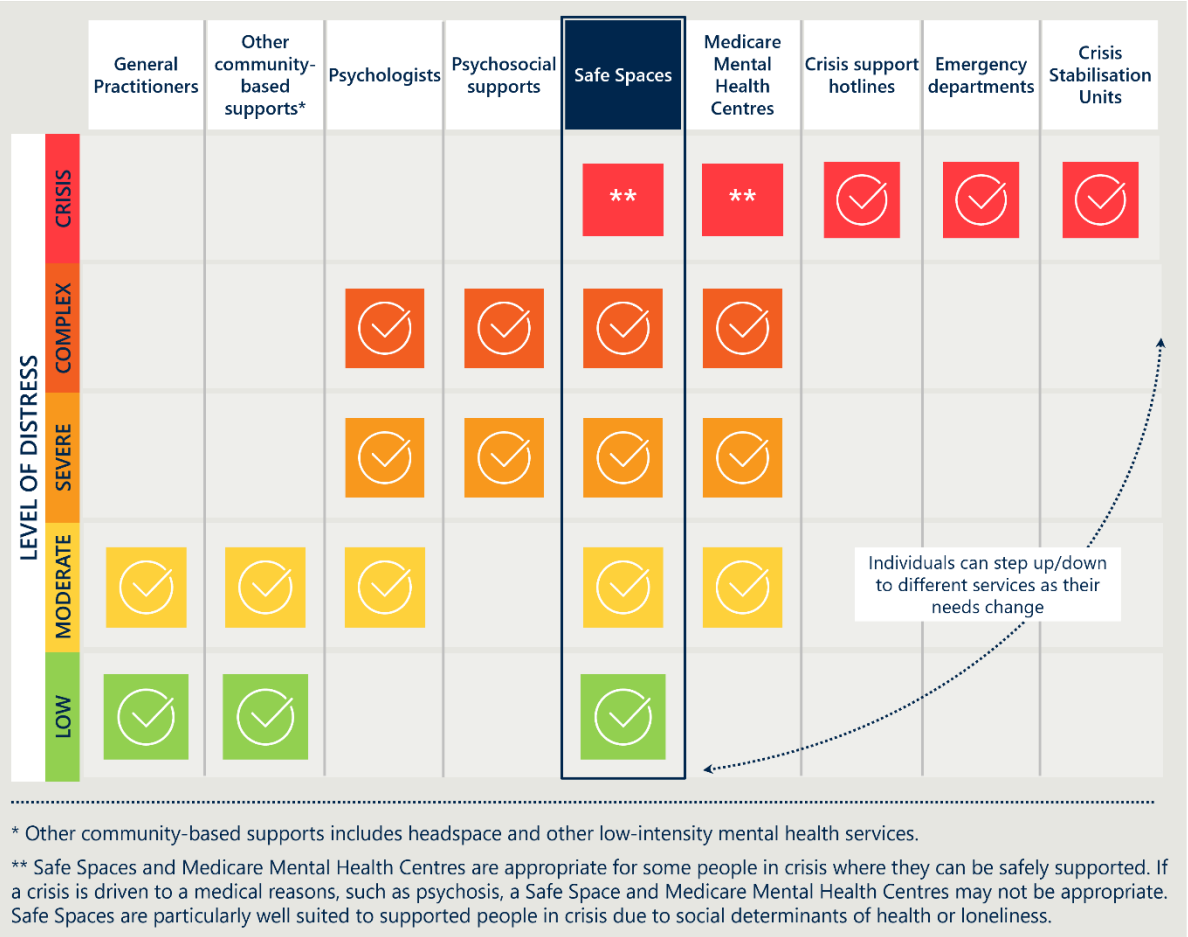
4.4 Safe Spaces are intended to provide complimentary support to people across the stepped care continuum and are intended to be delivered separately to clinical services

Being a walk in service, Safe Spaces cater to people across the stepped care continuum, as shown in Figure 11. The distinct design and service delivery of Safe Spaces are complimentary to existing clinical services by providing supports to people who are underserved by clinical services and by providing an alternative (and in some cases more effective) support for people using clinical services. They may be used by people who are not accessing clinical services or in conjunction with clinical services including as a key part of people's safety plans.

Given the significant differences between the design and delivery of Safe Spaces and clinical services, it would be challenging to effectively incorporate Safe Spaces into a predominately clinical service and would require considerable additional investment. As such, Safe Spaces are intended to be separate and complimentary services to other clinical services.

[69] Schmutte T, Flanagan E, Bedregal L, Ridgway P, Sells D, Styron T, Davidson L. Self-efficacy and self-care: missing ingredients in health and healthcare among adults with serious mental illnesses. Psychiatric quarterly. 2009 Mar;80:1-8.
[70] Castle DJ. Where to for Australian mental health services? Promoting self-efficacy. Australian & New Zealand Journal of Psychiatry. 2013 Aug;47(8):699-702.
[71] Bjørlykhaug KI, Karlsson B, Hesook SK, Kleppe LC. Social support and recovery from mental health problems: A scoping review. Nordic social work research. 2022 Dec 5;12(5):666-97.
[72] Perkins R. What constitutes success?: The relative priority of service users' and clinicians' views of mental health services. The British Journal of Psychiatry. 2001 Jul;179(1):9-10.

Figure 11 | Safe Spaces within the stepped care continuum of distress support services.



* Other community-based supports includes headspace and other low-intensity mental health services.

** Safe Spaces and Medicare Mental Health Centres are appropriate for some people in crisis where they can be safely supported. If a crisis is driven to a medical reasons, such as psychosis, a Safe Space and Medicare Mental Health Centres may not be appropriate. Safe Spaces are particularly well suited to supported people in crisis due to social determinants of health or loneliness.

5 The outcomes of the Safe Space model of care from evaluation of the Pilot

This chapter presents the outcomes of the Safe Space model of care from the evaluation and an analysis of the features of the model that contributed to these outcomes. The outcomes discussed are: the reach, demand and accessibility of the Safe Spaces (Chapter 5.1); the impact of Safe Spaces on guest health and wellbeing outcomes and the role Safe Spaces have played in guests' overall care as a compliment to clinical services (Chapter 5.2); and the system outcomes of Safe Spaces including the economic benefits of Safe Spaces and the impact of on service integration and community responses to distress (Chapter 5.3).

Key lessons relating to Safe Space staff outcomes are presented in Chapter 6.

5.1 Safe Spaces have reached nearly 2,500 people across broad demographics and socioeconomic statuses

5.1.1 There has been considerable demand for Safe Spaces

Demand for Safe Spaces has been consistently high

There was significant demand for Safe Spaces from when the first Safe Space opened in April 2022 and September 2024 (which is the latest data available for this report). In this period, 2,463 unique guests have received supports from a Safe Space over a total of 10,560 visits with 102 median weekly visits. The demand for Safe Spaces quickly increased as the Safe Space locations opened, with the Bardon, Caboolture and Strathpine Safe Spaces opening in late April and early March 2022 and the Redcliffe Safe Space being the last to open in August 2022. This is reflected in the rising number of visits from April 2022 until April 2024 as outlined in Figure 12. As the Safe Spaces hit capacity from May 2023 onward, the total number of monthly visits has remained high, with a median of 478 visits per month, ranging between 394 and 567. Over this period, the Safe Spaces has continued to support new guests, as shown in Figure 13 which highlights that the service is reaching an increasing proportion of new guests with the most recent month servicing a peak of 72.3 per cent. This indicates that the Safe Spaces have effectively balanced providing continued support to guests over multiple visits while ensuring access to other people in the community experiencing distress.

Figure 12 | Total number of visits per month across all providers

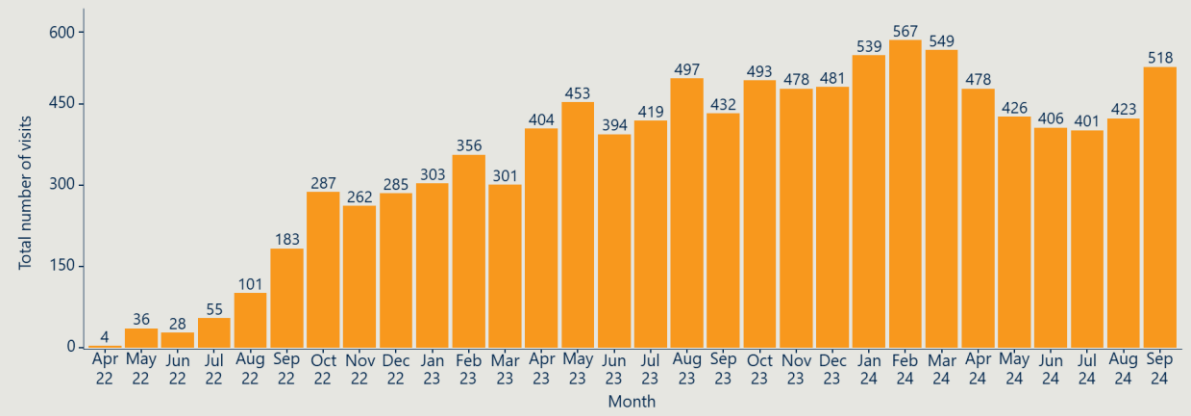
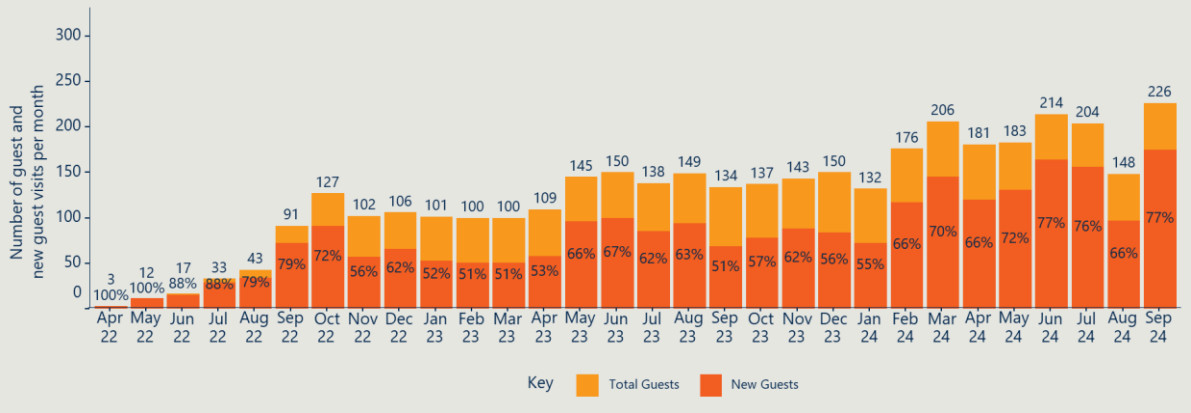


Figure 13 | Number of new guests per month across all providers



There was often excessive demand for Safe Space services, with more people requesting supports than the Safe Spaces had capacity to support

There was a total of 925 instances where guests were not able to attend safe spaces due to capacity constraints. Safe Space peer workers and managers reported instances of excess demand limiting the number of guests they could accept. Safe Spaces employed various measures to manage this excess demand including waiting rooms, encouraging guests to return when the spaces were less busy, providing follow-up telephone support and assisting them to gain access to other Safe Spaces with greater capacity. Safe Spaces proactively managed capacity constraints and excess demand by providing guests with a phone number they could call to check on capacity before visiting.

5.1.2 Safe Spaces have been accessible to a broad cross-section of diverse people, particularly those from cohorts underserved by clinical services

Guests at the Safe Spaces were very diverse

The Safe Space is highly inclusive and has supported a diverse range of guests across different ages, genders, cultures and sexual orientations. Safe Spaces are equipped to assist diverse guests with their specific distress support needs through staffing that consists of support workers from a wide range of backgrounds and lived experience.

Since April of 2022, the Safe Space program has supported the following guests across the four sites:

- 144 First Nations guests, comprising 6 per cent of all guests. This is higher than the 2.8 per cent share of First Nations people in the Brisbane North general population.[73]
- 392 guests who identify as LGBTQIA+, comprising 16 per cent of all guests. There is limited publicly available data relating to LGBTQIA+ communities in Brisbane North PHN, however this higher than broader Australia with the estimated 11 per cent of Australians who identify as lesbian, gay, bisexual, transgender or intersex.[74]

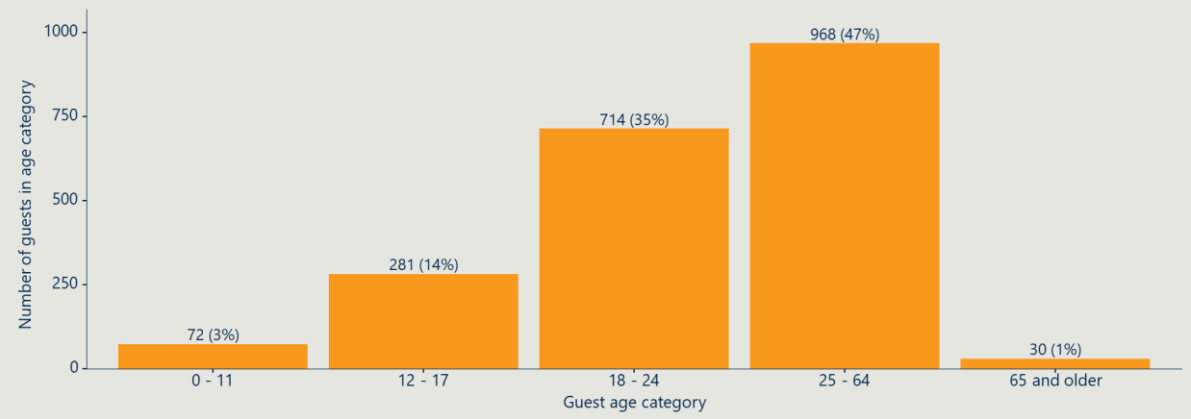
[73] Brisbane North PHN. Population health snapshot 2022 [accessed 3 Nov. 2024]. Available here: https://brisbanenorthphn.org.au/web/uploads/downloads/BNPHN-Population-health-snapshot-2022-p3-002.pdf
[74] End of Life Directions for Aged Care. Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) [accessed 3 Nov. 2024]. Available here: https://www.eldac.com.au/Resources/Diverse-Population-Groups/Lesbian-Gay-Bisexual-Transgender-and-Intersex

- 107 guests who identify as culturally or linguistically diverse, comprising 4 per cent of all guests, this is below the 19 per cent of people in Brisbane North who reported speaking a language other than English at home in the 2016 census.[75]

Safe Spaces guests reported the Spaces as being very accepting and not showing any judgement, always employing empathy towards guests of diverse background. Guests also reported positive experiences with diverse Safe Space peer workers with varied lived experience which they leveraged to support guests with their specific challenges.

Safe Space guests varied widely in terms of age, with close to half of guests ranging from 12 years of age to 24 years of age. Figure 14 below further illustrates the distribution of guests' ages.

Figure 14 | Guests' age distribution



Interviews conducted with Safe Space workers and guests revealed that the demand for the service existed across guests from a range of socioeconomic status backgrounds. Two guest case studies are outlined overleaf in Figure 15.

[75] ABS. Brisbane – North 2021 Census All persons QuickStats [accessed 4 Nov. 2024]. Available here: https://www.abs.gov.au/census/find-census-data/quickstats/2021/302

Figure 15 | Safe Space guest case studies

A refugee who is isolated from his family

A male refugee who had been living in Australia for a decade and hadn't seen his kids or spouse in that time.

Supports received:

- One-on-one time with peer workers to discuss his problems and the distress he feels, related to being isolated from his family. The staff were able to give him hope.
- He found that the Safe Space is also great for social interaction, both with other guests and staff.
- He also used the Safe Space as a place to eat, as he did not have an appetite when he was alone.

Outcomes from Safe Space visits:

- That by talking with the staff, he gained hope which helped him to not self-harm.
- By using the Safe Space, he was able to avoid going to hospital.
- He felt like he was listened to at the space and trusted what the workers said to him. He was able to receive the social interaction that he needs and felt that someone cares about him.

A woman dealing with mental illness and deaths in her personal life

A woman coming from a higher socioeconomic background with various mental health challenges exacerbated by deaths in her personal life and through her employment.

Supports received:

- Given her position in the community and her work, Safe Space has given her an avenue to deal with her struggles in an anonymous setting.
- Safe Space has allowed her to manage her depressive and lonely episodes and overcome her suicidal ideation.

Outcomes from Safe Space visits:

- Safe Space has provided her a private space where she is anonymous and can work through her challenges.
- She has gained an avenue to dispel loneliness and find people who can relate to her struggles.

Guests indicate that the staff are non-judgemental, accepting of differences and treat everyone equally within the space

The peer workers are effectively relating to guests, no matter their backgrounds. Guests greatly appreciated the diversity of peer workers as this allowed them to find someone who they could relate to. Neurodiverse guests found that the peer workers who were also neurodiverse can relate to them and greatly assisted them with their recovery; hospital staff typically have not been able to relate to these neurodiverse guests. Several culturally and linguistically diverse guests commented on how welcome they feel, and that the staff are not racist, these are outlined below in Figure 16.

Figure 16 | Safe Space guest quotes outlining the inclusiveness and accessibility of Safe Spaces

The non-clinical nature of Safe Spaces was critical to enabling access to support for guests who are not well supported by the clinical system

Many guests attended Safe Spaces specifically because they were non-clinical, noting past trauma within clinical settings as a barrier to seeking traditional mental health support as highlighted by the quotes in Figure 17. This clear, non-clinical positioning of Safe Spaces through its promotion as support for distress services rather than a mental health service and its separate location, staffing profile and peer-led approach to clinical services helped support access to several cohorts:

- **People with prior medical trauma:** For individuals who have experienced medical trauma, the non-clinical nature of Safe Spaces is crucial. It provides a supportive environment free from the medical cues that may trigger distress or re-traumatisation, enabling them to access help without fear.
- **People who have stigma around mental health:** For those affected by stigma around mental health, the non-clinical branding of Safe Spaces makes seeking support more approachable. By positioning itself outside of traditional mental health services, Safe Spaces avoids the labels that might otherwise prevent these individuals from accessing needed support.
- **Individuals who are not diagnosed with a mental health condition or who's issues stem from social determinants of health:** The non-clinical approach of Safe Spaces is essential for people who are not diagnosed with a mental health condition, or who do not believe they have a mental health condition. The challenges of this group may arise from broader life circumstances, such as housing or job insecurity rather than mental illness. This non-clinical approach allows them to seek support without a mental health diagnosis or needing to identify as having a mental illness (which can be a barrier to access), focusing instead on addressing the root causes of their distress in a welcoming, stigma-free environment.
- **People who do not meet clinical thresholds for support:** Safe Spaces helped fill in a gap in the 'missing middle'. This refers to the lack of services for between mental health phone-based services and the acute care delivered by the clinical system. To manage demand, clinical services often have eligibility criteria based on a clinical assessment of the level of distress people are presenting with. This means that people with lower distress levels or people that present distress in different ways. As one guest shared "I am autistic and so I don't present distress in a typical way," highlighting how those with internalised presentations distress can often be overlooked by clinical assessments.

Figure 17 | Safe Space guest quotes on the quality of a non-clinical option

The physical environment of the Safe Spaces was important to supporting accessibility

Safe Space guests emphasised that the bespoke physical environment of the service was a key element in making the service highly accessible for diverse cohorts. Guests frequently commented on importance of the "homely", "relaxed" and "cozy" physical design of the Safe Spaces in making them accessible compared to "lifeless, cold and clinical environment[s]". Guests' views on the importance of the physical location of Safe Spaces are further highlighted in Figure 18. Neurodiverse people reported and appreciated the sensory options available to them and commented that they were helpful in managing their distress, for example, the availability of essential oils. This is an important contrast to clinical environments which can be overstimulating, overly public and not conducive to emotional regulation and self-soothing as described by a guest in Figure 19.

Safe Space guests also emphasised the importance of being near public transport to ensure that community members from a broad range of localities were able to access the service. Safe Space guests praised the service for assisting them with transport options when there were fewer public transport options, such as during the evening. Safe Space workers would assist guests struggling with transportation through shuttling in some cases to ensure their safety after leaving the space.

