Safe Spaces Evaluation – Progress Report

28 April 2023

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.

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Executive Summary

Growing mental health emergency department presentations, as well as acknowledgement that the emergency department environment is not designed for individuals experiencing crisis have emphasised the need for emergency department (ED) presentation alternatives. Brisbane North PHN, alongside key design and implementation partners have supported the rollout of an innovative, evidence-based Safe Spaces program encompassing four Safe Spaces and a network.

Brisbane North Primary Health Network (the PHN) has engaged Nous Group (Nous) to conduct a three-year evaluation to monitor, measure and report on outputs, outcomes, impacts and opportunities for improvement of Brisbane North PHN's Safe Spaces program. This report presents early insights from the pilot informed by stakeholder engagement, key program documentation and quantitative service data.

Key findings

- Establishment of the Safe Spaces was well paced and collaborative. The implementation of the Network has progressed rapidly given the ambitious program of work and challenges of integration.
- The Safe Spaces model is meeting local needs and aligns with peer-led co-design principles. Demand for the Safe Spaces has been strong and increasing over the program. Most guests (86%) showed an improvement in distress levels between the start and the end of their Safe Space visit.
- Repeat visitors constitute a significant proportion of service activity, which highlights the need for the service. The model of care needs to adapt to accommodate repeat visitors and different presentations of distress.
- There is a need for clearer guidance on the service model, and to crystalise guidance and messaging on the target cohort without creating rigid exclusion criteria.
- Peer work is intensive and workforce structures need to accommodate for this. Expanded and standardised training and supports which recognised the intensity for peer workers are required.

Overarching recommendation: Iteratively develop Safe Space service guidelines to promote consistency over time.

1. **Workforce and training:** Consider approaches to expand and pool training resources across all levels as the Safe Spaces mature.
2. **Quality and safety:** Improve consistency in quality and safety, and develop longer-term models of care for repeat guests.
3. **Governance:** Refine governance structures to promote interaction and sharing of insights across all roles.
4. **Network:** Maintain the strong progress to date.

Contents

1. Key background

Overview of the Safe Spaces pilot and evaluation

Brisbane North PHN, alongside key design and implementation partners have supported the rollout of an innovative, evidence-based Safe Spaces program encompassing four Safe Spaces and a network. This program is funded through the Commonwealth Hospital and Health Program.

People present to hospital emergency departments in mental distress for a range of reasons.

These can include exacerbation of underlying mental health conditions, traumatic experiences, a situational crisis or because they are unaware of, or unable to, access alternative services. They may be experiencing domestic and family violence, stress, grief, or other personally distressing and adverse life situations.

However, emergency departments are complex clinical environments that are not always appropriate for people in distress.

As a result, people presenting to the emergency department in mental distress can experience a 'double disadvantage' in which they can experience negative and even traumatising impacts of the presentation to emergency department, 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.

Safe Spaces provide an alternative to emergency departments for people in distress through a non clinical service.

WHAT ARE SAFE SPACES?

A Safe Space is an inclusive, welcoming and supportive environment for people experiencing emotional distress. They are typically 'walk in' style spaces in accessible locations that offer people experiencing emotional distress with friendly and welcoming support in a safe and non-clinical environment. They use a peer-led workforce, and provide warm connections to appropriate and reliable supports.

There are a range of Safe Space models now implemented across Australia, including the Safe Haven Café at St Vincent's Hospital in Melbourne, 20 Safe Havens established across New South Wales, two Safe Haven Cafés established in Western Australia and a single Safe Haven in the ACT.

ABOUT THE EVALUATION

This evaluation seeks to understand the contextual landscape around the Safe Spaces, its outcomes to date and how it could be improved and sustained for the future. The evaluation will progress until December 2024. This report presents early insights. It is informed by engagement with stakeholders across the providers that are delivering the Safe Space, key program documentation and quantitative data relating to guests' usage of the program.