Figure 18 | Safe Space survey guest responses

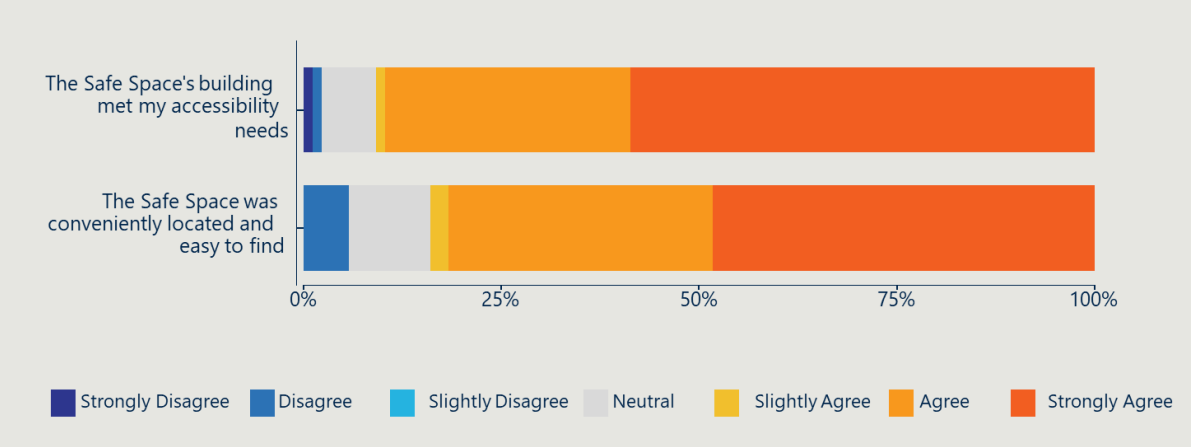


Figure 19 | Safe Space guest quotes highlighting the importance of an accessible physical environment

The ability to walk in without an appointment and the after-hours availability supported accessibility and filled a gap in available clinical services

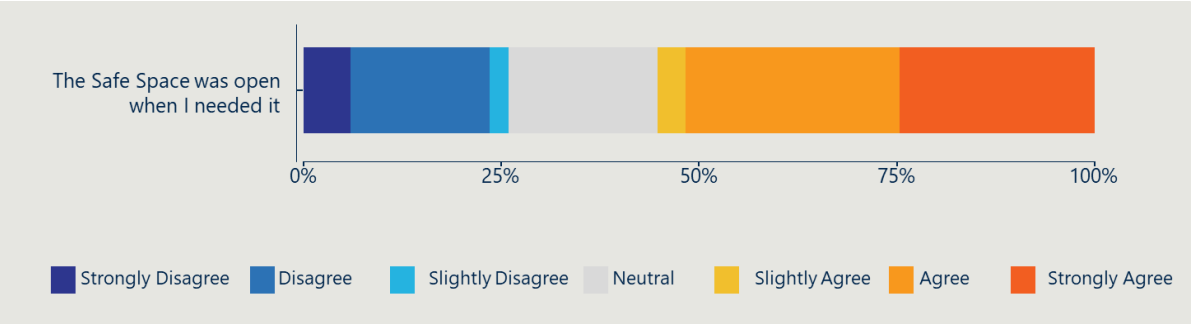
Guests indicated that being able to easily access services by walking in when needed without a booking and having low waiting times was also important as highlighted in Figure 20. Guests indicated that needing to wait a long time for support escalated their distress as shown in Figure 21. They valued the ability to call in advance to check capacity so they could come and receive support quickly. This aligns with a wide range of other literature reporting the importance of receiving support in a timely manner without long wait times for distress management,[76,77] in both acute ED and hospital settings[78,79,80,81]and for other

[76] Consumer of Mental Health WA (Inc). Alternative to Emergency Departments Project Report September 2019 [accessed 2 Nov. 2024]. Available here: https://www.mhc.wa.gov.au/media/2993/alt-to-ed-and-safe-havens-final-report-2019.pdf
[77] KPMG. National Safe Spaces Network Scoping Study [accessed 2 Nov. 2024] Available here: https://www.health.gov.au/sites/default/files/documents/2022/01/foi-request-3040-release-documents-national-safe-spaces-network-kpmg-national-safe-spaces-network-scoping-study.pdf
[78] Australasian College for Emergency Medicine (ACEM) (2018. *The long wait, an analysis of mental health presentations to Australian emergency departments*. Melbourne: ACEM [accessed 2 Nov. 2024]. Available here: https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018
[79] Australasian College for Emergency Medicine (ACEM) (2018). *Waiting times in emergency departments for people presenting with acute mental and behavioural conditions*. Melbourne: ACEM [accessed 2 Nov. 2024]. Available here: https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx
[80] Medeiros DT, Hahn-Goldberg S, O'Connor E, Aleman DM. Analysis of emergency department length of stay for mental health visits: a case study of a Canadian academic hospital. Canadian Journal of Emergency Medicine. 2019 May;21(3):374-83.
[81] Bost N, Crilly J, Wallen K. Characteristics and process outcomes of patients presenting to an Australian emergency department for mental health and non-mental health diagnoses. International Emergency Nursing. 2014 Jul 1;22(3):146-52.

clinical supports such as community mental health services, psychologists and outpatient psychiatrists.[82,83,84,85,86,87]

The after-hours availability of Safe Spaces filled an important gap in the availability of clinical services. Current supports and services for people experiencing distress and crisis tend to operate during business hours. Guest indicated that Safe Spaces were the only place they could go aside from EDs (which were not always beneficial in supporting guests through distress) as shown in Figure 21. Current opening hours are suitable for most guests, but there is a desire from guests for expanded hours. While 54 per cent of respondents to the guest survey agreed or strongly agreed with the statements "Safe Space was open when they needed it.", there were 26 per cent of respondents who disagreed or strongly disagreed with that statement. Expanded opening hours was the most common response to the interview and survey questions about how Safe Space(s) could be improved. This included comments such as "better if it was open at night on weekends." Some guests indicated that event later nighttime hours would be helpful as this is when their distress peaked.

Figure 20 | Safe Space guest survey responses



[82] Loumidis KS, Shropshire JM. Effects of waiting time on appointment attendance with clinical psychologists and length of treatment. Irish Journal of Psychological Medicine. 1997 Jun;14(2):49-54.
[83] Westin AM, Barksdale CL, Stephan SH. The effect of waiting time on youth engagement to evidence-based treatments. Community mental health journal. 2014 Feb;50:221-8.
[84] Grünzig SD, Baumeister H, Bengel J, Ebert D, Krämer L. Effectiveness and acceptance of a web-based depression intervention during waiting time for outpatient psychotherapy: study protocol for a randomized controlled trial. Trials. 2018 Dec;19:1-1.
[85] Snape C, Perren S, Jones L, Rowland N. Counselling—Why not? A qualitative study of people's accounts of not taking up counselling appointments. Counselling and Psychotherapy Research. 2003 Sep;3(3):239-45.
[86] Biringer E, Sundfør B, Davidson L, Hartveit M, Borg M. Life on a waiting list: How do people experience and cope with delayed access to a community mental health center?. Scandinavian Psychologist. 2015 Apr 25;2.
[87] Thomas KA, Schroder AM, Rickwood DJ. A systematic review of current approaches to managing demand and waitlists for mental health services. Mental Health Review Journal. 2021 Feb 17;26(1):1-7.

Figure 21 | Safe Space guest quotes emphasising the importance of operating hours

5.2 Safe Spaces have consistently and significantly reduced distress, saved lives and taught valuable self-management skills

5.2.1 Safe Spaces have supported guests to reduce distress

SUDS is a tool for measuring the intensity of a person's distress. Safe Space providers captured SUDS data for guests throughout the program, once when guests arrived and once when guests left the Safe Spaces. The key metric of interest was the level of improvement between the start and the end of the visit, represented by the difference between the arrival and departure SUDS score. SUDS improvement scores fell into three categories:

1. Improved distress: scores over 0
2. Unchanged distress: Scores equal to 0
3. Worsened distress: Scores below 0 – A small number of guests' anxiety would increase as the Safe Spaces were closing as they had become the guests key place of support in some cases.

Safe Spaces were effective at reducing distress among guests. Across the 7,145 visits which had SUDs scores recorded, the median SUDs score on entry to Safe Space was 60 points (moderate to strong anxiety) and the median SUDs score when leaving Safe Spaces was 30 points (mild anxiety distress, no interference in functioning) as highlighted in Figure 22. This translated to an average (mean) improvement in SUDs of 18.9 (95 per cent CI 18.6, 19.3). In most visits, guests experienced an improvement in SUDs scores with:

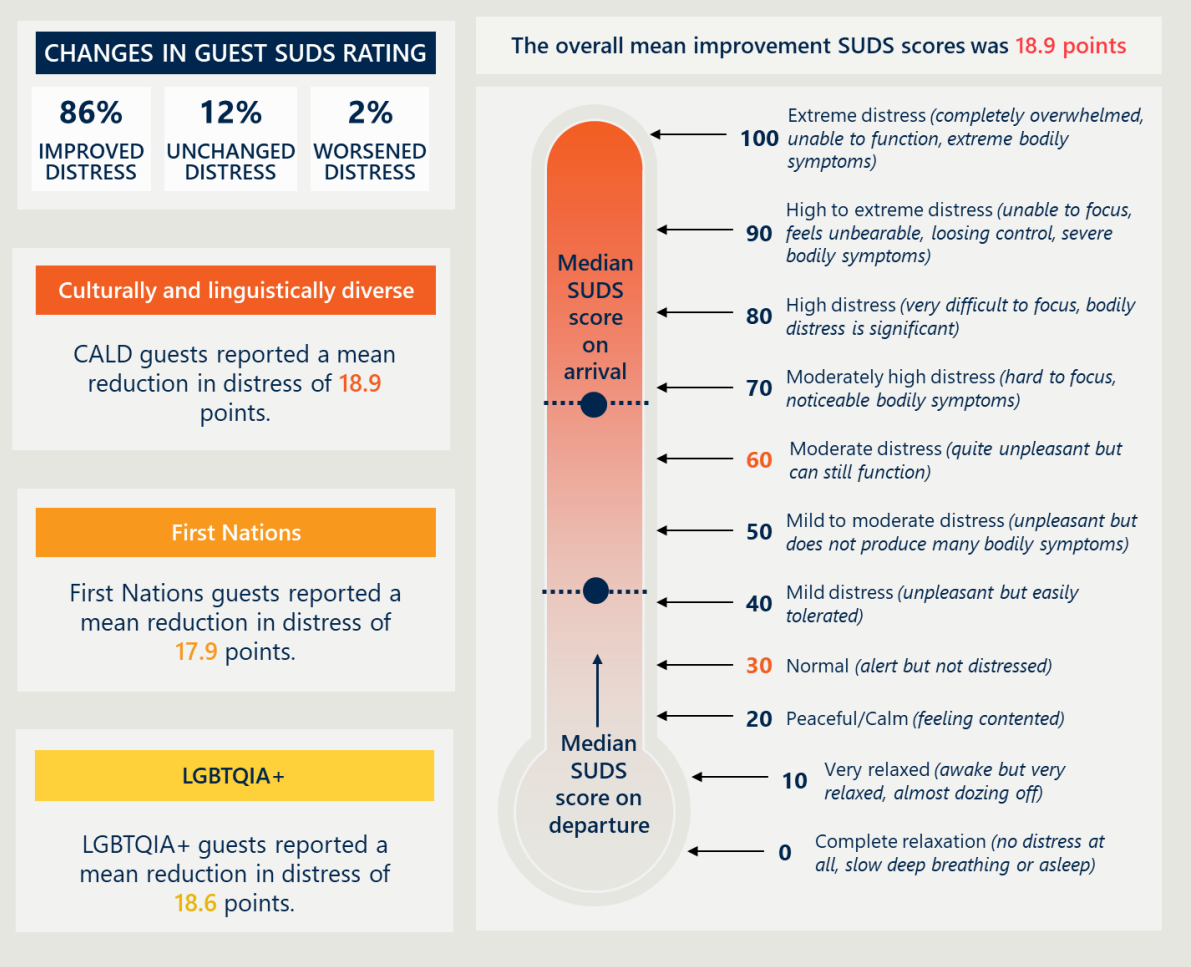
- 86 per cent of visits resulted in reduced distress [mean improvement in SUDs score = 22.5 (95 per cent CI 22.2, 22.8)]
- 12 per cent of visits resulted in no change in distress [mean improvement in SUDs score was 0 (95 per cent CI 0, 0)]

- 2 per cent of visits resulted in an increase in distress [mean deterioration in SUDs score was -20.5 (95 per cent CI -22.5, -18.4)]

In the small group of visits where guests experienced an increase in distress, their median SUDs score on arrival was 20 (feeling peaceful and calm), which is substantially lower than the overall median SUDS score on arrive of 60 (moderate distress). Guests who experienced a median SUDS score on departure was 40, which indicates mild to moderate anxiety and distress. Safe Space staff indicated that increases in distress were often associated with needing to leave the Safe Space at closing time as the Safe Space has become their key place of support.

The mean improvement remained relatively consistent across a range of diverse cohorts with no significant differences in the means between CALD guests 18.9 (95 per cent CI 18.2, 19.5), First Nations guests 17.9 (95 per cent CI 16.0, 19.9), LGBTQIA+ guests 18.6 (95 per cent CI 18.1, 19.2) and repeat guests 19.4 (95 per cent 19.0, 19.9). The overlapping confidence intervals indicate that the differences in the average improvement in suds between for the whole cohort and these subgroups are not significant.

Figure 22 | Safe Spaces SUDS distress scores



There were significant differences in the reduction in distress levels across groups. People aged 25-64 had an average improvement in SUDS of 20.3 points (95 per cent CI 19.7, 20.7) which is significantly higher than the average of all Safe Spaces guests as well as the average younger cohorts. This is evident because the lowest value in the 95 per cent CI for ages 25-64 is higher than the highest values in the 95 per cent CIs for other groups (i.e. there is no overlap in the confidence intervals):

- People aged 18-24 years who had a mean improvement in SUDs of 17.9 (95 per cent CI 17.3, 18.5),
- people aged 12-17 year who had a mean improvement in SUDs of 13.9 (95 per cent CI 12.4, 15.3)

- people aged 0-11 year who had a mean improvement in SUDs of 16.0 (95 per cent CI 12.5, 19.4).

There were no significant differences between the reduction in SUDs scores of people aged 25-64 years and people aged 65 + years, who had a mean improvement of SUDs of 20.5 (95 per cent CI 14.9, 26.1). The difference is insignificant as there is overlap in the confidence intervals.

Safe Spaces supported guests with all ranges of distress levels

To quantify the proportion of guests presenting across the stepped care continuum, we used SUDs scores on arrival as a proxy indicator for their level of distress. While this does not map perfectly onto the all elements of the stepped care continuum - as for example 'complex' refers to the need for coordinated care due to a range of comorbid issues - it provides an indicative view of the range of intensities of distress levels guests presented with. We used the ranges outlined below in Table 4 to define each step.

Table 4 | Distress levels and corresponding SUDS scores

Distress level	Corresponding SUDS score
Crisis-level distress	100
Complex distress	80-99
Severe distress	70-79
Moderate distress	50-69
Low-level distress	0-49

Guests presented a wide range of needs across the stepped care continuum as highlighted by guest interviews, illustrated in Figure 23 below.

Figure 23 | Guest interview stepped care continuum

5.2.2 Safe Spaces have saved lives and are critical to guest safety plans

Safe Spaces have played a key role in suicide prevention for many guests

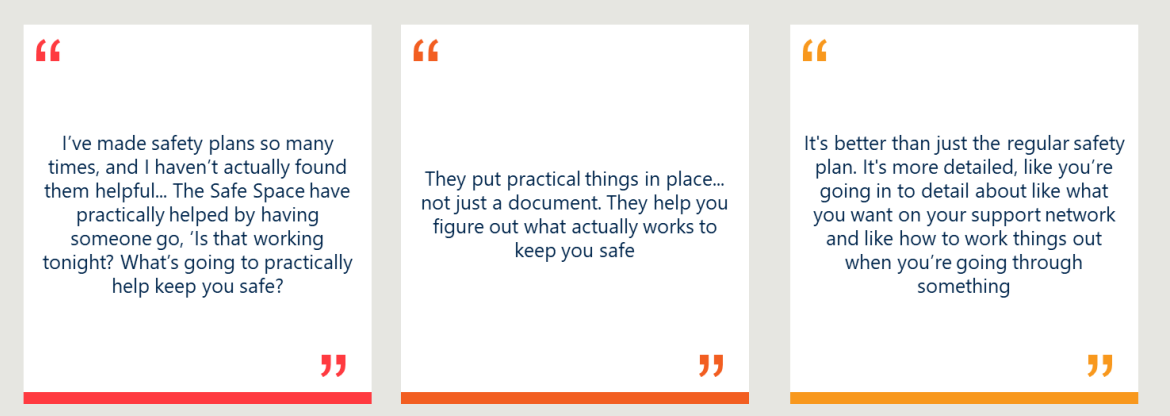
Safe Space guests have provided numerous testimonials supporting Safe Spaces as a critical service that has saved numerous lives and restored guests' sense of hope. They described Safe Spaces as a lifeline in moments when other support options were unavailable, and they credited it with preventing self-harm during times of acute distress. This has assisted guests to move past challenging life periods and find strong reasons to live. Some guests credited Safe Spaces entirely with their ability to keep going. Some of these testimonials are outlined below in Figure 24.

Figure 24 | Safe Space guest testimonials

Safe Spaces have supported the development of practical and effective safety plans for guests

Guests have indicated that the safety plans developed at Safe Spaces have been more effective and practical than their experiences with developing safety plans with clinical services. Safe Space staff work collaboratively with guests to build a personalised support plan, which includes practical strategies and a support network. The staff's genuine, empathetic responses, coupled with practical guidance, have enabled guests to establish a plan that they could realistically implement during moments of heightened distress. This is illustrated by the Safe Space guests quotes in Figure 25 below.

Figure 25 | Safe Space guest quotes emphasising the value of safety plans prepared at the Spaces



Safe Spaces are a critical part of many guests Safety Plans

Guests go to Safe Spaces to receive support when experiencing a crisis after hours because there are no other options available. If the Safe Spaces shut down, guests reported being afraid for their safety. This is highlighted by the guest quotes in Figure 26

Figure 26 | Safe Space guest quotes emphasising the harms from the spaces closing

5.2.3 The peer-led approach with a focus on addressing the root causes of distress was critical to the success of the model

Safe Spaces worked to target the root causes of distress in guests' lives, creating sustained improvements in outcomes

Safe Spaces have supported guests to address the root causes of their distress. Safe Spaces achieved this by i) equipping guests with the skills, confidence and self-efficacy to address challenges in their life; ii) by providing holistic supports considering broader social, emotional and tangible needs to deliver practical solutions to the issues that were most important to guests like housing, employment and substance misuse; and iii) by providing a sense of connection, belonging and hope. The following points highlight the specific ways in which Safe Spaces addressed the root causes of guest distress, supporting quotes from guest interviews are found in Figure 27.

Figure 27 | Supporting quotes from guest interviews

Improving guests' stress management skills self-efficacy, and ability to create safety for themselves: As outlined in Chapter 4.3, a lack of self-efficacy and skills are critical drivers of distress.[88] Through activities, structured support, and peer-led discussions, guests gained tools to manage stress and crises effectively. In response to the guest survey, 85 per cent of respondents agreed that they received useful information, strategies and support at the Safe Spaces. This support translated into better daily functioning and resilience as well as improved self-efficacy to navigate challenging circumstances and crises. This is evidenced by the guest survey in which 74 per cent of respondents agreed that their experience at the Safe Space(s) made them feel more confident to manage stress and difficult situations and 78 per cent of respondents agreed that they feel better able to create safety for themselves. Results across these survey questions are further displayed in Figure 28 below. By empowering guests with skills, tools and confidence Safe Spaces improved guests' ability to sustain improvements in their wellbeing into the future. The peer-relationship and approach to empowering guests in decision-making was important to this outcome and is described in the next section.

"Coming here has made me realise that… I used to be very worried about what if it gets worse. Now I feel more comfortable, just knowing I have this place to come to… It's given me a level of stability and confidence"

"For the first time, I feel like I can handle my own life… I don't feel helpless"

"I feel more in control and like I can actually make choices that are good for me"

"I'm not just surviving anymore—I feel like I'm actively taking care of myself"

"Safe Spaces taught me strategies for managing my stress… I actually feel equipped now"

"I've learned to manage my emotions better, which has helped me create a safer life for myself"

"I was dealing with so much stress and, coming here, I've learned new ways to manage it. The physical activities and the little bit of structure I get here make it easier to manage the day, and it's a relief"

"The techniques I learned here help me avoid panicking, and I can get through difficult moments"

[88] Cooper RE, Saunders KR, Greenburgh A, Shah P, Appleton R, Machin K, Jeynes T, Barnett P, Allan SM, Griffiths J, Stuart R. The effectiveness, implementation, and experiences of peer support approaches for mental health: a systematic umbrella review. BMC medicine. 2024 Feb 29;22(1):72.

Supporting guests to find housing: Housing insecurity has significant negative impacts on mental health and wellbeing,[89,90] and reduced housing insecurity significantly improves mental health, and wellbeing reduces ED and hospitalisation rates.[91,92] For individuals facing housing insecurity, Safe Spaces offered guidance and support, assisting guests in finding accommodation or navigating housing challenges. This practical support allowed some guests to achieve stable housing, reducing a significant source of distress.

"Safe Spaces helped me to transition from rough sleeping to a stable home… That change is massive."

"They helped me find housing and employment support, which has been life-changing for me"

"Without Safe Space, I'd be stuck… They helped me step-by-step in the housing process, which was so overwhelming alone"

"My circumstances result in these symptoms… and I have tried to voice that to psychologists in the past… they basically always go to Cognitive Behavioural Therapy oh, change your thinking and the way you behave. But I've tried that… and it doesn't fix the fact that I'm still homeless, poor and surrounded by crappy people…. However, when I'm at the Safe Space the workers really understand me and can help me find practical solutions to my issues."

Supporting guests to find employment and reduce financial stress: Unemployment and financial stress have negative effects on mental health and wellbeing[93,94] and significantly increase the risk of suicide.[95] Safe Spaces helped guests who were struggling with employment by connecting them to job services, assisting with applications, and offering encouragement. This support empowered guests to improve their economic circumstances and reduce financial stress.

"They helped me find work, even calling some job services for me… when I was too down to do it myself. It felt amazing because I didn't think anyone could do that for me"

"They gave me confidence to pursue work without fear of failure, which I struggled with before"

"When I was struggling financially, they connected me with services and resources that made a real difference"

"Safe Spaces taught me skills to manage my finances better and find work that fits my needs…

[89] Talmatzky M, Nohr L, Knaevelsrud C, Niemeyer H. Exploring the association between housing insecurity and mental health among renters: A systematic review. medRxiv. 2023:2023-11.
[90] Singh A, Daniel L, Baker E, Bentley R. Housing disadvantage and poor mental health: a systematic review. American journal of preventive medicine. 2019 Aug 1;57(2):262-72.
[91] Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health. 2019 May 1;73(5):379-87.
[92] Hock ES, Blank L, Fairbrother H, Clowes M, Cuevas DC, Booth A, Clair A, Goyder E. Exploring the impact of housing insecurity on the health and wellbeing of children and young people in the United Kingdom: a qualitative systematic review. BMC Public Health. 2024 Sep 9;24(1):2453.
[93] Paul KI, Moser K. Unemployment impairs mental health: Meta-analyses. Journal of Vocational behavior. 2009 Jun 1;74(3):264-82.
[94] Picchio M, Ubaldi M. Unemployment and health: A meta-analysis. Journal of Economic Surveys. 2022 Jul.
[95] Milner A, Page A, LaMontagne AD. Long-term unemployment and suicide: a systematic review and meta-analysis. PloS one. 2013 Jan 16;8(1):e51333.

Reducing substance misuse and healthier coping mechanisms: Substance misuse and distress are closely interconnected, often reinforcing each other in a cyclical relationship.[96] Distress, whether from mental health challenges, social isolation, trauma, or life stressors, can lead individuals to seek temporary relief through substances, as they may numb emotional pain or provide a momentary escape.[97,98]However, while substances may offer short-term relief, they can ultimately intensify distress by contributing to dependency, worsening mental and physical health, and causing social and financial problems.[99,100] Guests who previously relied on substances to cope with distress found alternatives at Safe Spaces. By offering a safe, substance-free environment and practical support, Safe Spaces helped guests develop healthier coping strategies, leading to decreased reliance on substances.

"When I'm struggling, I don't have to turn to bad habits anymore. I've cut down on drinking and smoking a lot because I have somewhere to go instead of numbing out… This place helped me find a better way to cope"

"Addiction was massive for me… but I've worked on cutting down massively and making huge lifestyle changes. Having Safe Space as an option at night helped me avoid those habits"

"I was drinking a lot… to cover it up, to cope. But now I don't feel like I need to drink because I have support and strategies to deal with things here"

"This space was really good… for learning how to regulate myself when things got overwhelming. I don't feel like I need to turn to something harmful, because I have tools and people who can help"

Improved sense of hope: Hope is important to wellbeing as it improves wellbeing through increasing coping ability, supporting engagement in healthy behaviours and being a protective factor in suicide and negative thoughts.[101,102,103] Safe Spaces significantly improved guests' sense of hope by providing a supportive and non-judgmental environment where individuals can connect with others who understand their life experiences and successfully worked through similar challenges in their recovery. Safe Spaces empower guests to envision a more hopeful future and build resilience in the face of adversity.

"Safe Space has given me a sense of hope, something I didn't feel before"

"It is the hope and the sense that, okay, there are people around who have been through that before."

"I finally feel like there's light at the end of the tunnel… Safe Space made that possible"

"For the first time, I feel like I have options… It's a real feeling of hope"

[96] Stewart SH, Conrod PJ. Anxiety and substance use disorders: The vicious cycle of comorbidity. New York, NY: Springer; 2008.
[97] Sinha R. How does stress increase risk of drug abuse and relapse?. Psychopharmacology. 2001 Dec;158:343-59.
[98] Swendsen J, Conway KP, Degenhardt L, Glantz M, Jin R, Merikangas KR, Sampson N, Kessler RC. Mental disorders as risk factors for substance use, abuse and dependence: results from the 10-year follow-up of the National Comorbidity Survey. Addiction. 2010 Jun;105(6):1117-28.
[99] Hudson A, Thompson K, MacNevin PD, Ivany M, Teehan M, Stuart H, Stewart SH. University students' perceptions of links between substance use and mental health: A qualitative focus group study. Emerging adulthood. 2018 Dec;6(6):399-410.
[100] Dawson DA, Grant BF, Stinson FS, Chou PS. Psychopathology associated with drinking and alcohol use disorders in the college and general adult populations. Drug and alcohol dependence. 2005 Feb 14;77(2):139-50.
[101] Griggs S. Hope and mental health in young adult college students: An integrative review. Journal of psychosocial nursing and mental health services. 2017 Feb 1;55(2):28-35.
[102] Lenz AS. Evidence for relationships between hope, resilience, and mental health among youth. Journal of counseling & development. 2021 Jan;99(1):96-103.
[103] Gallagher MW, Long LJ, Phillips CA. Hope, optimism, self-efficacy, and posttraumatic stress disorder: A meta-analytic review of the protective effects of positive expectancies. Journal of clinical psychology. 2020 Mar;76(3):329-55.

Improving relationships and social support and reducing isolation and loneliness: A lack of social connection and loneliness can increase the risk for premature death as much as smoking up to 15 cigarettes a day. [104] Loneliness and social isolation increase the risk of poorer mental health outcomes[105,106,107] and a lack of social support is a critical determinant of distress[108] (see Chapter 4.3 for further discussion). Many guests struggling with complex family or relationship dynamics found Safe Spaces to be a source of non-judgmental support, helping them to process issues, seek advice, and improve their relationship management skills. Furthermore, Safe Spaces provided a supportive community, addressing social isolation. Guests reported reduced feelings of loneliness through meaningful connections with staff and peers, leading to improved mental health and social engagement.

"I've started to repair relationships with family, knowing I have support from Safe Spaces"

"It's been easier to talk to people outside Safe Spaces after finding people here I could relate to"

"I can open up to people now without fear of judgment. Safe Spaces helped me build that confidence"

"Safe Space helped me realise I can trust people again, which I thought I'd never feel"

"Being able to come here has really helped with loneliness. I talk to people who understand, who are actually going through similar things… It gives me hope"

"I mean the major thing that I come here for is just like social interaction, like it's a very basic thing but it's the most effective thing for me, and it just feels like so many of my problems are related to loneliness."

"The social connection with guests at the Safe Space is critical. I feel less alone, and we support each other"

"I've met people here who I feel connected to… They get what I'm going through"

Figure 29, overleaf, outlines some case studies demonstrating the variety of supports offered by Safe Spaces and the transformational effect that has had on many guests' lives.

[104] Office of the Surgeon General. Our epidemic of loneliness and isolation: The US Surgeon General's Advisory on the healing effects of social connection and community [Internet]. Accessed 31/10/2024. Available at: https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf
[105] Leigh-Hunt N, Bagguley D, Bash K, Turner V, Turnbull S, Valtorta N, Caan W. An overview of systematic reviews on the public health consequences of social isolation and loneliness. Public health. 2017 Nov 1;152:157-71.
[106] Mann F, Wang J, Pearce E, Ma R, Schlief M, Lloyd-Evans B, Ikhtabi S, Johnson S. Loneliness and the onset of new mental health problems in the general population. Social psychiatry and psychiatric epidemiology. 2022 Nov;57(11):2161-78.
[107] Wang J, Mann F, Lloyd-Evans B, Ma R, Johnson S. Associations between loneliness and perceived social support and outcomes of mental health problems: a systematic review. BMC psychiatry. 2018 Dec;18:1-6.
[108] Ibid

Figure 28 | Guest responses to survey on experiences with the Safe Spaces

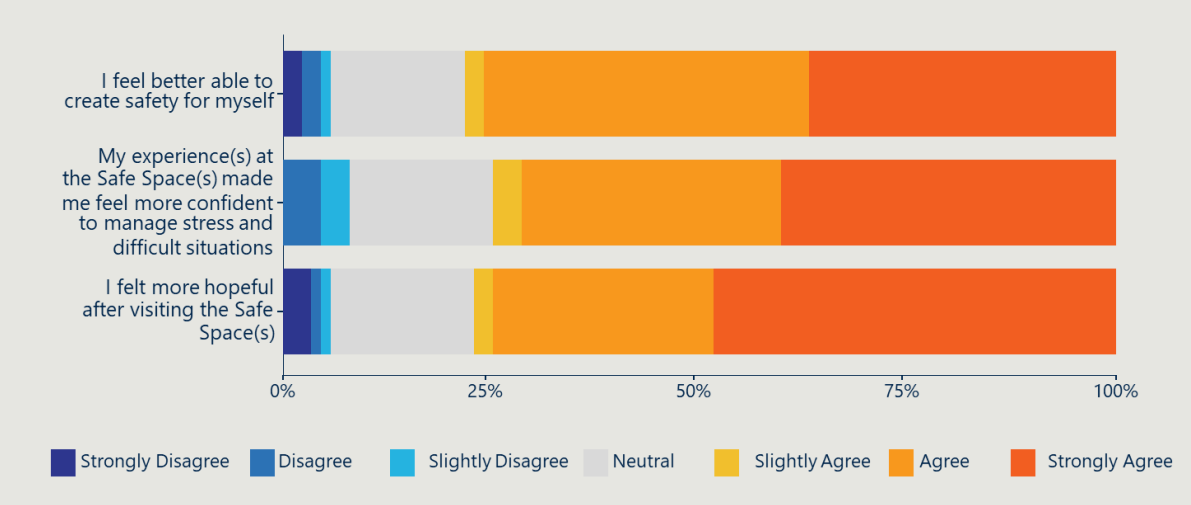


Figure 29 | Safe Space guest case studies

A woman seeking support due to trauma

A woman with a history of considerable trauma associated with domestic violence and sexual abuse, experiencing, anxiety, suicidal ideation as well as isolation, food insecurity and unstable housing.

Supports received:

- Safe Space provided strategies to self-regulate her emotions. She now enjoys relaxing essential oils and learning to crochet as a source of relaxation.
- She has accessed supports to help apply for housing, food hampers and places where she can get a hot meal.
- She gained a safe environment to make friends, and assistance to get out of her comfort zone in a relaxing and safe environment.

Outcomes from Safe Space visits:

- She credits Safe Space with saving her life. "If I hadn't been able to come to Safe Space, I would have offed myself. This has saved my life."
- She is more confident in managing anxiety and challenging times
- With support from Safe Spaces, she is now living in stable housing and is not experiencing food insecurity as frequently.
- She feels less isolated and has made friends

A man experiencing homelessness sought support to gain work and housing

A man struggling with loneliness, drug addiction, unemployment and homelessness was engaging in self-harm and experiencing suicidal thoughts.

Supports received:

- Gained strategies to improve his situation like short and long-term goal setting, adding structure to his weeks and achieving a sense of accomplishment.
- Received assistance dealing with Centrelink and in gaining employment.

Outcomes from Safe Space visits:

- Since participating with Safe Space, he is now drug-free for 11 months.
- Reported feeling hopeful after visiting Safe Space.
- Since Safe Space, he has gained employment and access to stable housing.
- He has since reconnected with his family, gaining vital support networks.

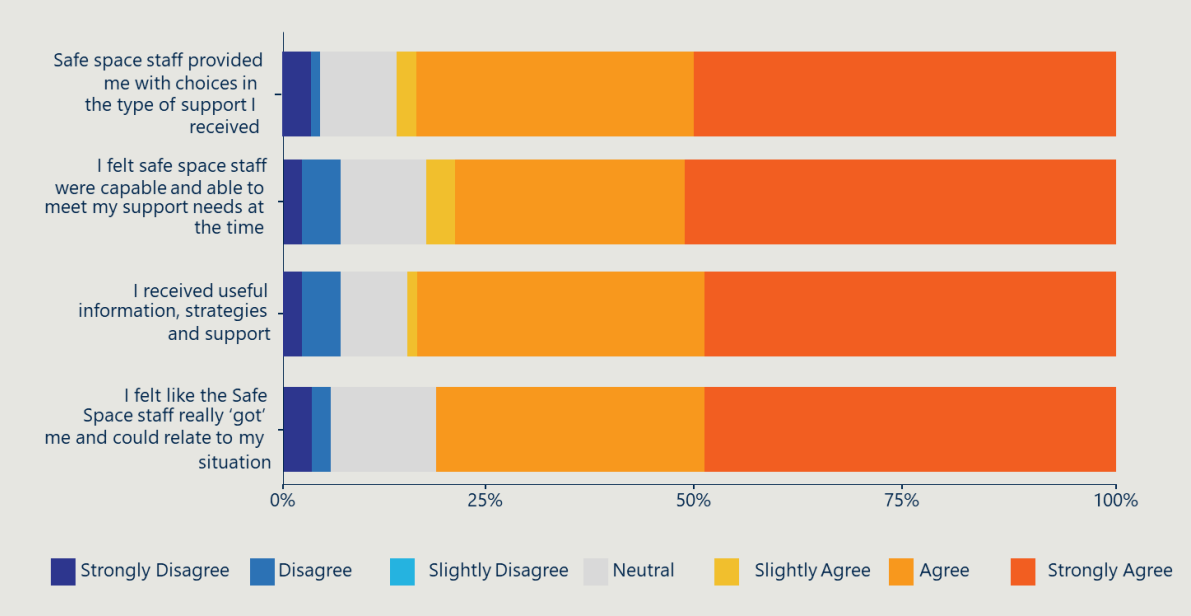
The non-clinical relationship dynamics and the empowering and empathetic approach taken by peer workers was critical to the success of the model

The Safe Space's non-clinical model of care was essential to the success of the Program. Several non-clinical design elements supported the Safe Spaces to achieve effective relationships with the guests as outlined in the dot points below. These themes are supported by guest quotes in Figure 31 and guest survey responses in Figure 31.

- **Non-hierarchical and warm relationship dynamics based on shared lived experience:** The non-hierarchical, mutual relationship dynamic developed between peer workers and guests made guests feel understood by peer workers as evidenced by Figure 31, whereby over 80 per cent of guests agreed that the Safe Spaces really 'got' and could relate to their situation. Guests indicated the warmer and more casual approach by peer workers made guests feel valued as humans and encouraged guests to explore solutions in a non-judgmental setting. These relationship dynamics was perceived as more effective than traditional clinical environments which has a focus on diagnoses and issues. This connection with peer workers over common experiences was critical in reducing feelings of isolation and improving guests' sense of hope shown in guest quotes, found above in Figure 27.
- **Focus on strengths rather than diagnoses or deficits:** Safe Spaces adopt a strengths-based approach that emphasises individuals' inherent capabilities rather than their challenges, creating a supportive environment that fosters empowerment and connection. This contrasts with clinical models which focus on diagnosis treatment and management of mental health symptoms and conditions, exercising a more deficit-focused approach. Guests frequently express feeling valued for who they are, rather than being defined by their mental health issues, which enhances their sense of hope and facilitates personal growth as highlighted by the quotes.
- **Empowering guests to make decisions on a flexible range of supports:** The supports provided to guests were highly flexible and guests were empowered to make decisions about their supports based on their care needs and preferences. This flexibility meant that supports focussed on the issues that were important to them and targeted at the root causes of distress ranging from one-on-one chats over coffee to tailored assistance to find housing, employment and government support. This approach placed guests at the centre of their own recovery, ensuring greater agency and ownership for long-term solutions and reduction of distress, with approximately 86 per cent of surveyed guests reporting that the Safe Spaces provided them with choices in their support options.
- **Not feeling rushed:** Guests at Safe Spaces consistently express appreciation for the unhurried environment, which allows them to take their time in processing emotions and experiences. This contrasts with clinical services, which often involve time-limited appointments that can create pressure and anxiety for individuals seeking support. The lack of urgency in Safe Spaces fosters a sense of safety and comfort, which contributed to positive experiences of care and was an effective environment to address their distress.

Figure 30 | Safe Space guest quotes highlighting the benefits of a non-clinical model of care

Figure 31 | Guest responses to survey on experiences with the Safe Spaces



5.2.4 Safe Spaces have provided effective support for people across the stepped care continuum which is complementary to clinical supports

Guests' attendance patterns reflect the wide variety of support needs Safe Spaces supported

Some guests would seek support from the Safe Spaces to manage brief periods of challenge, while others would seek more ongoing support to help manage ongoing complex and compounding crises, often exacerbated by circumstances out of their control. The types and degree of support provided to guests varied by a guest's specific support needs. This is reflected in the frequency with which guests visited the Safe Spaces which are visualised in Figure 33 overleaf.

The wide array of guest visit frequencies reflects the varying level of supports provided by Safe Spaces. Nearly all Safe Space guests visited only one time, while 16.6 per cent of guests were repeat visitors. Safe Space guests who visited once were typically mild presentations requiring less support than repeat visitors who required more ongoing support. Guest reflections on different visit frequency rates are outlined below in Figure 33 which also demonstrates the communities strengthening understanding of the level and types of support provided at the Safe Spaces with guests reportedly moderating their visit frequency according to their level of need.