Design of the evaluation
2022

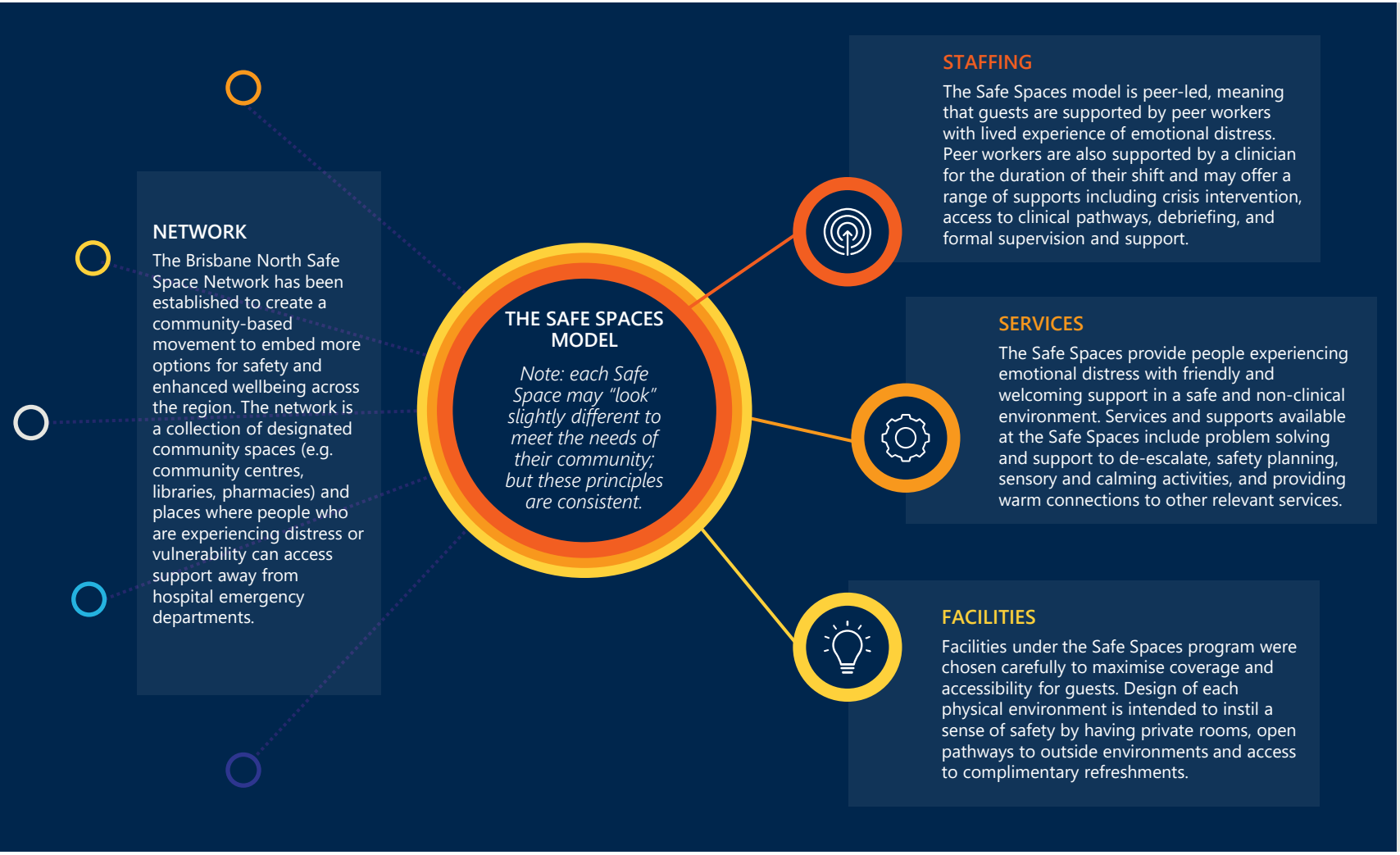
This progress report
March 2023

Interim reports
September 2023 and March 2024

Final evaluation report
September 2024

Overview of the Safe Spaces model

Brisbane North PHN was funded to establish and operate four Safe Spaces (one in each hospital catchment) and to build capacity in the community through a Safe Spaces network. The model is summarised below.