Figure 32 | Distribution of guests' visit frequencies since program inception

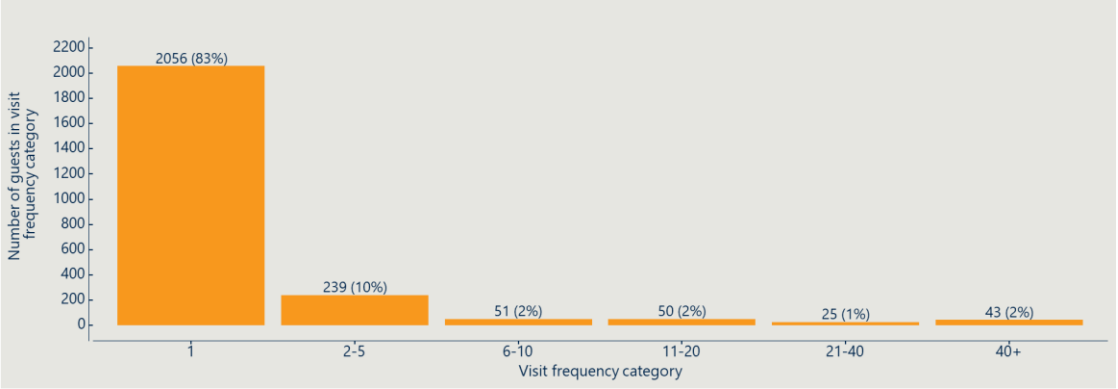


Figure 33 | Safe Space guest visit frequency reflects their specific support needs

Once-off: some guests indicated attending Safe Spaces to deal with a once off crisis. In these instances, guests reported this being effective in supporting their needs without a clinical support.	"I used Safe Space only once, but that time helped me handle things without needing the hospital" "When I was at a low point, I came in for the first time… Haven't needed to come back, but I know it's an option" "I visited just that once when I felt lost, and it really helped even though I didn't have to keep coming back"
Infrequently to manage acute crises: Some guests rely on Safe Spaces as an infrequent, crisis-specific resource, using it only during acute moments when other supports are insufficient. The option to access Safe Spaces during these critical times provides a safety net that guests may not need regularly but find essential when distress escalates.	"I know Safe Space is there if I hit a low point, even if it's just once every few months… It helps knowing I have somewhere to go when it gets bad" "It's good to have a place that's there just when things get really bad; I don't have to be there regularly" "Whenever I'm in a really rough patch, I know I can come here for support, but I don't come all the time"
Regularly as part of a care plan: Safe Spaces are a consistent component of some guests' care plans, offering accessible, peer support that helps individuals manage mild to moderate distress and maintain emotional stability. Regular and preventative use of Safe Spaces enables guests to proactively address their mental health needs through a calming environment and personalised support, reducing the likelihood of crisis escalation and easing pressure on emergency services.	"I have to frequent Safe Space… because when I hit low, I hit really low, and so it's actually part of my program to go there". "It's actually in my agreement with my support coordinator that I have to go to Safe Space every fortnight… when I remember, I go, and it helps me get through those low points". "This place is a preventive measure for me; I come here to keep things from building up". "It's about keeping calm before things spiral. Safe Space is where I go to catch my breath".
Intensive support to achieve a significant change: Some guests regularly attended the Safe Spaces to work through a significant crisis or to achieve significant, tangible changes, such as securing housing and finding employment. Safe Spaces provided essential encouragement and practical assistance to navigate complex processes and challenges.	"Having that constant support allowed me to pursue things like housing and work. I can't imagine making it without them". "It was essential to go regularly at the beginning. Now, I'm in a much better place, but that intensive support was what got me there". "For a few months, Safe Space was my lifeline. I don't know what I would have done without it during that time".
Chronic and ongoing: A small number of guests attended the Safe Spaces frequently to manage intensive distress from chronic or ongoing challenges. For example, one guest attends the Safe Space regularly due to the challenges he faces as a refugee including coping with family separation, desire for community and connection and struggles with daily life.	"I've been coming here for years because of my situation. I haven't seen my wife or kids in over 12 years, and it's so hard…. Safe Space helps me manage that." "When I come here, it's because can't eat. When I'm by myself, yeah, I don't have no appetite to eat. When I see people around me, I share with them because I'm more generous. I come from culture, where we eat together… I come to Safe Space, I eat, I bring my food here, then I can sit with people" "If I didn't have the space available, where would I go? I will hurt myself. I will do something to myself, honestly"

Safe Spaces provide complementary care to existing clinical care options

Evidence from interviews outlined below in Figure 34 and Figure 35 indicate that Safe Spaces are complimentary to clinical services, with some guests visiting both and others visiting only access Safe Spaces. Safe Spaces complement formal mental health services, offering immediate support between clinical appointments and providing a unique alternative that many find essential in managing their mental health.

Guests who access both Safe Spaces and clinical services: Safe Spaces worked as a complement to traditional clinical services, providing immediate, accessible support between appointments. This gap-filling role allowed guests to maintain stability and avoid crises when clinical support was unavailable. Moreover, the supports provided at Safe Spaces were different to clinical support. Safe Spaces provided social support and connection, a sense of hope, resilience and empowerment as well as practical supports to address the root causes of distress (as discussed in 5.2.3). Guests' reflections of the complementary value of Safe Spaces are outlined below in Figure 34.

Figure 34 | Guests using the safe spaces and clinical services

Guests who only access Safe Spaces: Some guests have found Safe Spaces to be more effective than clinical supports and so no longer attend clinical services. Other guests are unable to access clinical services due to financial hardship (including refugees without access to Medicare), not meeting the eligibility criteria challenges attending services during business hours attend Safe Spaces once or for a short period of time for support through a challenging situation in their life which are driven by social determinants of health rather than a mental health condition. These guest observations are illustrated overleaf in Figure 35.

Figure 35 | Guests using only the Safe Space because it meets their support needs at no cost

Safe Space peer workers can identify out of scope presentations and escalating as appropriate

While Safe Spaces are appropriate for guests across a continuum of mental health needs, there are two key areas that the Safe Spaces were not suitable for providing support for:

1. Guests who require urgent medical treatment
2. Guests who are unable or unwilling to engage with peer workers

These two areas are described further in Figure 36. Safe Space peer workers were capable of recognising when a guests presentations aligned with these two areas and followed the appropriate procedure of referring these guests to services that are better equipped to handle their specific support needs. This was further enabled by the strong relationships that were formed between the Safe Spaces and Queensland emergency services, allowing a cross-service health response tailored to the needs of guests.

Figure 36 | There are two key areas that Safe Spaces are not appropriate for

5.3 Safe Spaces have reduced the burden on EDs, improved community responses to distress and integration of supports

5.3.1 Safe Spaces have avoided over 1500 ED presentations and saved over $16 million since 2022

Safe Spaces produce more savings in ED presentations than their operating costs

Since 2022, guests reported that Safe Space attendance avoided 1,596 ED presentations, which corresponds to a total avoided cost of $16,262,562 (lower = $16,191,252, upper = $16,334,021), comprising $1,692,486 from avoided ED presentations and $14,570,076 in avoided subsequent acute admissions following ED presentations.

Going forward, assuming Safe Spaces continue operating around current demand levels, Safe Spaces are expected to deliver $9,117,363 (lower = $7,960,074, upper = $10,284,588) savings per year at 895 avoided ED admissions. This has been calculated by calculating the mean weekly savings from avoided admissions since Safe Spaces have been operating at full capacity from May 2023 to September 2024 (which is the latest data available for this report. The mean savings from avoided ED admissions was $142,618 per week with 17.4 (lower = 15.04, upper = 19.26) avoided ED admissions per week on average. Extrapolating these results out to a year, an estimated $9,117,363 savings per year at 895 avoided ED admissions. The operating costs of the Safe Spaces are $924,000 per site per year, for a total of $3,696 ,000 per year. This result in a positive net economic benefit of $5,421,363 per year (lower = $4,264,074, upper = $6,588,588).

It is possible that guests of Safe Spaces who would attend Safe Spaces are not representative of the broader Australian population which present to EDs for mental health reasons. If the Safe Space cohort is not representative of this larger Australian cohort, the proportion of ED presentations that are subsequently admitted to hospital may be different to the 36.4 per cent used in the analysis. While there is no indication to suggest that the Safe Space population is not representative, the evaluation does not have the data to test the comparability of the cohorts and as such the proportion may be higher or lower which would mean the results respectively underestimate or overestimate the total economic benefit. To explore this, the evaluation tested how different the rate of ED presentations being subsequent acute admissions would need to be change the result from a net positive economic value to a net negative economic value from avoided ED presentations and subsequent acute admissions alone. This tipping point was 12.24 per cent, below which the annual savings from avoided ED presentations and subsequent acute admissions alone (not accounting for other economic benefits discussed in the next subsection). Given this tipping point is much lower than the proportion used in the analysis, this provides confidence that Safe Spaces delivers a net positive economic benefit based on avoided ED presentations and subsequent acute admissions alone.

Confidence intervals have been calculated for the number of weekly avoided ED admissions, the proportion of mental health ED presentations that become hospital admissions and the subsequent total savings. These are outlined below in Table 5 and Table 6 and details around methodology are outlined in Appendix C.

Table 5 | 95 per cent confidence interval for the number of weekly avoided mental health ED presentations

Value	Lower bound	Central value	Upper bound
Weekly avoided mental health ED admissions (from Safe Space data)	15.04	17.15	19.26
Proportion of Australian mental health ED presentations that become hospital admissions	36.22%	36.4%	36.58%

Table 6 | Sensitivity analysis for total yearly savings from avoided mental health ED admissions

		Weekly avoided mental health ED admissions		
		Lower bound (15.04)	Central value (17.15)	Upper bound (19.26)
Percentage of mental health ED admissions admitted to hospital	Lower bound (36.22%)	$7,960,074	$9,077,384	$10,194,694
	Central value (36.4%)	$7,995,132	$9,117,363	$10,239,594
	Upper bound (36.58%)	$8,030,263	$9,157,425	$10,284,588

There are likely additional economic benefits to Safe Spaces not quantified in this evaluation

There are likely other economic benefits of the Safe Spaces, aside from avoided ED presentations, that this evaluation does not have the data to quantify, including:

- **Quality-adjusted life years (QALYs):** Safe Spaces have contributed to improved QALYs for individuals by reducing distress and preventing potential suicide, leading to overall improvements in mental well-being (as discussed in Chapter 5.2.1). In health economic terms, QALYs assign a financial value to health improvements, capturing both the quality and length of life gained from interventions. While the value of a QALY varies across countries and contexts, in Australia an increase in one quality year of life ranges between $108,000 and $151,000 according to Department of Finance guidance.[109]
- **Productivity:** Safe Spaces have contributed to improvements in workforce participation by supporting people to get employed, increased employment retention and reduced distress-related absenteeism as highlighted in Chapter 5.2.3. By helping individuals manage mental health challenges, Safe Spaces may reduce the frequency of missed workdays and enhance guests' ability to sustain employment over the long-term. This leads to fewer disruptions in workplace productivity. These factors collectively enhance economic stability, as consistent employment contributes to higher income generation, increased spending power, and greater tax contributions.

[109] Abelson P. Establishing a monetary value for lives saved: issues and controversies. Canberra: Office of Best Practice Regulation, Department of Finance and Deregulation. 2008;5:2012.

5.3.2 A peer-led workforce offers a cost-effective solution to clinician shortages

A peer-led workforce for Safe Spaces is more cost effective than a clinician-led workforce

Having a peer-led workforce is more cost effective than a clinician-led workforce. Table 7 outlines a comparison in staffing costs between Safe Spaces and two hypothetical service comparisons – one with four Safe Space equivalent clinicians (Comparative service 1) and one with three Safe Space equivalent clinicians and a senior registrar (Comparative service 2). This highlights that a comparative service with a senior clinician (such as a senior registrar),[110] is significantly more expensive per year than Safe Spaces (33 per cent or $137,000 more expensive per year for a Safe Space with a permanent peer workforce). Having more than one senior registrar (or other specialist) would further create a disparity in cost between a Safe Space and a different clinical service.

Table 7 | Staffing cost comparison between Safe Spaces and a comparative service.

Service	Worker	Number	Hourly rate[111]	Shift cost	Yearly cost
Safe Space with a permanent peer workforce	Peer worker	3	$44.20	$795.60	$290,394.00
	Safe Space Clinician	1	$56.00	$336.00	$122,640.00
	Total			**$1,131.60**	**$413,034.00**
Safe Space with a casual peer workforce	Peer worker	3	$53.85	$969.30	$353,794.50
	Safe Space clinician	1	$56.00	$336.00	$122,640.00
	Total			**$1,305.30**	**$476,434.50**
Comparative service 1 (Safe Space-equivalent clinicians only)	Safe Space equivalent clinician	4	$56.00	$1,344.00	$490,560.00
	Total			**$1,344.00**	**$490,560.00**
Comparative service 2 (Safe Space-equivalent clinicians with a senior registrar)	Safe Space equivalent clinician	3	$56.00	$1,008.00	$367,920.00
	Senior registrar	1	$83.35	$500.10	$182,536.50
	Total			**$1,508.10**	**$550,456.50**

[110] Senior registrar assumed to be paid at Classification 'L10' – the lowest classification for a senior register. Queensland Health, Medical Officers' (Queensland Health) Certified Agreement (No. 6) 2022, 2 June 2023 (accessed 23 October 2024), https://www.qirc.qld.gov.au/sites/default/files/2023-06/2023_cb53.pdf

[111] Queensland Health. Peer worker and Safe Space Clinician rates based upon current rates at Communify. Senior register rate (classification L10), MOCA6 - Resident Medical Officers and Senior Medical Officers Wages Schedule, 2022 (accessed 23 October 2024), https://www.health.qld.gov.au/data/assets/pdf_file/0027/1245384/Medical-Stream-wage-rates_Senior-medical-officers-and-resident-medical-officers.pdf

A peer-led workforce in Safe Spaces helps address clinician shortages and promotes engagement in the peer workforce by guests

Queensland's mental health services are currently facing significant clinician shortages, with up to one in four psychiatric positions unfilled in some areas.[112] This shortage has led to increased reliance on locum psychiatrists and extended wait times for patients. A report from 2023, indicated that three out of four psychologists now have waitlists. Additionally, 52.84 per cent of clients on waiting lists are waiting longer than 4-6 weeks, and 27 per cent waited longer than two months.[113] A peer-led workforce in Safe Spaces offers a viable solution to alleviate these pressures on the clinical workforce.

The Safe Spaces strengthens the peer workforce by creating virtuous cycles of employment. Some peer workers at Safe Spaces are former guests to Safe Spaces who have progressed in their recovery journey. Moreover, in interviews guests indicated they were inspired by peer workers and were working towards becoming a peer worker so they could work at the Safe Spaces as shown by the quote below:

"When I found out that it existed, it just gave me a place to go... because I've got a CERT4 in peer support mental health... I found all the staff... they weren't patronising... I really felt like I was talking to my peers and when I arrived, I was with peers" very good advocate... that's just what I do until I'm well enough to take on a peer role. See, that's what I don't want to start a peer role till I'm really good... I'll still do it when I start working as well".

5.3.3 The Safe Space program has improved integration and referral pathways between health services and other places within the community

Safe Spaces have effectively integrated with emergency services and hospitals

Safe Spaces have established strong working relationships with Queensland Ambulance Service, Queensland Police Service and a range of health and social services including local EDs and hospitals. Safe Space peer workers reported engaging with the local ambulance service, police and hospital staff regularly outside of opening hours to develop strong working relationships. This has enabled staff from these organisations to have a strong understanding of the purpose of the Safe Spaces and how they can work with emergency services to support people experiencing mental distress. This has enabled smooth referral pathways between these services and Safe Spaces both into these services and into the Safe Spaces as demonstrated in the examples below:

- **Example of effective referrals to other services:** where guests were not able to be effectively supported at Safe Spaces and guests agreed they needed support from the ED (see circumstances outlined Figure 36), paramedics were conscious of arriving without sirens, and to not disrupt the calm atmosphere of the Safe Spaces. This ensured that all guests at the Space are not triggered by the ambulance sirens and so they could continue their care without disruption.

[112] Booth M. Psychiatrists are fleeing the public system in record numbers. The Australian [Internet]. 2023 Aug 4 [cited 6 Nov 2024]. Available from: https://www.theaustralian.com.au/nation/psychiatrists-are-fleeing-the-public-system-in-record-numbers/news-story/0473bb4a5228fa0c902f19f309fff610

[113] McKell Institute. *A Mental Health Emergency: How Australia's mental health system failed us, and how we can fix it* [Internet]. Sydney (AU): McKell Institute; 2023 Feb [cited 5 Nov 2024 Nov]. Available from: https://mckellinstitute.org.au/wp-content/uploads/2023/02/McKellMentalHealthEmergency.pdf

- **Examples of effective referrals into Safe Space:** Safe Spaces established strong relationships and agreements with hospitals, police and ambulance to ensure appropriate referrals of people into Safe Spaces. This included ensuring a strong understanding of the Safe Space's scope and for the need for appropriate transport arrangements made to ensure the safe arrival of guests to the Safe Space. For example, when Queensland Police wanted to refer someone to Safe Spaces, they would call ahead of time and not enter the Safe Space (to avoid triggering other guests and maintain the privacy of the guests within the Safe Space). This allowed for the appropriate referral of new guests without compromising the other guests at the Safe Space.

Safe Spaces have collaborated closely with other health and mental health services to ensure integrated supports for guests

Safe Spaces have proactively integrated with guests and other health providers to ensure guests receive comprehensive support that addresses not only their immediate distress but also any ongoing health issues, promoting a more integrated pathway to recovery. Peer workers actively engage with guests to understand their existing connections with healthcare providers, such as mental health specialists, general practitioners, and community mental health services including the Mental Health Hubs, which provide integrated clinical and non-clinical services for people with severe mental illness. This understanding allows Safe Spaces to tailor their supports to fill gaps in their existing services and facilitate introductions or follow-ups with these providers, enhancing the overall care experience. By fostering collaborative relationships with various health services. Safe Spaces facilitate effective handovers and referrals that align with the specific needs of individuals to ensure smooth transitions between supports so that guests' care is not interrupted by service fragmentation.

The Compassionate Village has fostered connections between community places and social services to enable stronger collective community responses to distress

Compassionate Villages have played a pivotal role in fostering strong, supportive networks within local communities around the Safe Spaces. This has been driven by the Compassionate Village Coordinator who has connected a diverse range of community places—such as libraries, cafes, op shops and a range of local health and community services, including employment and homeless services – through one-on-one meetings and community workshops. Workshops include basic training to upskill people in how to manage distress and created the opportunity to discuss approaches to supporting distress in communities. The number of community places connected in the Compassionate Village around each Safe Space site and an example Compassionate Village is shown in Figure 37 below.

Figure 37 | Community engagement with the Safe Spaces.

This network-driven approach has allowed grassroots initiatives to flourish, as local organisations and community members work together to meet the needs of people in distress. This has improved community responses to distress in the following ways:

- **Improved skills in responding to distress:** Community places are part of the Compassionate Village indicated in interviews that the training provided to these spaces has empowered community members to recognise and respond to distress as highlighted by a participant in a community place, "the workshop has been really helpful for me and my staff in knowing what to do when someone comes in really stressed." The result is a community-based framework that complements clinical supports, offering early, empathetic interventions that can reduce distress and enhance the community's capacity to support mental well-being more broadly.
- **Better integration and connection of supports for Safe Spaces guests:** The Compassionate Villages supported increased flow of distressed individuals both from community places to Safe Spaces, and from Safe Spaces to community places. This has supported better access to Safe Spaces and a better support for Safe Space guests outside of the Safe Spaces. One member of the Compassionate Village highlighted that "Reciprocal support pathways are essential to stop people from falling through" This is important in creating a sense of connectedness and reducing isolation which as discussed in 5.2.3.
- **Grassroots initiatives to improve community responses to distress:** The Compassionate Village has fostered collaborations that enable community places to provide practical, immediate support for individuals in distress. For example, libraries and op shops have established relationships to offer essentials like clothing and toiletries and some gyms and pools are being better resourced to respond to growing distress in the community and making it more accessible for homeless people who can then access shower facilities, have opportunity for exercise and increased sense of belonging in the community. Other examples include employment services that aid individuals in distress with resume creation and interview practice and organisations such as Police Citizens Youth Clubs (PCYCs) connecting in with distressed individuals to participate in social activities to combat loneliness.