SAFE SPACE TERMINOLOGY

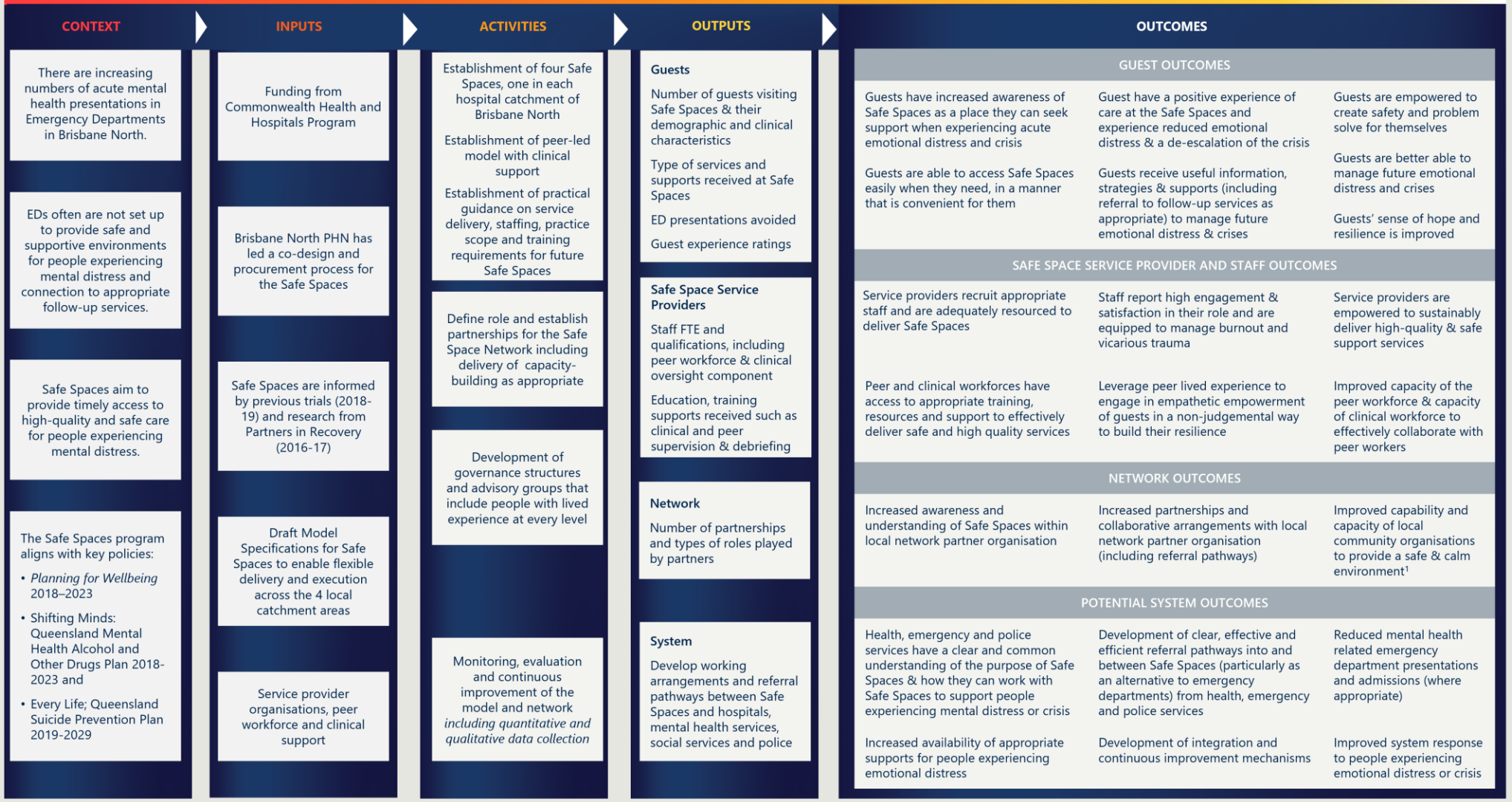
The language used in Safe Spaces environments is important; with the potential for 'traditional' language used within clinical services to be problematic, stigmatising and harmful. As a result, non-stigmatising language is preferred that is empowering, person-centred and strengths based. Terminology includes:

- People attending Safe Spaces are referred to as 'guests', rather than 'patients'.
- 'Guests' refers to each unique individual attending the Safe Space – a guest can have multiple contacts or visits (discussed below).
- 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.
- A 'visit' refers to a contact in which a guest was physically accessed the Safe Space. Note that a guest can have multiple visits.

The evaluation is guided by a program logic approach

Program theory provides a rationale for what change is expected, why, for whom, and how. This allows a shift in focus from what did or did not happen, to interpreting why it happened. Program logic provides a graphical representation of this theory.

A program logic, adapted from that developed by Brisbane North PHN, is displayed below.



The evaluation was guided by key evaluation questions building off the program logic structure

The KEQs that guide the evaluation are outlined below.

Key lines of enquiry (KLEs)	Key evaluation questions (KEQs)
1. Implementation & 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 & 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 & Impacts *What were the outcomes and impacts of the Safe Space 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 Network outcomes and impacts across contexts? 3.4 What were the system outcomes and impacts across contexts?
4. Improvement & 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?

This report provides a summary of findings from across the course of the evaluation, synthesising qualitative and quantitative inputs

The below tables summarises the sources of information for this document. The findings of this report triangulate insights from across the range of data sources.

Consultation inputs

Provider organisation	Position
RAYS	Operations Manager & Clinical Lead
	Peer worker
Communify	Operations Manager
	Team Leader (Peer)
Stride	Operations Manager
	Team Leader
NEAMI	Operations Manager
	Team lead (Peer)
Wesley Mission	Network Coordinator
Brisbane North PHN	Program Development Lead
	Program Development Coordinator
	Executive Manager of Commissioned Services

Data and documents analysed

Data or document	Description
Contact form data	Administrative data collected by Safe Space providers with deidentified data on contacts, visits and guests.
Australian Bureau of Statistics	Census data was used to provide contextual information on the socio-demographic characteristics of each of the Safe Spaces' regions.
Six-monthly provider reporting	Bi-annual reports Safe Spaces provide to Brisbane North PHN which includes guest case-studies.
Alcohol and Drug Audit conducted by WMQ Queensland	This audit identifies key capacity building resources needed across Safe Spaces to support people who are experiencing emotional distress or vulnerability and who use drugs (illicit and non-illicit) and alcohol.
Safe Space co-design materials by Roses in the Ocean	These materials provide the high-level principles and design for the Safe Spaces which were created in an extensive co-design process with representation from people with lived experience, service providers and Brisbane North PHN.
Key policy documents	Queensland Mental Health, Drug and Alcohol Strategic Plan; Brisbane North PHN. Planning for Wellbeing Regional Plan.

2. Context and Implementation

Each Safe Space faces a unique set of geographic conditions requiring service delivery to be tailored to the local demographic and social context

STRIDE - CABOOLTURE

OPENING HOURS:

5pm – 9pm weekdays,
10am – 2pm weekends

- The Moreton Bay-North region has the highest rate of adults with high or very high psychological distress in the Brisbane North region.[1]
- The region also has higher socioeconomic disadvantage, a higher unemployment rate, the most low-income families in the PHN's region, and more people living with disability.[2]
- Caboolture has the state's second-highest rate of people at risk of homelessness, with approximately 1 in 7 people at risk.[5]

RAYS - REDCLIFFE

- Residents in the Redcliffe - North Lakes region have higher levels of socioeconomic disadvantage, and limited access to health services.[2]

OPENING HOURS:

5pm – 9pm weekdays
3pm – 7pm weekends

- Redcliffe has a higher unemployment rate, and lower median income than Queensland overall.[3]

PHN REGION

COMMUNIFY - BARDON

- The Bardon area is generally less disadvantaged than other parts of the region, with a median household income more than double the Queensland average.[6]
- This region is also younger than average, and more likely to have degree-level qualifications.[6]
- However, the surrounding Inner Brisbane region also has a very high rate of homelessness - the 4th-highest rate in Queensland with one in seven people at risk of homelessness.[5]

Opening hours:

5pm – 9pm weekdays
9am – 2pm weekends

NEAMI - STRATHPINE

- One third of renter households in Strathpine are in rental stress (spending more than 30% of their income on rent).[4]
- Unemployment in Strathpine is 27% higher than in Queensland overall. [4]
- Strathpine is the only catchment that also contains a Queensland Health Safe Space.

Opening hours:

5pm – 9pm weekdays
3pm – 7pm weekends

1. Queensland Mental Health Commission, Improving mental health and wellbeing: Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019. 2014.
2. Brisbane North PHN. Planning for Wellness Regional Plan 2021.
3. ABS. All person QuickStats 2021 - Redcliffe SA3
4. ABS. All person QuickStats 2021 – Strathpine SA3
5. AHURI. A nationwide analysis of the risk of homelessness in Australia.
6. ABS. All person Quickstats 2021 – Bardon.

Summary of Safe Space contacts and visits between April 2022 and February 2023

ALL CONTACTS

Information below refers to any contact with Safe Spaces.

TOTAL NUMBER OF CONTACTS **2298**

PROPORTION OF CONTACTS BY GUESTS / POTENTIAL GUEST **97%**

PROPORTION OF CONTACTS BY FAMILY / FRIENDS / CARERS **1%**

GUEST CONTACTS WHO WERE UNABLE TO ENTER THE SPACE

TOTAL NUMBER OF CONTACTS FROM GUESTS WHO DID NOT ENTER THE SPACE **115**

64% Entry not required (Enquiry)

12% Transport difficulties

10% Outside of opening hours

7% Medical issue

7% Other

SAFE SPACE VISITS

Information below only refers to guest visits to the Safe Spaces.