6 Key lessons for the successful implementation and sustainability of Safe Spaces

This chapter outlines key lessons learnt throughout the evaluation of the Pilot to support the successful implementation and sustainability of Safe Spaces. It aims to provide an evidence base for decisions around the future operations of the Safe Spaces in Brisbane North PHN and to provide lessons for other stakeholders who are considering establishing a Safe Space service. The lessons in this chapter are informed by the evaluation findings including analysis of staff outcomes from the last Interim Evaluation Report from October 2023 as well as broader evidence from the literature.

6.1 Incorporating with clinical services would be costly and likely compromise the features that have made it successful

6.1.1 It would be challenging to run Safe Spaces within a clinical service

Incorporating Safe Spaces with clinical services would likely undermine the model's core features that have proven effective for underserved populations. Safe Spaces are intentionally designed from a strong evidence base to be non-clinical services (see Chapter 4.2) and these features are critical the model's success (see Chapter 5.2.3). This section examines three key differentiators between Safe Spaces and clinical services, highlighting why these distinctions are crucial for Safe Spaces' success, and explores practical challenges of delivering the Safe Space model within a clinical context.

The non-clinical identity and physical separation from clinical services are integral to the accessibility for a range of guests.

Safe Spaces are intentionally designed and marketed as non-clinical environments, distinctly separate from medical settings. This separation is not merely a logistical decision; it is fundamental to Safe Spaces' accessibility. As highlighted by evidence from literature in Chapter 4.2 and evidence from the evaluation in Chapter 5.1.2, the non-clinical nature is an important factor in enabling access to support for:

- **People who may avoid clinical environments due to past negative experiences with the healthcare system:** For individuals who have experienced medical trauma, the non-clinical nature of Safe Spaces is crucial. It provides a supportive environment free from the medical cues that may trigger distress, enabling them to access help comfortably and without fear.
- **People who feel stigma associated with mental health treatment:** For those affected by stigma around mental health, the non-clinical branding of Safe Spaces makes seeking support more approachable. By positioning itself outside of traditional mental health services, Safe Spaces avoids the labels that might otherwise prevent these individuals from accessing needed support.
- **People who are not diagnosed with a mental health condition or who's issues stem from social determinants of health:** The non-clinical approach of Safe Spaces is essential for people who are not diagnosed with a mental health condition or for people whose challenges arise from broader life circumstances, such as housing or job insecurity. These groups often do not want to access clinically based services because their issues do not stem from clinical mental health issues. The non-clinical identity makes it easier for this group to seek support without a formal mental health diagnosis, focusing instead on their immediate needs in a welcoming, stigma-free environment.

Incorporating Safe Spaces into a clinical service would make it challenging for the service to maintain a non-clinical identity, which is essential for engaging individuals with prior medical trauma, stigma around mental health, and non-medical life challenges. This would make it difficult to accommodate individuals

who have prior medical trauma, face stigma around mental health, or lack a formal mental health diagnosis to access the supports. Efforts to rebrand a clinical setting as non-clinical would be complicated by the established expectations, formal reception areas, and clinical signage that signal to visitors that they are entering a medical facility. For individuals wary of medical settings or mental health labels, any association with a clinical service could create a barrier to attending the Safe Space. Similarly, some guests may be concerned about privacy with those attending the greater service for a clinical reason would be able to see those at the Safe Space.

Safe Space's peer-led, flexible, and relational approach, which has been critical to supporting sustained improvements in guests' lives, would be compromised within a clinical environment

Safe Spaces are rooted in a peer-led model that emphasises empathy, flexibility, and strength-based support rather than clinical assessment or treatment. Peer workers use their lived experiences to build trusting, non-hierarchical relationships, which helps guests feel understood and validated. This approach contrasts with the medical model typical in clinical environments, which focus on diagnosis (a deficit-oriented approach) and focus more narrowly medical symptom management. In clinical services the relationship between service providers and patients is often formal and hierarchical with clinicians leading decision making on the treatment patients need. Further, guests do not only interact with peer workers and/or clinicians, but also other guests. They support each other and can provide additional feelings of hope – at times organic relationships between guests can be formed (including outside of Safe Spaces), reducing feelings of loneliness. As detailed in Chapter 5.2.3 these differences from clinical services are critical to the Safe Spaces success by helping address the root causes of distress in guests' lives, creating sustained improvements in outcomes.

As described in Chapter 4.2.2, this way of working is at odds with clinical ways of working. Transitioning Safe Spaces into a clinical framework may disrupt this relational, flexible peer-led approach. Successfully running a Safe Space model requires not just a peer-led approach but also a supportive organisational culture that values and upholds peer leadership and governance structures where lived experience and clinical governance systems run in parallel. Cultivating this culture and governance structure takes time, dedicated effort, and an ongoing commitment to maintain the empowerment, empathy, and mutuality that define the peer-led model as highlighted by the following evaluation findings:

- **Safe Spaces operate under a governance structure, where lived experience and clinical governance systems run in parallel** to allow for both high-quality peer-led supports with supports from clinicians when necessary. In this model, peer workers have the authority and autonomy to make care decisions independently, providing guests with tailored, non-clinical support without fear of being overruled by clinical staff. This governance approach is described further in Chapters 6.5.
- **Organisational leaders need to fully understand and support the value of a non-clinical, peer led service** so that clinical tendencies do not creep into the service model and undermine its effectiveness. Some examples from the evaluation include proposals to introduce tablets to collect data from guests on intake and to hire a full-time psychologist to oversee and manage peer workers.
- **The evaluation indicated that developing the appropriate culture and governance structures for a peer-led service was more challenging and took more time for clinically focussed services.** Across the Pilot all providers have progressively improved and continue to improve their organisational cultures and governance structures to support the effective delivery of Safe Spaces.

Incorporating Safe Spaces into a separate clinical service therefore would be challenging, and risk undermining the non-hierarchical, non-clinical approach to care that has made Safe Spaces effective. It would take considerable time for a new service to develop a supportive organisational culture and appropriate governance structures to run the services effectively, which risks disrupting care for current guests and reducing the return on the effort existing providers have put into Safe Spaces.

The unique, calming physical environment of Safe Spaces supportive of distress reduction, would be costly to replicate within clinical settings, which are designed for different purposes

The physical design of Safe Spaces also plays a vital role in reducing guests' distress:

- Safe Spaces are intentionally designed to create a calming, private, and welcoming atmosphere, with features like sensory rooms, quiet areas, and cozy, informal furnishings that foster a sense of control and comfort. As highlighted in Chapter 4.3.2 the design features of Safe Space align with research on supportive design which indicates that healthcare services can support distress reduction by providing a calming environment that fosters control and privacy and provides access to positive distractions (like sensory supports).
- The Safe Space model also relies on spatial design that supports positive distraction and reduce risks of overstimulation. Safe Spaces have specific capital requirements including dedicated sensory areas where guests can engage with soothing activities, bespoke furniture and sensory toys and activities. Safe Spaces are designed to avoid overstimulation – including avoiding bright lights, background noises like televisions, phones ringing or loud typing.
- The private and flexible layout of Safe Spaces (which include group spaces, sound-proof private spaces, sensory spaces and outdoor spaces) empowers guests to choose where they want to be, whether in a quiet corner, a group area, or a sensory room, giving them a sense of autonomy over their environment. Further details about the design requirements of Safe Spaces are in Chapter 6.2.
- The welcoming process in Safe Spaces supports a sense of privacy and control. Upon arrival, guests are greeted warmly by peer workers who approach them with empathy and understanding, often offering refreshments and an immediate place to sit without the need for formal check-ins or paperwork. This process helps guests feel at ease and valued from the moment they enter, putting the guest in control of their supports.

Clinical services are typically designed with different goals, promoting functional efficiency and that prioritising patient throughput rather than relaxation or privacy. Incorporating Safe Spaces into clinical facilities would require developing duplicating key infrastructure and developing new infrastructure:

- Clinical appointment spaces typically follow standardised layouts which do not include the flexible range of spaces that Safe Spaces require (e.g. group spaces, sound-proof private spaces, sensory spaces and outdoor spaces) and do not promote privacy for guests. Clinical facilities are also structured around booked, appointment-based spaces tailored for treatment sessions, which contradicts the flexible, unstructured nature of Safe Spaces that allows guests to move between sensory rooms, quiet areas, and social spaces as they need.
- Reception areas in clinical services is generally a formal, administrative space where people are typically required to register, complete intake forms, and sometimes wait for extended periods – in a space that is not private before receiving support. As highlighted in Chapter 2.1 extended waiting time exacerbates distress and in Chapter 4.3.2 privacy and a sense of control over one's environment is important to stress reduction.
- Many clinical settings include bright lighting, background noises like televisions, phones ringing or loud typing. These environments, even in non-emergency mental health services, can be overstimulating for guests and do not enable control over a guest's environment.

Achieving this level of flexibility within a clinical environment would necessitate additional spaces dedicated exclusively to Safe Space activities, adding significant costs without providing operational efficiencies. Therefore, integrating Safe Spaces into clinical services is unlikely to yield practical benefits.

6.1.2 Potential efficiencies from incorporating Safe Spaces with clinical services are minimal

While incorporation with clinical services might offer potential efficiencies, such as shared administration and clinical backup, these benefits are unlikely to be meaningful

The benefits of incorporating Safe Spaces into a clinical setting are unlikely to be significant and would likely be outweighed by the additional investments required to set up appropriate physical environments, establish a non-clinical identity, and build a supportive organisational culture and governance structure (discussed above). Two potential efficiencies of incorporating Safe Spaces into a clinical service are outlined below:

- **Shared Facilities and Administration**: Although co-location could provide cost-sharing opportunities, the Safe Spaces are already run by services which have clinical components to their service delivery. Moreover, administration for Safe Spaces requires distinct processes focused on peer support rather than clinical case management, limiting the administrative synergy with clinical facilities.
- **Clinical Backup:** Incorporating Safe Spaces into clinical environments would ostensibly allow peer workers to have access to additional clinical back up support. However, for clinical staff to provide backup, they would need to have the time and capacity to assist Safe Spaces without interrupting their own clinical duties. This would need to be resourced on top their existing clinical services, attracting additional costs and this capacity may not be available given the strain on mental health clinicians described in Chapter 5.3.2. As such benefits of incorporation are not likely to be realised.

Incorporating Safe Spaces would reduce the return on investment already made in current providers

The Brisbane North PHN has invested over $10 million over 3 years in Safe Spaces. This significant investment has already gone into establishing Safe Spaces as an effective peer-led alternative to EDs through:

- capital investments to ensure buildings and physical spaces are fit for purpose
- attracting, retaining and training a capable workforce of peer workers and clinicians to deliver the Safe Spaces model of care effectively
- cultivating a supportive organisational culture and appropriate governance structures to run the services effectively
- establishing a distinctive non-clinical branding and community recognition, with consistently high demand for Safe Spaces
- establishing a strong network of relationships with emergency services and hospitals, other health services and community places
- improving community responses to distress through the Compassionate Villages in which strong relationships.

Divesting from Safe Spaces now would risk removing the ongoing benefits from this investment. Moreover, it would take considerable time and money for new organisations to establish this service. There is a risk of disruptions in service quality or availability as services transition which would put guest safety at risk – Safe Spaces play an important role in keeping many guests safe, being an essential element of their safety plans as highlighted in Chapter 5.2.2.

6.1.3 Safe Spaces should work alongside Medicare Mental Health Centres

MMHCs are being rolled out nationally

MMHCs, formerly known as Adult Head to Health Centres, are progressively being rolled out across Australia. Brisbane North PHN is currently in the process of commissioning MMHCs for the Brisbane North region. These centres aim to address mental health needs through a clinical, multidisciplinary approach focusing on moderate to severe mental health conditions. One of the functions of MMHCs is to provide walk-in crisis supports to those requiring urgent mental health assistance as an alternative to ED.[114]

MMHCs vision for crisis support as an alternative to EDs is clinical

The design of MMHCs prioritises structured assessment, treatment protocols, and a team of mental health professionals to manage complex mental health conditions, which stands in contrast to Safe Spaces' non-clinical approach. The MMHC service model emphasises clinical governance, structured care, and crisis management protocols.[115] The MMHC's service model envisages a clinical crisis support as indicated by the following:

- The MMHC service model indicates that staff for the crisis function should have the following three skills or competencies: 1. ability to de-escalate high levels of distress; 2. capacity to complete assessment, including identifying individuals requiring acute ED care; 3. medical skills, including knowledge of medication.[116] The need for knowledge of medication indicates a clinical approach at odds with the Safe Spaces model.
- The MMHC service describe crisis care through a clinical, episode of care lens: "support and short term targeted therapeutic care, based on an episode of care model, including while waiting connection to longer term support."[117] This is fundamentally different to the Safe Space approach which aims to provide meaningful and transformative change in guest's lives by addressing the root causes of distress (as discussed in Chapter 5.2.3).
- Having "Mental Health" in the name of the service would deter guests who attend Safe Spaces from attending as discussed above in Chapter 6.1.1 and Chapter 5.1.2.

The MMHC service guidelines recognise the value of maintaining peer-led crisis services

The MMHC guidelines acknowledge the unique value that peer-led services, such as Safe Spaces, bring to crisis care. They specifically encourage referrals to "peer support groups and peer-led safe spaces," emphasising the importance of these community-based options for providing support beyond clinical environments. This approach allows MMHCs to refer individuals to peer-led services where they exist, ensuring that the diverse needs of individuals in crisis are met. Furthermore, MMHCs are designed with flexibility in service offerings to complement, not duplicate, existing regional services. The guidelines recommend that in locations where peer-led, person-centred alternatives already provide a welcoming and supportive crisis option, MMHCs may focus resources on other needs, maximising the effectiveness of both clinical and non-clinical supports in the community.

[114] Department of Health, Service Model for Head to Health Mental Adult Mental Health Centres and Satellite, June 2021, (accessed 2 October 2024), https://www.health.gov.au/sites/default/files/documents/2022/07/service-model-for-head-to-health-adult-mental-health-centres-and-satellites---revised-june-2021.pdf
[115] Ibid.
[116] Ibid.
[117] Ibid.

It would be challenging to incorporate Safe Spaces into MMHCs without compromising their effectiveness and risking guest safety disruptions

Given their highly clinical nature, it would be challenging, time consuming and expensive to implement Safe Spaces effectively within MMHCs.

- As described in detail in Chapter 6.1.1 the non-clinical nature of Safe Spaces is critical to i) providing an accessible and supportive environment for those with prior medical trauma, stigma around mental health, and non-medical life challenges and ii) the effectiveness of the program in reducing distress and empowering guests to address the root causes of their distress. Embedding Safe Spaces within would risk diluting these unique strengths thereby diminishing the program's effectiveness, creating safety risks associated with disruptions to service quality or availability.
- As described in detail in Chapter 6.1.2, incorporating Safe Spaces into MMHCs would require duplicative staffing and infrastructure, reducing any potential efficiencies from incorporating Safe Spaces with clinical services. Indeed, this would require significant additional investment in time and money to re-establish Safe Space.

Safe Spaces should continue to provide peer-led supports to complement clinical supports provided by MMHCs

The existing Safe Spaces have proven effective at establishing efficient referral pathways and collaborative relationships with other mental health service providers in their area including the existing Mental Health Hubs. In the commissioning process for the MMHCs, Brisbane North is focussing on close integration of MMHC's into the existing Mental Health Hubs. Furthermore MMHCs are structured to work in partnership with local services to provide holistic support. By establishing clear referral pathways and protocols, Safe Spaces can effectively complement MMHCs, ensuring that individuals who need immediate, non-clinical support are directed to Safe Spaces, while those requiring clinical intervention are referred to MMHCs. This arrangement would ensure integration between the services without duplicating efforts or compromising their distinct service models.

6.2 Safe Spaces are effective when they have a homely, non-clinical feel and are in an accessible location to reach its target cohort

Safe Spaces should be located somewhere that is accessible to allow guests to reach the service with ease – many guests from diverse backgrounds may not have access to a car or may have a disability. This means that the location should:

- be close to public transport
- have parking near by
- be located centrally within the community
- make considerations for potential guests with disabilities (such as ramps or disabled toilets)
- have clear signage to help guests navigate there.

Consideration should be given to if the Safe Space can be located somewhere where there are greater populations of those from marginalised groups. For example, a Safe Space located near social housing or in a neighbourhood with high numbers of refugees could improve the potential reach of these groups (that may be experiencing increased levels of distress due to social determinants of health). A central location within the community also allows nearby businesses or services to point people in distress towards the service.

The building itself should provide a warm, homely or cozy feel – that is, avoid being a clinical space (see Chapter 5.2.3 for the benefits). Table 8 contains the characteristics that a Safe Space should include and avoid.

Table 8 | Characteristics to include and avoid at a Safe Space.

Characteristics to include	Characteristics to avoid
• Warm lighting instead • A variety of seating options, including couches, chairs or bean bags • Gender neutral bathrooms • Decorative elements such as paintings flowers or other natural elements	• Fluorescent lights • Strong or overpowering scents or aromas • Loud music or be located near noisy spaces • Cool or overly intense colours

Within the building, there should be a combination of a central space for shared use and peer-led group sessions, and private areas for one-on-one support. Facilities need to have options for sensory activities and kitchenette facilities for food and refreshments. Ideally private rooms should be soundproof to ensure that guests feel comfortable sharing their experiences without concerns of being overheard.

6.3 When recruiting, Safe Spaces should focus on hiring peer workers from diverse backgrounds who are able to effectively apply peer skills to support guest outcomes

6.3.1 Peer workers have specific qualifications, knowledge and experience requirements

Peer workers require:

- Personal lived experience with distress, mental health challenges and/or recovery, and a rich understanding of your own recovery processes with the ability to apply this experience to support others.
- A relevant qualification in peer work (such as Certificate IV in Mental Health Peer Work or equivalent Certificate IV qualification or above).
- Demonstrated knowledge and experience in supporting people in distress.
- Knowledge of local mental health, community, and social services or ability.
- A Working with Children card and Working with People with a Disability check (or the ability to obtain one).

Other qualifications, knowledge and experience that are helpful:

- Completion of trauma-informed care training or willingness to undertake this training.
- Experience of goal setting and capacity building.
- Experience facilitating or supporting the facilitation of group's interactions.
- Experience developing personal Safety and Wellbeing Plans.
- Cultural Competency Training: Special training in cultural awareness and sensitivity is beneficial for working with diverse populations, ensuring inclusive and respectful support.

- Training in Intentional Peer Support, Recovery-Oriented Practice and/or trauma-informed practice.
- Training in Addictions or Substance Abuse: Knowledge of addiction recovery principles is valuable for supporting guests who may have co-occurring mental health and substance use challenges.
- Certification in Suicide Prevention (e.g., Applied Suicide Intervention Skills Training [ASIST] or Question, Persuade Refer (QPR)): This prepares peer workers to respond appropriately to individuals experiencing suicidal thoughts.

6.3.2 Peer workers need the skills to effectively apply their lived experience to support guests

Peer workers bring specific expertise in applying their lived experience to support improvements in guests' lives – simply having lived experience is not enough. There is a distinction between lived experience, lived experience expertise and lived experience leadership – someone with expertise knows how to use their lived experience to help others and leaders advocate for the importance of lived experience within their organisations and more broadly. Figure 38 further outlines and highlights the difference between each.

Figure 38 | The difference between lived experience, lived experience expertise and lived experience leadership.

Peer workers require a range of key skills outlined in Figure 39 that will enable them to apply their peer skills effectively. Peer workers need to be able to apply on their lived experience to create trust and understanding, empowering individuals in distress to find their own path to recovery. Through authentic connections, peer workers need to be able to support each person's unique values and goals, fostering positive changes in their live drawing on their strengths and helping them to prevent or address challenges.