TOTAL NUMBER OF GUEST VISITS **1899**

MOST COMMON DAY TO VISIT SPACE **17% OF VISITS THURSDAY**

MOST COMMON TIME FOR VISITS

WEEKDAYS 5pm-5.59pm **38% VISITS**

WEEKENDS 3pm-3.59pm **20% VISITS**

3814 TOTAL HOURS OF GUEST SUPPORT PROVIDED

2 HOURS MEDIAN GUEST VISIT DURATION

50% OF GUEST STAYS RANGE BETWEEN 1-3 HOURS

TOTAL NUMBER OF VISITS BY PROVIDER

28% COMMUNIFY

25% NEAMI

21% STRIDE

26% RAYS

SUPPORT TYPE PROVIDED

53% PEER SUPPORT

30% CAPACITY BUILDING & SAFETY PLANNING

27% DISTRESS MANAGEMENT

27% BRIEF STRUCTURED INTERVENTION

Guest characteristics between April 2022 and February 2023

TOTAL NUMBER OF GUESTS **483**

32% REPEAT VISITOR
39% ONE-OFF VISITOR
30% ANONYMOUS VISITOR

75% OF GUESTS HAVE VISITED
1-2 TIMES

HIGHEST NUMBER OF VISITS FOR A GUEST
126 VISITS

10% OF GUESTS IDENTIFY AS ABORIGINAL AND/OR TORRES STRAIT ISLANDER

15% OF GUESTS IDENTIFY AS LGBTQIA+

33% OF GUESTS WHO WERE ACCOMPANIED TO THE SAFE SPACE

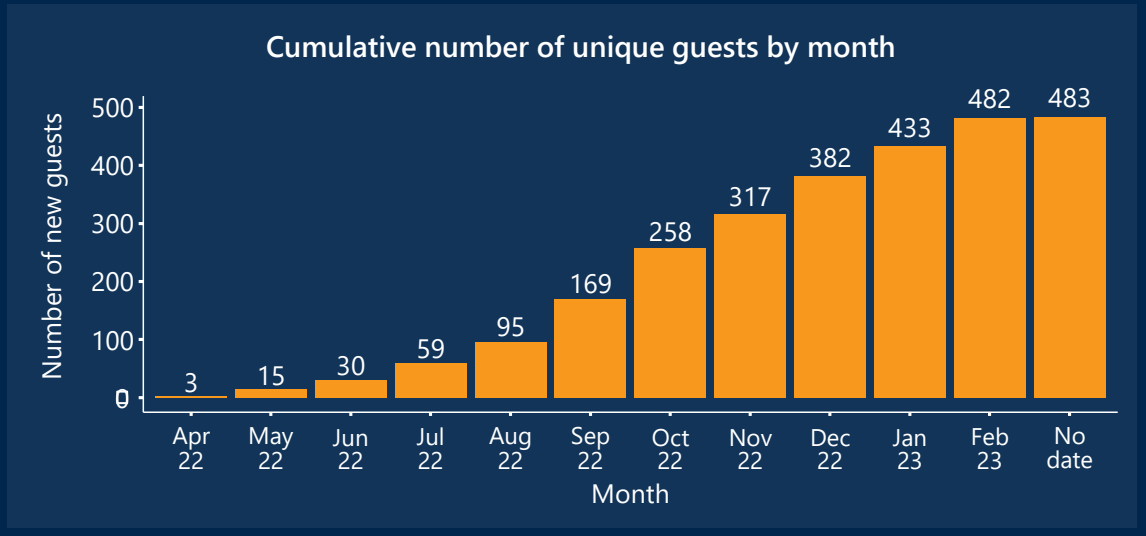
4% OF GUESTS WERE CULTURALLY OR LINGUISTICALLY DIVERSE

AGE OF GUESTS

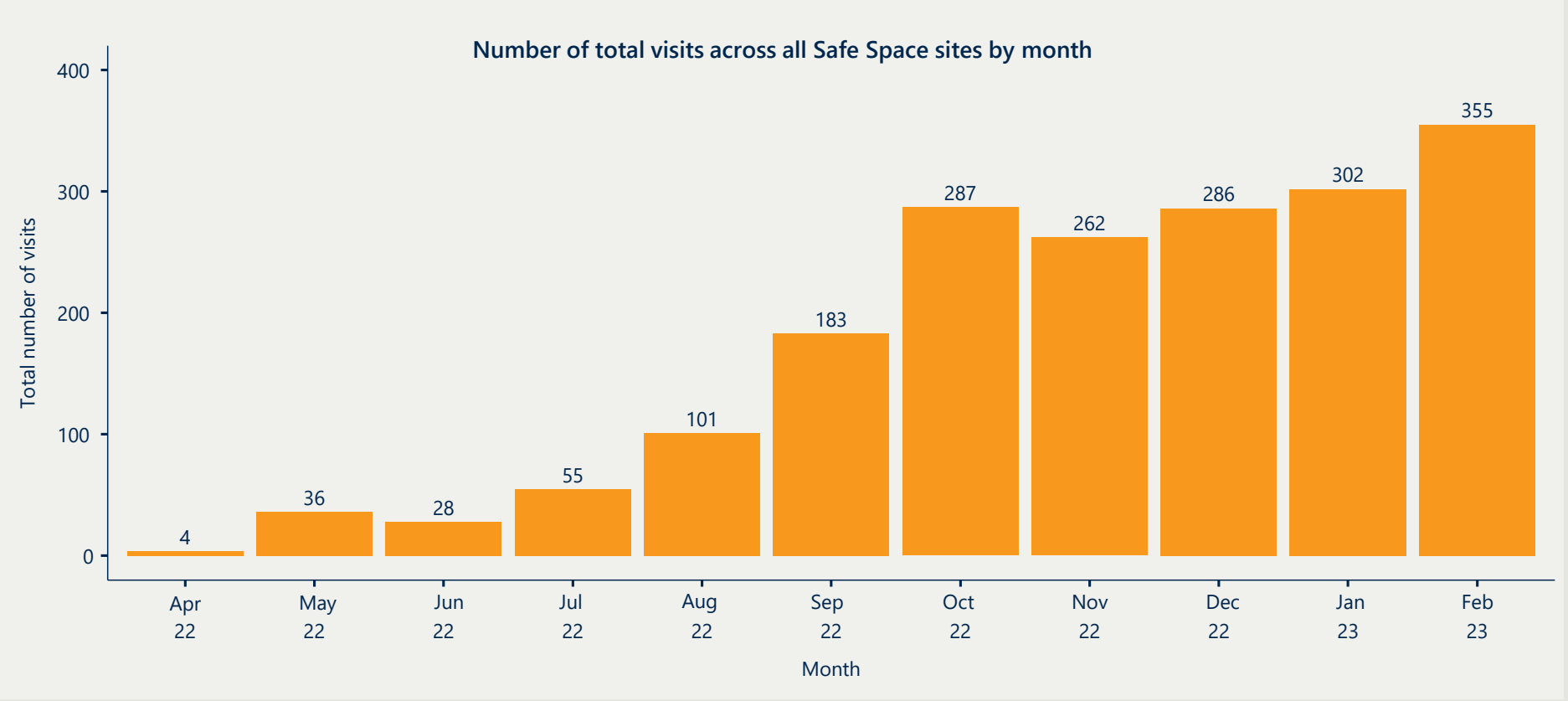
0-11	3.1%
12-17	18.2%
18-24	15.%
24-64	56.5%
65+	1.4%

GENDER DISTRIBUTION OF GUESTS

FEMALE	54%
MALE	30.8%
NON-BINARY	3.2%
NOT DISCLOSED	12%



Demand for the Safe Spaces has been strong and increasing over the program



IMPLEMENTATION TIMELINE

Previous research undertaken by PiR program
2016 - 2017

Safe Spaces trial undertaken with Metro North Health Link funding
2018 - 2019

Co-design undertaken in partnership with Roses in the Ocean
July 2021 – December 2021

Safe Spaces opened
January 2022 (Bardon, Caboolture, Strathpine)
April 2022 (Redcliffe)

Ongoing operation and continuous improvement
Until July 2024

Establishment of the Safe Spaces was well paced and collaborative

While implementing an innovative model has been challenging, the collaborative and effective approach to establishment has supported effective implementation.