Figure 39 | Skills of an effective peer worker

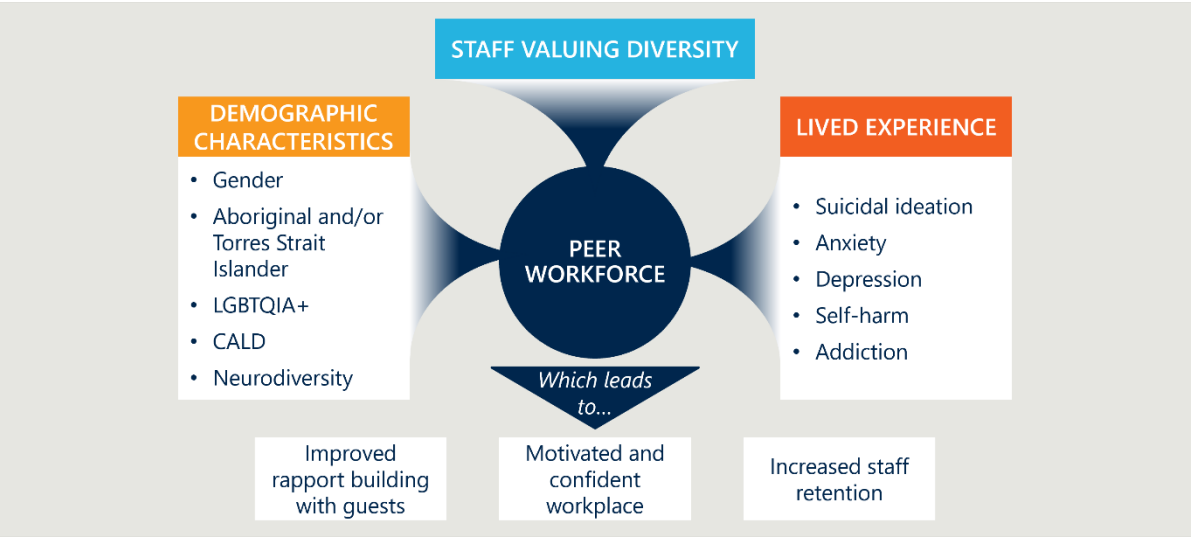
6.3.3 Peer worker diversity is beneficial to both staff and guests

A diverse peer workforce - in terms of demographic characteristics and lived experience – is important to driving positive outcomes for both guests and staff:

- **Guests** are more able develop a positive rapport with peer workers with similar backgrounds or lived experience. During interviews, the increased reliability due to similar backgrounds was highlighted by female, neurodiverse and multicultural guests.
- **Staff** are often more confident at providing care for guests with similar lived experience to them and thus having diversity in lived experience can increase overall confidence. Staff that feel that their diversity is celebrated and that their views are valued within a culturally safe workplace can increase staff satisfaction and retention – especially from culturally diverse backgrounds.

Figure 40 below presents the different types of diversity and the benefits having this brings.

Figure 40 | Diversity within the workforce at a Safe Space



6.3.4 Recruitment processes need to be informed by the practical reality of the peer worker role

Providers need to have a good understanding of the peer worker role to effectively recruit

Providers need to have role clarity – that is a clear understanding of the peer worker role - to be able to hire peer workers with the right skillset and qualities. Involving peer workers (or those with peer work experience) throughout the hiring process - including designing the recruitment processes, developing position descriptions and conducting interviews – is good practice and can help ensure that recruitment processes are effective. To attract peer workers with the right skills, job advertisements and position descriptions need to clearly convey the realities of the role.

Interviews should aim to test the skills needed to do the peer roles

Interview questions should be tailored to the unique nature of the peer support role. This means assessing whether the candidate is able to apply expertise they gained from their lived experience to assist others, and not simply asking what their lived experience is. A range of example interview questions aligned with the skills above for peer workers are listed in Appendix B.

6.4 To mitigate risks of burnout, Safe Spaces staff need to be effectively resourced and supported

6.4.1 Burnout is a key risk for peer workers

Burnout is a state of emotional, mental, and physical exhaustion resulting from prolonged or repeated stress due to occupational exposure.[118] Burnout is characterised by emotional exhaustion, depersonalisation and a diminished sense of personal accomplishment. It can lead to higher rates of staff turnover and absenteeism as well as poorer job performance.[119]

The evaluation found that without appropriate supports in place, burnout among peer workers in Safe Spaces is a risk. In a survey of peer workers using the Maslach Burnout Inventory, 93 per cent of peer workers reported moderate signs of depersonalisation, 48 per cent reported moderate signs of occupational exhaustion and 10 per cent indicated high signs of occupational exhaustion. There are nine key drives for burnout in peer workers, with distinct challenges from clinical work which are informed by academic literature and interviews with Safe Spaces staff:

1. **High workload and time pressure:** Excessive workloads and time constraints can overwhelm peer workers, making it difficult to provide effective support and maintain personal well-being.120 Clients can spend up to four hours in the Safe Space and can return multiple times in a week. On the other hand, in clinical settings clinicians typically only spends around one hour with a client once or twice a week (or considerably less frequently depending on the client's needs).
2. **Exposure to secondary trauma and compassion fatigue**: Regularly engaging with individuals who have experienced trauma can lead to secondary traumatic stress in peer workers and compassion fatigue, increasing their risk of burnout.[121]

[118] Bianchi R, Schonfeld IS. Examining the evidence base for burnout. Bulletin of the World Health Organization. 2023 Nov 11;101(11):743.
[119] Maslach C, Schaufeli WB, Leiter MP. Job burnout. Annu Rev Psychol. 2001;52:397–422. doi: 10.1146/annurev.psych.52.1.397.
[120] Bywood P, du Plessis K, Moo A, McMillan J. Fatigue and burnout in healthcare: prevalence, impact and interventions. Institute for safety, compensation and recovery research. Evidence review. 2020 Sep;271.
[121] Ibid

3. **Staff shortages and limited opportunities for rest and recovery**: Insufficient staffing levels can lead to heavier workloads for peer workers, resulting in fewer opportunities for rest and recovery. This continuous strain can exacerbate stress and fatigue, heightening the risk of burnout.[122]
4. **Inadequate supports:** Lack of organisational backing, including insufficient supervision and resources, can leave peer workers feeling isolated and overwhelmed.[123] These include regular structured supervision and mentorship, training and professional development opportunities, and access to mental health resources to manage their own well-being.
5. **Job insecurity and limited career prospects:** Peer workers often face temporary contracts and unclear career advancement paths, leading to feelings of instability and uncertainty.[124]
6. **Perceived lack of valuation and professional recognition:** Peer workers may feel undervalued compared to clinicians, especially when their contributions are not equally acknowledged. This disparity can lead to feelings of inadequacy and decreased job satisfaction, contributing to burnout.[125]
7. **Boundary Challenges:** Peer workers often draw upon their personal experiences to support others, which can blur the lines between professional and personal relationships. This overlap may lead to emotional strain, as peer workers might find it challenging to maintain appropriate professional boundaries while sharing personal stories. Such boundary issues can result in over-involvement or difficulty in detaching from clients' problems, increasing the risk of burnout. Whereas the boundaries of a clinician's roles are typically well defined by professional codes of practice and ethics and clinicians undergo extensive and rigorous training to understand these boundaries.
8. **Role ambiguity:** Peer workers may encounter unclear job expectations and responsibilities, leading to confusion about their specific duties within a team. This uncertainty can cause stress and frustration, as they might struggle to understand their role's scope and how it integrates with other professionals. Where organisations do not have clear peer practice frameworks and how clinical governance works alongside this, it can create role confusion and stress for peer workers.[126]
9. **Role unpredictability:** In a walk-in environment, the nature and intensity of client needs can vary significantly. This unpredictability makes it challenging to prepare for each encounter, leading to increased stress and potential burnout.[127] Whereas in clinical settings such as psychology, there is often some form of eligibility screening a person goes through to test whether the clinician has the right skills-set for the client's needs. The clinician typically receives some information about the client ahead of time.

6.4.2 Four to five staff are required on a typical shift for staff safety

Correct staffing is essential to ensuring Safe Spaces run smoothly, safely and sustainably. Safe Spaces should plan to have four or five workers on each shift so that the service to run effectively, address demand and minimise burnout for workers. While the bare minimum number of staff required to open a Safe Space is three staff, this should be avoided on a regular basis as with current demand levels this is

[122] Cohen C, Pignata S, Bezak E, Tie M, Childs J. Workplace interventions to improve well-being and reduce burnout for nurses, physicians and allied healthcare professionals: a systematic review. BMJ open. 2023 Jun 1;13(6):e071203.
[123] Gillard S, Foster R, White S, Barlow S, Bhattacharya R, Binfield P, Eborall R, Faulkner A, Gibson S, Goldsmith LP, Simpson A. The impact of working as a peer worker in mental health services: a longitudinal mixed methods study. BMC psychiatry. 2022 Jun 1;22(1):373.
[124] Ibid
[125] Ibid.
[126] Reeves V, McIntyre H, Loughhead M, Halpin MA, Procter N. Actions targeting the integration of peer workforces in mental health organisations: a mixed-methods systematic review. BMC psychiatry. 2024 Mar 18;24(1):211.
[127] Reeves V, Loughhead M, Halpin MA, Procter N. "Do I feel safe here?" Organisational climate and mental health peer worker experience. BMC Health Services Research. 2024 Dec;24(1):1-8.

unsustainable for peer workers and requires turning away guests. The staff is usually comprised of two to four peer workers and one clinician (who can be on-call).

Four or five staff members should be planned for on a regular basis as:

- Staff need to be able to support guests within both one-on-one and group settings.
- There need to be capacity to safely support transfers to EDs when required or resolve any issues arising which can be unpredictable due to the walk-in nature of Safe Spaces.
- There needs to be capacity for peer workers to swap in and out of support roles to manage potential triggers and distress for their own safety and to reduce the risk of burnout. Walk-in spaces are an unpredictable environment where peer workers cannot prepare for who will come into the Safe Space. There is a huge variety of guest needs and presenting issues ranging from alcohol and drug, domestic violence and severe mental health issues such as schizophrenia. Clients can spend up to four hours in the Safe Space and can return multiple times in a week. Furthermore, using your lived experience can be very taxing – peer workers need to manage triggers in an environment they cannot control.

6.4.3 Having a pool of at least ten peer workers that have opportunities for career growth reduces the risk of staff burnout and turnover

Safe Spaces need a pool of at least 10 peer workers to run sustainably

The pool of staff that a Safe Space draws upon must be large enough to avoid overworking peer workers. Staff expressed that within a fortnight, seven shifts is the most that a single peer worker should do (due to the mental burden of the work). Too many shifts in a row also can lead to increased burnout and potential staff turnover. Also, staff should have the opportunity to take leave (including sick leave) or have opportunities to attend training and obtain other continual professional development (similar to other professions). It is recommended that a Safe Space should have at least ten peer support workers within their workforce pool to meet these requirements.

Opportunities for career progression at Safe Spaces are important to attract and retain staff

Establishing multiple levels of peer worker seniority, along with pathways into service management roles, creates long-term career opportunities within Safe Spaces. Senior peer workers play a crucial role in supporting and training newer staff, contributing to the model's sustainability over time. This aligns with the National Mental Health Workforce Strategy 2022-23 that states that "[there is a] need to enhance pathways to promote career development and growth [for the peer workforce]".[128]

6.4.4 A Safe Space shift requires time before and after the shift to prepare and debrief

Allocating dedicated time before and after shifts is crucial for peer workers' well-being and effectiveness. Pre-shift preparation allows staff to mentally and emotionally ready themselves, review any pertinent information, and communicate specific needs—such as additional support following a challenging prior shift—with colleagues. Post-shift debriefing sessions with fellow staff or supervisors (including clinicians) provide essential opportunities to process experiences, discuss any distressing events, and receive guidance, thereby mitigating the risk of burnout and secondary traumatic stress. Implementing these

[128] Department of Health and Aged Care, National Mental Health Workforce Strategy 2022-32, 10 October 2023 (accessed 29 October 2024), https://www.health.gov.au/sites/default/files/2023-10/national-mental-health-workforce-strategy-2022-2032.pdf

practices fosters a supportive work environment, ensuring peer workers can perform their roles safely and sustainably. Figure 41 summarises the minimum requirements for shifts at Safe Spaces.

Figure 41 | Minimum requirements of a Safe Space shift.

6.4.5 Ongoing supports, resources and a supportive organisational environment are critical to prevent burnout

A whole-of-organisation approach is required for effective employment of lived experience workers

Research in effective employment of lived experience workers suggest the whole-of-organisation approach is needed[129]:

- **Leadership support:** Ensure that organisational leaders actively support and advocate for the incorporation of a peer-led service. Leadership commitment is crucial in setting the tone for an inclusive, peer-led culture.
- **Peer leadership culture:** Cultivate an environment where peer workers are empowered to lead service delivery and decision-making. This approach leverages their lived experiences to shape practices and policies, ensuring services are truly peer-led. This includes employing lived experience workers in senior roles.
- **Adequate financial support:** There is a need for financial investment in lived experience workforce development to ensure adequate supports, leadership and influence on workplace culture.

Organisations need to provide a range of supports and resources

To ensure Safe Space staff are effective, organisations should provide the following supports and resources for peer workers and clinicians:

- **Comprehensive training programs and ongoing professional development:** Offer foundational training covering core competencies and understanding workplace legislative requirements. Facilitate ongoing learning through workshops, seminars, and courses to keep peer workers updated on the latest practices and emerging challenges. Training and ongoing professional development is required for clinicians and peer workers and should be delivered from a lived experience perspective. The focus of training for clinicians should be on how to work effectively to support peer workers in peer-led environments.

[129] Byrne, L., Roennfeldt, H., & Wolf, J., Linfoot, A., Foolesong, D., Davidson, L & Bellamy, C. (2021). Effective peer employment within multidisciplinary organizations: Model for best practice. Administration and Policy in Mental Health and Mental Health Services Research. doi: 10.1007/s10488-021-01162-2

- **Regular supervision and mentorship:** Implement structured supervision sessions and mentorship programs from a lived experience perspective to provide guidance, emotional support, and a platform for discussing complex situations.
- **Reflective practice**: Peer workers should have the opportunity to engage in ongoing reflective practice for example through communities of practice within the lived experience discipline. This is an active process of looking at your practice or the work you do in order to examine it more closely, give meaning to it and learn from it.
- **Access to mental health supports:** Provide resources such as employee assistance programs to support peer workers' own mental health and prevent burnout.
- **Clear role definitions and expectations:** Establish well-defined roles and responsibilities to reduce role ambiguity and enhance collaboration with other professionals including clinicians.
- **Clear burnout management protocols and staffing requirements:** Establish protocols for identifying and managing burnout, including minimum staffing requirements to ensure peer workers have adequate support and rest. These standards are essential to maintain safe, sustainable working conditions and avoid overloading staff.

6.5 Lived experience and clinical governance structures need to run in parallel to enable the peer-led model of care

Safe Spaces operate under a dual governance structure where lived experience and clinical governance systems run in parallel, allowing for both high-quality peer support and appropriate clinical interventions when necessary. Clinical governance is a cornerstone for ensuring services are safe and high quality. However clinical governance structures are designed and implemented in partnership with and alongside continued investment and development of lived experience governance.

In this model, peer workers have the authority and autonomy to make care decisions, providing guests with tailored, peer support without concern that their decisions may be overruled by clinical staff. Figure 42 overleaf, illustrates the parallel nature of the governance, clarifying roles and responsibilities in guest care and showing when clinical input is required. As explained by SA Lived Experience Leadership & Advocacy Network (LELAN): "Lived experience governance intentionally embeds organisational cultures and systems that give primacy to centring or being led by lived experience perspectives, principles, and ways of working in the decision-making, oversight and evaluation of systems, structures, policies, processes, practices, programs and services."[130]

A key role for clinicians in this governance arrangement is structured debriefing and support for peer workers before and after shifts, especially following challenging interactions. To maintain role clarity, it is recommended that peer workers and clinicians have distinct responsibilities within shifts, avoiding dual roles that could compromise the effectiveness of either function.

[130] Hodges, E., Leditschke, A., Solonsch, L. (2023). The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra.

Figure 42 | The parallel lived-experience-clinical governance structure.

Clinical governance structures are in place at the Safe Spaces as they are an established structure of safety and effectiveness. Providers of Safe Spaces are in the process of evolving and refining lived experience governance as this becomes more prominent within the mental health ecosystem. The dual, parallel structure ensures the safety of guests while effective lived experience practices can be maintained.

6.6 To achieve continual improvement throughout implementation, Safe Spaces should embed ongoing collaboration, monitoring and evaluation within program governance structures

Safe Spaces are a service that must be able to adapt to their local context. For example, a Safe Space may have higher numbers of guests from certain populations (such as Aboriginal and/or Torres Strait Islanders or refugees) which may find benefits in adjustments to the Safe Space model – providers must have some agency to adjust the delivery of Safe Spaces. This is best achieved through governance structures and arrangements between the provider and PHN that enable continual improvement.

There are several mechanisms that enable ongoing progress:

- **Ongoing PHN performance management** – the PHN leading the program should meet regularly with providers from the outset of implementation and work closely with them to resolve any emerging issues collaboratively. Consistent messaging on the importance of peer work from the PHN drives a more consistent regional response around distress. These meetings enable the PHN to hold providers to the principles of the model and to prescribe performance management actions if they are not meeting expectations.
- **Cross-provider collaboration and sharing of resources** – workforces from each provider should be provided forums to meet, train, share resources and discuss ways of effectively implementing and running the Safe Space model. These forums can be used as ways to collaborate on issues that providers may be having – it is likely that issues will be similar across services, and some may have already devised solutions to each other's problems.
- **Local-context adaptations and flexibility guidance** – the PHN must provide guidance as to what components of the model are flexible or not. For example, peer-led care is a non-negotiable aspect of the model, but the peer care framework used could vary (such as the Alternatives to Suicide

intentional peer support frameworks).[131] This will enable providers need to adjust their service delivery to meet the needs of their communities. Including an initial co-design process of the Safe Spaces can help ensure the design meets local community needs.

- **Monitoring and evaluation frameworks** – evaluating the implementation of the service and its effectiveness at semi-regular intervals throughout the program determines if the service is working as intended, if outcomes are being achieved and how the program can be sustained longer-term. It allows for the identification of any emerging issues and provide recommendations as to how they can be addressed before they become larger issues. In addition, having an evaluation framework (including key evaluation questions and a program logic) clearly communicates to providers what the program should achieve from the outset and what ongoing data should be collected to determine if outcomes are being achieved.

Minimal regular data collection should be supplemented with periodic in-depth mixed methods evaluations

The data collection required for each service interaction should be kept to a minimum, with simple digital systems that allow peer workers to collect key data points without guests filling out forms. Minimal data collection is critical to the approach taken by Safe Spaces. As this evaluation was of a Pilot Program, Safe Space providers collected substantial data for each service interaction so that a robust evidence base could be established regarding the effectiveness of Safe Space. This evaluation has indicated that Safe Spaces are effective and going forward less data should be captured at each service interaction to minimise burden on peer workers and guests. Key information to collect at each service interaction include:

- data that will support understanding of the reach of the program (particularly for priority cohorts) as well as any unmet demand to support ongoing resourcing decisions
- quantification of the program benefits through avoidance of ED admissions
- guest contact details (if the guest wants a follow-up contact) - guests right to anonymity needs to be maintained
- providers may wish to capture information about timing of arrivals to optimise staffing levels over time.

Data that should no longer be required to be collected for each service interaction includes the collection of SUDs scores, details about the type of supports provided to guests, postcode of usual residence

To supplement minimal regular data collection, more in-depth evaluations should be conducted periodically, for example every 3-5 years. These evaluations should be designed to understand what is working well and what could be improved about the service and to advance the evidence base of the enablers and barriers to implementing Safe Spaces and the impact of Safe Spaces on guests, staff and the broader system and community. These evaluations could include the following data collection approaches:

- **In-depth interviews with guests, families and carers:** These interviews offer qualitative insights into the personal experiences and perceived impact of Safe Spaces on guests' wellbeing. This can also give insights into the reasons why something is working or not working generating actionable feedback that can help refine service delivery.
- **Surveys of guests:** Conducting surveys with a representative sample of guests enables robust estimates of the overall effects of Safe Spaces, providing valuable data on guest satisfaction and program impact. By analysing responses across demographic groups, these surveys can identify which

[131] Flick Grey, Sar Bostock & Jo Farmer, Lean Alternatives to Suicide (Alt2Su) Evaluation – Final Report, February 2024 (accessed 6 Nov. 2024). Available here: https://www.lelan.org.au/wp-content/uploads/2024/05/Alt2Su-Evaluation-Final-Report.pdf

cohorts benefit most from Safe Spaces, offering detailed insights into the program's effectiveness across priority populations and helping to tailor services for greater impact.