ENABLERS	BARRIERS
• Realistic and phased timelines allowed for a thorough stakeholder engagement and design process. The gradual establishment of the Safe Spaces helped ensure effective implementation without undue pressure on providers to deliver. • The 'soft launch' marketing approach led to steady, gradual increases in visitor numbers. This provided the opportunity to build staff confidence and establish processes before operating at full capacity. • Alongside operational meetings, the PHN and providers have kept in regular contact to discuss and resolve challenges as they arise and to share resources and practices. The collaborative, flexible approach taken by the PHN has supported providers to be comfortable raising challenges and has fostered continuous improvement in the service. • Providers and the PHN have been flexible and have put in considerable effort adapting and translating co-design principles into clear operational procedures and messaging about the service; in other words, to translate principles into their day-to-day, 'on the ground' and tangible application.	• There is no 'roadmap' for implementing this type of service. Particularly, compared to previous PHN-commissioned services, this program is unique in its peer-led, deliberately non-clinical nature. • Similarly, the service is new to other stakeholders in the service system. Explaining and communicating the service has been challenging in some instances, particularly to help them understand the scope of the service. This is driven by a lack of internal clarity on the scope of the Safe Space model. • Some Safe Spaces have reported persistently low awareness of the service in the community. This may be related to the above challenges in communicating. • There has been some variation in the interpretation and implementation of the model between different service providers. Particularly, some service providers have 'defaulted' to more clinically oriented ways of working, rather than the intended model focused on peer support.

The Network is delivering an ambitious program of work to connect Safe Spaces to the community

The Network will be a set of partner organisations (e.g. libraries, cafés) who are equipped to provide an informal supportive & calming environment. It is designed to provide a warm pathway of care, connecting people across safe places and safe spaces. The Network will upskill and provide resources to staff in these locations to support them in this role.

> *"Strong, connected communities become pathways to healing"*

Network implementation pathway

WE ARE HERE

PHASE 1	PHASE 2	PHASE 3
Make Safe Space practices and processes consistent	**Establish relationships with community partners**	**Establish locations and Implement training**
Harmonise the safety and quality of the Safe Spaces to ensure consistent service delivery	Consult and network with potential community safe place locations (libraries, cafés etc.) to assess interest in joining the network	Ensure community partners have the necessary skills to provide temporary support for acute mental distress and connection to the Safe Spaces if needed
	Establish relationships with the broader community and key partners	Continue to build relationships and establish locations.
Build Safe Space capabilities through focused training and refining operational experience	Develop and implement training materials for community partners in conjunction with Safe Space Providers	

The Safe Spaces Network has established a relationship with the Queensland Police Service (QPS) and Queensland Rail (QR), each interested in reforming their approaches to acute mental distress.

QR is interested in training on how to appropriate community interaction and refining its approaches to be more compassionate. Its current referral pathways are formal and potentially distressing using emergency services (ambulances) to transport people.

QPS and QR have collaborated on an initiative to map distress to specific rail platforms. The initiative aims to identify high demand areas of acute distress to inform resource prioritisation.

The implementation of the Network has progressed rapidly given the challenges of integration

The Network has made impressively rapid progress to date despite considerable barriers and challenges due to a range of enabling factors (discussed below).

Progress for the next phase of the integration work, formalising partnerships and implementing initiatives, may occur at a slower pace. This is because it will require considerable stakeholder engagement to get agreement on the specifics of changes to organisational and system levers.

ENABLERS

- Network development has fostered a supportive environment where trial and error are encouraged and people are given flexibility to see what works.
- The Network Coordinator's clear leadership and persistence has enabled the establishment of strong and trusting relationships.
- Clear and compelling messaging around connecting communities to support has generated considerable interest in stakeholders, from a wide range of traditionally siloed sectors.

BARRIERS

- Integration efforts for the Safe Space are challenging due to the huge variety of guests needs and stakeholders involved and the wide range of organisational and system levers required for effective integration (see right-hand side of page).
- High intensity work which is largely relationship driven means that the work is very dependent on the Network Coordinator.
- Established processes, policies and perceptions of risk must be shifted to accommodate the integration of Safe Spaces (e.g. police and ambulance referral patterns). This is a particular barrier for larger organisations, who may be more hesitant to engage with the Network for this reason.
- Community organisations do not have existing knowledge, resources and skills to provide distress support.

Integration efforts for Safe Spaces are challenging

1 Complexity of integration increases with the variety of guests, service types and stakeholders involved.

The Network's integration efforts are challenging due to:

- Engagement of a very wide range of stakeholders from very different fields including police, railways, libraries, clinical mental health supports, psychosocial supports, alcohol and drug supports and housing supports.
- Wide variety of guest needs due to the walk-in, open door nature of the Safe Spaces.