- **In-depth interviews or focus groups with Safe Space staff:** Engaging staff in interviews or focus groups gathers valuable feedback on operational challenges, successes, and ideas for improvement, helping to identify barriers and enablers in service delivery.
- **Surveys of Safe Space staff:** Staff surveys can capture trends in workforce satisfaction, burnout levels, skill development, and perceived program effectiveness, informing resource and training needs.
- **Linked data prospective cohort studies:** Enrolling a representative sample of Safe Space guests in a prospective cohort study, and getting consent to link their Safe Space usage data with other health service datasets, would enable the generate more robust estimates of:
  - broader system-level impacts of Safe Spaces, such as reductions in ED visits and changes in other health service use
  - quantitative estimates of the longitudinal impacts of Safe Spaces on physical and mental health outcomes as well as other outcomes like housing or employment security.

6.7 A strong community network bolsters the reach of the Safe Spaces and improves the integration of care and supports

Developing a strong connection to community places through Compassionate Villages improved the reach of Safe Spaces and supported grassroots initiatives to improve community responses to and support for distress (see Chapter 5.3.3). The development of the network is a slow process that required significant groundwork – dedicated coordination efforts are required over a long period of time. Table 9 outlines some of the barriers to developing a network and enabling strategies and learnings to overcome these issues.

Table 9 | Barriers and enablers for the creation of Compassionate Villages.

Barrier	Enabling strategies and learnings
Community places priorities are not focussed on participating in Compassionate Village initiatives, leading to slow communication (from community places) and limited relationship building.	• Provide different options for participation and involvement e.g. digital and in person options. • Work with community places to learn what achievable involvement looks like for them.
Community place staff are frequently on short-term contracts and may leave their roles resulting in rebuilding relationships from scratch.	• Connect with services/businesses and try to avoid single person dependencies. • Encouraging staff from community places to share or rotate involvement in the Compassionate Village.
Confusion around the Compassionate Village concept/model.	• Communication must be clear and consistent early on, and it should proactively share the Compassionate Village vision, model and purpose. • Articulate what the Safe Space is and how it is different from the Compassionate Village.
Uncertainty around long-term funding.	• Focus investment on what will achieve the most longevity once the funding ends such as connections between community places. • Funding is needed to conduct engagement but is not needed to maintain connection if there is already relationship. Focus on

Barrier	Enabling strategies and learnings
	relationships between services within the community and not between a place and the coordinator.
Inconsistency within the coordinator role.	• Ensure there is handover time between coordinators if one resigns. • Have multiple coordinators to ensure some continuity of the role.

6.8 Ongoing clarity around funding is necessary for continued delivery of the Safe Spaces

Ongoing funding clarity is essential to plan for the future and deliver plans along a long delivery timeline. Funding uncertainty presents Safe Spaces with challenges in managing staffing requirements and in planning how to make strategic plans, train staff and further develop the service. It also presents a major challenge to the Safe Space network coordinator in properly establishing the Compassionate Network.

Funding clarity is essential for Safe Spaces to manage workforce and plan for the future

Safe Space peer workers and managers have expressed concerns about being unable to meet the level of demand for the service, resulting in peer workers struggling with unmanageable workloads. It is important for Safe Spaces to have the funding to ensure their workforces are large enough to meet the service demand and flexibility requirements of an after-hours service. It is also essential for the Safe Spaces to have funding clarity to allow them to plan things such as through training, workforce planning and long-term strategic plans for the service. Safe Space worker reflections on these issues are further highlighted below in Figure 43.

Figure 43 | Safe Space peer worker reflections on the need for funding clarity

The Compassionate Village requires ongoing funding to invest in long-term relationships with community places

A challenge of establishing the Compassionate Village is achieving buy-in from community places to become involved. This requires the Network Coordinator to spend time establishing these relationships through workshops and events, facilitating discussions and learning opportunities. Interviews with the Network Coordinator revealed that this is particularly challenging because integration into the Compassionate Village is not necessarily aligned with the core business operations of the community places, making it difficult to align timelines to run workshops and incentivise action. Therefore, this process is time consuming and there is reduced incentive for community places to become involved if the Safe Spaces and Compassionate Village has uncertain funding.

7 Recommendations

This chapter provides five recommendations informed by the evidence presented across this report including: the evidence that EDs are often not appropriate to help people in distress (presented in Chapter 2); the gap Safe Spaces fill in the support system and the evidence based underpinning the design of the Safe Space model of care (presented in Chapter 4); the outcomes of the Safe Space model of care from evaluation of the Pilot (presented in Chapter 5) and the key lessons for the successful implementation and sustainability of Safe Spaces (presented in Chapter 6).

Recommendation 1: Continue funding Safe Spaces as a stand-alone, peer-led service

It is recommended that funding for Safe Spaces accounts for the following core features at a minimum:

- Fit-for-purpose buildings with a homely, calming and non-clinical feel, in an accessible location within community, separate from clinical services. Facilities need a mix of group and private spaces, options for sensory activities and kitchenette facilities for food and refreshments.
- A peer-led and non-clinical model of care, focused on providing holistic and flexible supports to guests to reduce immediate distress and to address guests' needs and the root causes of distress. The model of care needs to be characterised by:
    - Non-hierarchical relationship dynamics based on shared lived experience
    - A focus on strengths rather than diagnoses or deficits
    - Empowering guests to make decisions about their care with a flexible range of holistic supports
    - A relaxed and unhurried approach to support.
- A walk-in, no wrong door approach to a welcoming environment including minimal formal intake or data collection processes that resemble clinical services.
- Non-clinical branding and marketing – this should avoid discussion of mental health or clinical supports in guest-facing communications.
- A minimum of four staff (including at least three peer workers) are rostered onto shifts and that providers have access to pools of at least 10 peer workers (See Recommendation 3).
- Funded time before and after shifts to support preparation and de-briefing.
- Provision of consumables such as food and refreshments and materials for sensory activities.

One-off additional funding may be considered for:

- Establishing ways of working and referral pathways with Medicare Mental Health Centres.
- Limited capital upgrades to support improvements to Safe Spaces buildings (e.g. soundproofing of private rooms).

Additional ongoing funding may be considered for:

- Extending opening hours of Safe Spaces.
- Initiatives to expand the pool of available peer workers and to improve provider capacity to deliver peer-led programs effectively with sound parallel lived experience and clinical governance.

Rationale: Safe Spaces should be continued to be funded as a stand-alone, peer-led service because they have proven a safe, high quality and cost-effective model of care to support guests through immediate distress, to address the root causes of guest distress to sustain long-term positive improvements in guests' lives and to divert guests from EDs. Safe Spaces need to be run separately from clinical services as the

non-clinical, peer-led nature of the service is critical to the effectiveness of the model of care. Removing Safe Spaces or integrating them into a clinical service would create considerable safety risks and disruptions to guests' care plans and would likely increase strain on EDs.

Recommendation 2: Provide funding certainty to the Safe Spaces and the Compassionate Villages

It is recommended that Safe Spaces and Compassionate Villages receive stable, long-term funding to prevent disruptions and ensure sustainable growth.

Rationale: Long-term funding is essential to build a sustainable model, avoid high staff turnover, and foster strong community partnerships. With assured funding, Safe Spaces can retain skilled workers, invest in training, and strengthen networks, ensuring that guests receive consistent, high-quality support and feel confident in returning when needed.

Recommendation 3: Ensure adequate staffing levels and workforce supports

It is recommended that:

- Safe Spaces must be staffed by a minimum of four workers on each shift, drawing from a larger pool of at least 10 peer workers to prevent staff burnout and ensure continuity of care.
- Protocols ensure that Safe Spaces do not open where fewer than three staff are available to work a shift to ensure worker and guest safety. These protocols need to include mechanisms to alert potential guests about the closure in a timely manner and for alternative supports to be arranged.
- All Safe Space staff including peer workers, clinicians and management have access to resources and supports to create a positive peer-led culture and to the risk of and support staff to recover from burn out. At a minimum access, this needs to include access to comprehensive induction and initial training; ongoing professional development; regular supervision and mentorship; reflective practice; debriefing; access to confidential mental health supports (such as through an Employee Assistance Program)
- All Safe Spaces are governed by parallel lived experience and clinical governance appropriate for a peer-led service, with clearly defined roles and responsibilities for peer and clinical staff.

Rationale: Adequate staffing and ongoing supports are crucial for both guest and staff safety, particularly as peer work involves drawing on personal lived experiences. Ensuring a well-trained, resilient workforce maintains service quality and helps reduce burnout, enhancing both immediate support and the long-term sustainability of the Safe Spaces model.

Recommendation 4: Continue to strengthen community networks and referral pathways

It is recommended that that:

- Certainty for ongoing funding is provided to the Compassionate Village (see Recommendation 2)
- Network coordinator/s continue to expand the breadth and depth of partnerships with local businesses, organisations, and other health and social services to improve awareness and reach of the Safe Space program, and improve community responses to distress.
- Network coordinator/s continue to co-design and co-deliver initiatives to facilitate improved community responses to distress tailored to the needs and strengths of local communities.

Rationale: A strong community network enhances Safe Spaces' reach and impact by providing additional support options, promoting early intervention, and ensuring continuity of care beyond Safe Space facilities. This approach builds a comprehensive support system within local communities, which can help reduce distress escalation and improve overall mental health outcomes.

Recommendation 5: Develop comprehensive service guidelines and embed continuous improvement mechanisms

It is recommended that:

- Comprehensive service guidelines are developed which clearly outline the minimum requirements and expectations of providers and where providers have flexibility to adapt according to local needs and context. Suggested content for comprehensive service guidelines are outlined in Figure 44.
- An ongoing monitoring and evaluation framework is developed based on minimal targeted service data supplemented with periodic in-depth mixed methods evaluations every 3-5 years.
- Regular mechanisms for cross-provider collaboration and sharing of resources are held.

Rationale: Ongoing mechanisms for continuous improvement will ensure that going forward, Safe Space care is high quality and that it meets the needs of the community. This includes driving improvements in peer-led practices and strengthening the parallel nature of lived experience and clinical governance within the PHN and providers. Providers should also continue to have opportunities to share learnings and resources, and problem solve.

Figure 44 | Suggested content for comprehensive service guidelines

Comprehensive service guidelines should include at a minimum:

1. The aims, purpose and desired outcomes of Safe Spaces.
2. The key features of the non-clinical and peer-led model of care (this may include evidence, supporting theory and practice frameworks as well as expectation about how supports should be delivered)
3. Expectations for Safe Space shifts including:
    i. Marketing and communication of Safe Spaces
    ii. Opening hours
    iii. Minimum staffing requirements
    iv. Pre-shift preparation and Post shift activities
    v. Supporting new and returning guests: greeting and welcoming guests, supports provided at the safe space and guest follow up
    vi. Referral pathways (in and out)
    vii. Data collection and quality assurance.
4. Workforce skills and supports
    i. Staff competency frameworks – for peer workers, clinicians and managers and organisational executives.
    ii. Expectations around access to training, regular supervision and mentorship, reflective practice, debriefing and confidential mental health supports (such as through an Employee Assistance Program).
5. Expectations around peer-leadership, organisational culture and parallel lived experience and clinical governance.

Appendix A Comparison to other services

Table 10 | Comparison between Safe Spaces and other community-based services.

Domain	Safe Spaces	Medicare Mental Health Centres	headspace	Psychosocial services
Purpose	A non-clinical, peer-led service located within the community for individuals in distress or crisis that can be used as an alternative to Eds.	A welcoming, low-stigma entry point for assessment and treatment for individuals in distress or crisis, including those with complex conditions not suited for primary care or needing faster care than public community mental health services offer.[132]	A range of early intervention services targeted at young people with mental ill-health (and other related issues, such as alcohol and drug support or support in achieving work or study goals). Both in person and online/phone support can be provided.[133]	Non-clinical community-based supports that are tailored to meet the needs of each client and their community. They focus on building personal capacity and life skills to live independently (where possible) in the greater community.[134]
Age group	Any age.	Targeted at adults (18 years or older) – children will be recommended to headspace	Young people (12- to 25-year-olds)	Varies depending on the program (typically 16 years or older).
Target level of distress	Immediate crisis and/or low to severe distress.	Immediate crisis and/or moderate to severe distress	Low to moderate.	Severe to complex.
Cost	Free.	Free.	Free, $15 or $39 out-of-pocket, depending on circumstances (including ability to pay the full fee, or having Centrelink or a Health Care Card).[135]	Free.

[132] Australian Government Department of Health and Aged Care, Medicare Mental Health Centres, 11 October 2024 (accessed 21 October 2024), https://www.health.gov.au/our-work/medicare-mental-health-centres

[133] headspace, our services, 2024 (accessed 21 October 2024), https://headspace.org.au/services/

[134] Department of Health and Aged Care, Commonwealth Psychosocial Support: Program Guidance, 6 September 2024 (accessed 30 October 2024), https://www.health.gov.au/sites/default/files/2024-09/commonwealth-psychosocial-support-program-guidance.pdf

[135] headspace, headspace Primary Fees, 2024 (accessed 21 October 2024), https://headspace.org.au/assets/Uploads/Centres/Syndal-v2/headspace-Primary-Fees.pdf

Domain	Safe Spaces	Medicare Mental Health Centres	headspace	Psychosocial services
Referral	Not required.	Not required.	Not required.	Required.
Entry/assessment	Walk-in service. New guests are first greeted by a peer worker, before being provided a brief tour of the Safe Space.	Walk-in service or appointment. Initial Assessment Referral Decision Support Tool is used for assessment.	Appointments only. Before a first appointment, individuals will be asked to complete a brief survey before spending time with a headspace team member. Assessments are available.	Appointments only. Each service will provide different services, and some may have an assessment component.
Services/supports	Immediate or short- to medium-term support which can include: • one-on-one time with a peer worker or clinician to de-stress, develop safety plans or referrals to other services. • group sessions with peer workers and other guests. • sensory toys and calming activities. • Follow-up is available.	Immediate or short- to medium-term support which can include: • evidence-based and evidence-informed care to manage symptoms • providing a central point to connect people to other services. • Follow-up is available.	Short- to medium-term support which can include: • support with mental ill-health such as anxiety or depression • evidence-based and evidence-informed care to manage symptoms • care that is tailored to meet the needs of the young person. • Follow-up is available.	Short- to medium-term support which can include (and will be service dependent): • one-on-one support through coaching and care coordination • group therapy sessions to learn strategies to support a meaningful life • therapies such as Dialectical Behavioural Therapy. • Follow-up may be available.
Opening hours	5pm – 9pm Monday to Friday, with staggered opening hours from 9am – 7pm across the four sites on Saturday and Sunday.	Typically, 8:30am – 5pm Monday to Friday (13 out of 29 MMHCs are open regularly after 6pm).[136]	Typically, 8:30am – 5pm Monday to Friday (closing and opening times can vary).	Typically, 8:30am – 5pm Monday to Friday (but dependent on service).
Staffing model	2-3 peer workers and one clinician.	Each site has a multidisciplinary team that could include different roles, including (but not limited to): • mental health nurses	Each site has a variety of mental health-related roles including: • psychologists • psychiatrists	Each service will have different staffing models but may include (but not limited to): • mental health nurse

[136] Australian Government Department of Health and Aged Care, Medicare Mental Health Centres, 11 October 2024 (accessed 21 October 2024), https://www.health.gov.au/our-work/medicare-mental-health-centres

Domain	Safe Spaces	Medicare Mental Health Centres	headspace	Psychosocial services
		• occupational therapists • care navigators • psychologists and other allied health professionals • GPs • peer support workers.	• counsellors • GPs.	• social worker • mental health clinician • peer support worker • peer wellbeing coach.

Table 11 | Comparison between Safe Spaces and other mental health and crisis support services.

Domain	Safe Spaces	Crisis Stabilisation Units	Crisis support hotlines	Psychologists	EDs	General Practitioners
Purpose	A non-clinical, peer-led service located within the community for individuals in distress or crisis that can be used as an alternative to EDs.	An alternative to ED within a hospital that supports individuals experiencing a mental health crisis through a short-term stay and supervision.[137]	Support hotline to provide immediate, confidential support and intervention for individuals experiencing suicidal thoughts or emotional crises. This includes services such as Lifeline, 13Yarn, Suicide Call Back Service, yourtown's Kids Helpline and Beyond Blue Support Service.	To assess, diagnose, and treat mental health issues, helping individuals improve their emotional well-being and functioning.	To provide immediate medical care to patients with acute illnesses or injuries that require urgent attention – including those who are experiencing suicidal ideation.	A doctor that provides medical assistance, diagnoses and manages health conditions, and acts as the first point of contact for the greater healthcare system. Not specific to mental health.
Age group	Any age	16 years old or older,[137] or 18 years old or older.[138]	Any age (yourtown's Kids Helpline is for 5- to 25-year-olds).	Any age.	Any age.	Any age.

[137] Metro North Health, Crisis Stabilisation Units, 2024 (accessed 21 October 2024), https://metronorth.health.qld.gov.au/tpch/healthcare-services/mental-health/csu
[138] Gold Coast Health, Crisis Stabilisation Unit, 1 October 2024 (accessed 21 October 2024), https://www.goldcoast.health.qld.gov.au/our-services/crisis-stabilisation-unit

Domain	Safe Spaces	Crisis Stabilisation Units	Crisis support hotlines	Psychologists	EDs	General Practitioners
Target level of distress	Immediate crisis and/or moderate to severe distress.	Immediate crisis.	Immediate crisis.	Low to severe distress.	Immediate crisis.	Low distress.
Cost	Free.	Free.	Free.	• $311[139] without Medicare rebate for a 46-to-60-minute private session. • $17 out-of-pocket after Medicare benefit of $96.65[140] for one-on-one psychology session.	Free (with Medicare).	• $80[141]/$125[142] without Medicare for a short/long session respectively. • $40[141]/$48[142] out-of-pocket after Medicare rebate of $40[141]/$77[142] for a short/long session respectively.
Referral	Not required.	Required – accessed through ED, police, ambulance or phone.	Not required.	Not required but significantly cheaper with referral.	Not required.	Not required.
Entry / assessment	• Walk-in service • New guests are first greeted by a peer worker, before being provided a brief tour of the Safe Space.	• Appointments only. • New guests are welcomed by a clinician and peer worker. • Clinicians will undertake a mental health risk	Call-in service.	• Appointments only. • Anyone can go to a psychologist (typically requiring a booking ahead of time).	• Walk-in service. • Present to the ED, and if required, admitted to the acute mental health unit. • Mental assessment will be undertaken.	• Appointments only. • Anyone can go to a GP (typically requiring a booking ahead of time). • GP may undertake an assessment.

[139] Australian Psychology Society, Private practice services, 2024 (accessed 21 October 2024), https://psychology.org.au/psychology/about-psychology/what-it-costs/private-practice-services

[140] Medicare Benefits Schedule, Item 80112, (accessed 21 October 2024), https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=80112&qt=item&criteria=80112

[141] Australian Department of Health and Aged Care, Medical Costs Finder: Standard GP consult (in rooms), (accessed 21 October 2024), https://medicalcostsfinder.health.gov.au/services/G23?specialty=019999

[142] Australian Department of Health and Aged Care, Medical Costs Finder: Long GP consult (in rooms), (accessed 21 October 2024), https://medicalcostsfinder.health.gov.au/services/G36/oh?term=long+gp&specialty=019999

Domain	Safe Spaces	Crisis Stabilisation Units	Crisis support hotlines	Psychologists	EDs	General Practitioners
		assessment on guest.		• Psychologist will undertake an assessment.		
Services / supports	Immediate or short- to medium-term support which can include: • one-on-one time with a peer worker or clinician to distress, develop safety plans or referrals to other services • group sessions with peer workers and other guests • sensory toys and calming activities. Follow-up is available.	Immediate support (for up to 23 hours short-term or 72 hours at a short-stay unit) which can include: • time with a counsellor, peer worker or social worker to assist symptom reduction • holistic care with a multidisciplinary term using brief interventions. Follow-up is available.	Immediate support (calls last around 20 minutes for Lifeline[143] and Beyond Blue[144]) which can include (depending on the service): • speaking with a crisis support worker who will listen without judgment and explore what is causing distress • speak through what is causing distress with a counsellor • identifying other services that can assist, tailored to the caller. Follow-up is typically unavailable.	Short- to long-term support which can include: • different forms of therapy, such as cognitive behavioural therapy • support through life transitions, for example, death or divorce • psychoeducation • behavioural interventions. Follow-up is available.	Short-term support which can include: • crisis intervention and de-escalation (including medication or restraints) • safety planning • referrals to ongoing assistance • admission to acute mental health unit if required. Follow-up not typically available.	Long-term, continual support acting as a point of contact for other health professionals. Support can include: • development of a mental health treatment plan • provision of referrals to other services • brief interviewing and physical examinations. Follow-up is available.
Opening hours	5pm – 9pm Monday to Friday, with staggered opening hours from 9am – 7pm across the four	24 hours a day, 7 days a week.	24 hours a day, 7 days a week.	Typically, 8:30am – 5pm Monday to Friday, but some provide an after-hours service.	24 hours a day, 7 days a week.	Typically, 8:30am – 5pm Monday to Friday, but some provide an after-hours service.

[143] Lifeline, Annual Report FY2022–2023, 2023, (accessed 21 October 2024) https://www.lifeline.org.au/media/dixbsmcy/233-017-lifeline-annual-report-2023-v8-lr-1.pdf
[144] Beyond Blue, Get mental health support, 2024, (accessed 21 October 2024), https://www.beyondblue.org.au/get-support

Domain	Safe Spaces	Crisis Stabilisation Units	Crisis support hotlines	Psychologists	EDs	General Practitioners
	sites on Saturday and Sunday.					
Staffing model	2-3 peer workers and one clinician.	Combination of mental health specialist clinicians and peer support workers.	Crisis support workers, counsellors or other mental health professionals.	Psychologists.	Mainly ED doctors and nurses, with access to other specialists and allied health in the hospital if required.	GPs (often with support from nurses within the practice).

Appendix B Interview questions for peer workers

This appendix includes a series of example interview questions for peer workers which aim at assessing their ability to apply their peer skills in practice at the Safe Spaces. The questions are intended to be examples showcasing the application of specific peer worker skill, values and principles relevant to Safe Spaces.

Each of the questions is mapped onto the relevant services principles and values of Safe Spaces outlined in Chapter 4.1 as well as the skills of an effective peer workers outlined in Chapter 6.3. The relevant service values and principles and peer worker skills are highlighted in blue.

Across all interview questions, interviewers should be looking for:

- Effective communication: the candidate's ability to actively listen to interview questions, and provide clear responses to questions
- Relationship-building: the candidate's ability to establish an authentic, trust-based relationship with the interviewers.

B.1 Understanding of a designated peer role

Interview question: In our work, we sometimes hear, "But I have lived experience too." Can you describe the differences between a designated lived experience role and a role that is filled by someone who happens to have a personal lived experience? "

What to Look For:

- Understanding of peer work as a discipline the candidate demonstrates an understanding of peer work as a unique discipline including key frameworks, competencies and/or theories, and that this informs all aspects of peer roles. Non-designated roles may have different theoretical underpinnings (e.g. clinical frameworks).
- Understanding of the key principles and values that underpin peer work: the candidate demonstrates an understanding of the key principles (e.g. self-determination, relational, trauma-informed, recovery-focussed and strength-based) and values (e.g. choice, mutuality, hope, belonging, interconnected and justice) that underpin peer work. The candidate can contrast these values and principles with non-designated roles (which could be clinical roles) which are driven by other priorities.
- Intentional use of lived experience: the candidate demonstrates an understanding that a key part of the peer role is drawing on their lived experience to empower guests to work towards specific outcomes, whereas this is not a requirement in non-designated roles.

Alignment with Safe Spaces service values and principles and peer worker skills

Principles	Self-determination	Relational	Trauma-informed	Recovery-focussed	Strengths-based	Culturally responsive
Values	Choice	Mutuality	Hope	Belonging	Interconnected	Justice

Peer worker skills				
Intentional use of lived experience	Empathy and compassion	Effective communication	Relationship-building	Boundary management
Service navigation	Cultural competency	Self-awareness and self-care	Teamwork	De-escalation

B.2 Approach to supporting a guest through distress

Interview question: The visitors of the Safe Space can be experiencing significant levels of distress when presenting to the service. As a peer worker, how would you support a person who had presented in distress and was expressing that they felt hopeless in their situation?

What to Look For:

- Use of de-escalation techniques: Look for specific de-escalation techniques or brief interventions to reduces distress (e.g. using grounding techniques, guest-directed positive distractions).
- Intentional use of lived experience: The candidate's response should include the intentional and appropriate disclosure of their lived experience using expertise and person-centred application relevant to individual guests.
- Strengths-based approach centred on guest choice: The candidate's response should indicate that they believe that all people have unique characteristics that can assist them in managing distress. Their response should highlight that the guest is the primary change agent and is the source of expertise to manage their distress. They should emphasise a guest's agency to make decisions about the support they need and to have control over their own recovery.
- Hope: The candidate supports guests to feel hope that the circumstances/experiences that have brought them to the Safe Space can have a positive resolution, or that they can plan to manage these circumstances.
- Empathy, compassion and relationship building: The candidate should show a compassionate and non-judgmental stance to the guest, focusing on building an authentic connection with guests.
- Trauma-informed approach: The candidate should demonstrate an understanding of how to approach the situation respectfully, recognising that the guest's behaviour might stem from underlying challenges.

Alignment with Safe Spaces service values and principles and peer worker skills

Principles	Self-determination	Relational	Trauma-informed	Recovery-focussed	Strengths-based	Culturally responsive
Values	Choice	Mutuality	Hope	Belonging	Interconnected	Justice

Peer worker skills				
Intentional use of lived experience	Empathy and compassion	Effective communication	Relationship-building	Boundary management
Service navigation	Cultural competency	Self-awareness and self-care	Teamwork	De-escalation

B.3 Handling an inappropriate request

Interview question: During your shift at the Safe Space, a guest becomes highly agitated and appears to be a danger to themselves. A recently joined clinician decides to call an ambulance for the guest's safety and asks you, as a peer worker, to stay with and support the guest during the call. Importantly, the clinician requests that you do not inform the guest that an ambulance is being called, fearing it might escalate their distress further.

To what extent is this request appropriate and why? How would you handle the clinician's request, considering the principles and values of peer work?

What to Look For:

- Explain why the request is inappropriate: The candidate's response should clearly identify that the clinician's request is inappropriate and explain why. Not informing the guest about calling an ambulance goes against the principles and values of Safe Spaces as: i) it undermines trust in the relationships; ii) it creates a power imbalance going against the value of mutuality and justice; iii) it does not support guest choice or self-determination; it may traumatise the guest.
- Maintaining professional relationships: The candidate's response should respectfully recognise their colleague's intention to prevent further escalation of the guest's distress. The response needs to address the issue with their colleague in a professional and collegiate manner. The candidate may suggest debriefing after the shift to maintain a positive team relationship and to reinforce appropriate practices at the Safe Space going forward (involving a supervisor as needed).
- Advocate for guest choice and self-determination: The candidate's response should emphasise the importance of involving the guest in decisions about their own care and express the belief that transparency is critical to empower the guest into the future and to maintain trust and a mutual relationship without power imbalances.
- Facilitate open communication and joint decision-making: The candidate's response should suggest engaging with the guest to understand where they are at, assess risk and make a joint decision about supports option which may or may not include an ambulance.
- Understand the boundaries of the peer role: The candidate should demonstrate an awareness of the peer worker's scope and recognise where external support is needed (e.g. medical emergencies).

Alignment with Safe Spaces service values and principles and peer worker skills

Principles	Self-determination	Relational	Trauma-informed	Recovery-focussed	Strengths-based	Culturally responsive
Values	Choice	Mutuality	Hope	Belonging	Interconnected	Justice

Peer worker skills				
Intentional use of lived experience	Empathy and compassion	Effective communication	Relationship-building	Boundary management
Service navigation	Cultural competency	Self-awareness and self-care	Teamwork	De-escalation

B.4 Self-awareness and boundary management

Interview question: While working shifts at the Safe Space, you may encounter scenarios that are triggering while supporting guests. How would you manage triggers during your work shift and what might you do after the shift to ensure your wellbeing?

What to look for:

- Self-Awareness: The candidate's response should demonstrate recognition of personal emotional triggers that may arise during shifts and show an understanding of how these triggers can affect interactions with guests and overall job performance.
- Immediate Coping Strategies: The candidate's response should detail specific methods employed during shifts to manage emotional responses (e.g., deep breathing, grounding exercises, taking brief moments to compose oneself) and strategies to maintain professionalism and provide effective support despite personal emotional challenges. Additionally, it should include seeking support from colleagues if needed and being transparent with the guest about needing a break to continue to effectively support them.
- Effective Use of Support Systems: The candidate's response should illustrate how they utilise supervision, peer support, mentoring, or counselling to process emotions and how they communicate openly with colleagues about challenges faced during the shift.
- Proactive Self-Care Practices: The candidate's response should describe post-shift activities that promote mental and emotional well-being (e.g., exercise, meditation, hobbies) and how they set boundaries to prevent burnout and ensure sustained ability to support guests.

Alignment with Safe Spaces service values and principles and peer worker skills

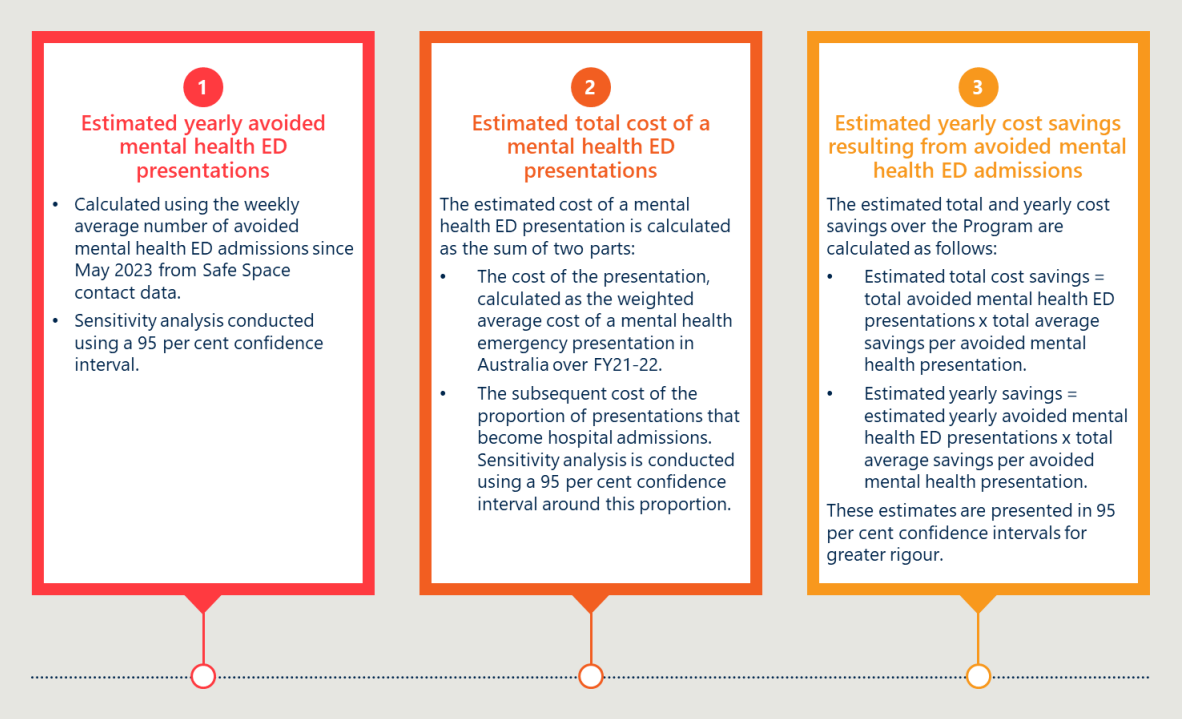
Principles	Self-determination	Relational	**Trauma-informed**	Recovery-focussed	Strengths-based	Culturally responsive
Values	Choice	**Mutuality**	Hope	Belonging	Interconnected	Justice

Peer worker skills				
Intentional use of lived experience	Empathy and compassion	**Effective communication**	Relationship-building	**Boundary management**
Service navigation	Cultural competency	**Self-awareness and self-care**	**Teamwork**	De-escalation

Appendix C Economic and data analysis

This appendix outlines the methodology used to calculate the economic benefits of the Safe Spaces, determined by the number of avoided mental health ED presentations and subsequent admissions. This was calculated along with the resulting economic savings per year over the duration of the Safe Spaces. This process followed the steps outlined in Figure 45 below.

Figure 45 | Economic cost savings methodology



C.1 Estimation of the number of yearly avoided mental health ED presentations

To estimate the yearly avoided mental health ED admissions, a weekly average number of avoided admissions was calculated from May 2023 based on Safe Space contact data which outlined guest responses to the following question:

"If you hadn't come here, where would you have gone?"

The weekly mean number of guests that responded to this question with "*Hospital/Emergency Department*" was determined from May 2023. This is when Safe Space services began delivering services at full capacity after an initial ramp up period.

To add further rigour, sensitivity analysis has been completed through the calculation of confidence intervals for the number of weekly avoided mental health ED admissions and the proportion of mental health ED presentations that become inpatient admissions.

The 95 per cent confidence interval calculated for the number of weekly avoided mental health ED presentations was determined by conducting a t-test and results are shown in Table 12 below. There is 95 per cent confidence that the true mean number of avoided weekly mental health ED admissions falls between 15.04 and 19.26.

Table 12 | 95 per cent confidence interval for the number of avoided mental health ED presentations

Measures	Lower bound	Central value	Upper bound
Weekly number of avoided ED presentations from Safe Space visits	15.04	17.15	19.26
Annual number of avoided ED presentations from Safe Space visits	784.64	894.77	1004.91

C.2 Estimation of the cost of mental health ED admissions

There are two key components to the estimated cost savings from avoided ED presentations we must determine:

- Cost savings due to mental health ED presentation avoided (calculated by the number of ED presentations avoided multiplied by the average cost of a mental health ED presentation)
- Cost savings due to the subsequent mental health inpatient stays avoided (calculated by the number of subsequent inpatient admissions diverted multiplied by the average cost of mental health inpatient admission).

The parameters to calculate these are shown below in Table 13.

Table 13 | Cost savings parameters

Parameter	Value	Source
Cost per mental health ED presentation.	$1,060.46	Weighted average cost of mental health emergency presentations in Australia FY21-22. The calculation of this value is shown below in Table 15.
Proportion of mental health ED presentations that result in an admitted inpatient stay.[145] Sensitivity analysis was completed to add further rigour to this value and is outlined in Table 14.	36.4%	Proportion of mental health ED presentations that separate into an admitted inpatient stay in Australia FY21-22.
Average cost of mental health inpatient admission.[146]	$25,080	Average cost of admitted mental health phase in Queensland FY21-22.
Total average cost saving per ED presentation avoided.	$10,189.57	Cost of ED presentation + Average proportional inpatient costs. Cost of ED presentation: 1 (ED presentation) x $1,060.455 (Cost of mental health ED presentation) = $1,060.455.

[145] AMA, 2023 Public Hospital Report Card, Mental Health Edition. Available here: https://www.ama.com.au/sites/default/files/2023-11/Public_Hospital_Report_Card_Mental_Health_Edition.pdf
[146] IHACPA, National Hospital cost Data Collection (NHCDC) Public Sector 2021-22. Available here: https://www.ihacpa.gov.au/resources/national-hospital-cost-data-collection-nhcdc-public-sector-2021-22

Parameter	Value	Source
		Average proportional inpatient costs: 1 (ED presentation) x Proportion of mental health ED presentations that result in an admitted inpatient stay (36.4 per cent) x average cost of mental health inpatient admission = $9,129.12.

The calculation to determine the weighted average cost of a mental health emergency department presentation is show below in Table 14.

The 95 per cent confidence interval calculated for the percentage of mental health ED presentations was calculated using a one-sample proportion test and results are shown in Table 14 below. This means that we have 95 per cent confidence that the true percentage of mental health ED presentations that are admitted to hospital lies between 36.22 per cent and 36.58 per cent.

Table 14 | 95 per cent confidence interval for the percentage of mental health ED presentations that were admitted to hospital

Measure	Lower bound	Central value	Upper bound
Proportion of mental health ED presentations admitted to hospital (Australia, FY21-22)	36.22%	36.4%	36.58%

Table 15 | Weighted average ED presentation cost calculation

Presentation category	Australian Emergency Care Classification code and description	Number of separations	Proportion of presentation category	Cost	Weighted average Mental Health cost
Mental health ED.[147]	E1990A Mental, behavioural and neurodevelopment disorders, other Complexity level A.	88,289	39.3%	$1,329	$1,060.455 Calculation: ($1,329 x 39.2%) +($1,002 x 34.1%) + ($739 x 26.6%)
	E1990B Mental, behavioural and neurodevelopment disorders, other Complexity level B.	76,637	34.1%	$1,002	
	E1990C Mental, behavioural and neurodevelopment disorders, other Complexity level C.	59,821	26.6%	$739	
Total		224,747	100%		

[147] IHACPA, National Hospital cost Data Collection (NHCDC) Public Sector 2021-22. Available here: https://www.ihacpa.gov.au/resources/national-hospital-cost-data-collection-nhcdc-public-sector-2021-22.

C.3 Estimation of yearly cost savings derived from avoided mental health ED admissions and sensitivity analysis

To calculate the estimated yearly cost savings and the total cost savings from avoided mental health ED presentations, the below formulas and calculations outlined in Table 16 were used:

Table 16 | Calculations to determine yearly and overall savings

Estimated total yearly savings	Estimated total savings over the course of the program
$Total\ savings\ over\ the\ program = total\ avoided\ mental\ health\ ED\ presentations \times total\ average\ savings\ per\ avoided\ mental\ health\ presentation$	
$Estimated\ Total\ yearly\ savings = 894.7736 \times \$10{,}189.57 = \$9{,}117363$	$Estimated\ total\ savings = 1{,}596 \times \$10{,}189.57 = \$16{,}262{,}562$

Overall costs savings from avoided ED presentations and subsequent admissions over the life of the program

Figure 46 below outlines the calculated confidence interval for the overall savings from avoided mental health ED presentations resulting from the Safe Spaces.

Figure 46 | Confidence interval for the estimated overall savings

Percentage of mental health ED admissions admitted to hospital	Lower bound (36.22%)	Central value (36.4%)	Upper bound (36.58%)
Estimated overall savings	$16,191,252	$16,262,562	$16,334,021

Projected annual savings from avoided ED presentations and subsequent admissions

Based on the confidence intervals calculated previously, a range of possible overall yearly estimated savings values are shown in Table 17 for each possible combination. These range from $7,129,061 on the most conservative end to $9,219,988 at the highest end.

Table 17 | Yearly estimated values for savings from avoided mental health ED admissions

		Weekly avoided mental health ED admissions		
		Lower bound (15.04)	Central value (17.15)	Upper bound (19.26)
Percentage of mental health ED admissions	Lower bound (36.22%)	$7,960,074	$9,077,384	$10,194,694
	Central value (36.4%)	$7,995,132	$9,117,363	$10,239,594

		Weekly avoided mental health ED admissions		
		Lower bound (15.04)	Central value (17.15)	Upper bound (19.26)
admitted to hospital	Upper bound (36.58%)	$8,030,263	$9,157,425	$10,284,588

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