2 Successful integration requires action on a wider range of organisation and system levers.

Coordination and navigation of care mechanisms	Communication and information sharing mechanisms	Skill and capability improvement initiatives
Aligned funding and commissioning	Common tools, processes and systems	Collaborative leadership & joint governance arrangements

3. Appropriateness and Design

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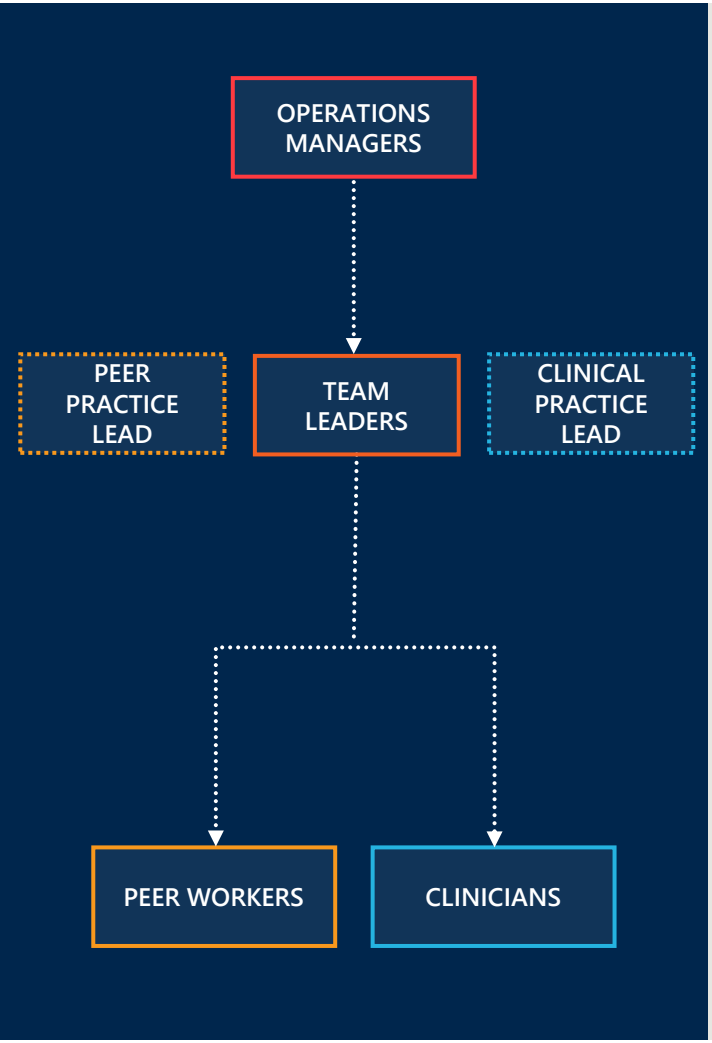
Safe Spaces typically include the following roles

While there is variation across Safe Space sites in the naming and distribution of responsibilities across roles, each Space tends to include the following roles.



OPERATIONS MANAGERS PROVIDE STRATEGIC-LEVEL OVERSIGHT OF THE SAFE SPACES.

Typical roles and responsibilities

- Providing strategic-level oversight of operations and risk.
- Communicating and coordinating between the Safe Space and organisational management.
- Creating the right authorising environment.

PEER PRACTICE LEADS AND CLINICAL PRACTICE LEADS PROVIDE PEER-LED AND CLINICAL LEADERSHIP, RESPECTIVELY. ONE OF THESE IS TYPICALLY ALSO THE TEAM LEADER (BELOW)

Typical roles and responsibilities

- Provide support, supervision, and advice on practice from either a clinical or peer-led perspective.

TEAM LEADERS LEAD STAFF MEMBERS AND OVERSEE THE DAY-TO-DAY OPERATIONS AND LOGISTICS OF THE SAFE SPACES.

Typical roles and responsibilities

- Undertaking operational management - e.g. scheduling shifts.
- Fulfilling reporting and monitoring requirements.
- Acting as point of escalation, support and advice for peer workers and clinicians.

PEER WORKERS UNDERTAKE THE MAJORITY OF SUPPORT TO GUESTS, INFORMED BY THEIR LIVED EXPERIENCE.

Typical roles and responsibilities

- Supporting guests through a range of approaches include problem solving, safety planning and sensory and calming activities.
- Providing connections to other services and referrals.

CLINICIANS SUPPORT GUESTS USING CLINICAL SKILLS.

Typical roles and responsibilities

- Assisting with crisis intervention.
- Providing access to clinical pathways.
- Supporting other staff through debriefing and supervision / support.

The Safe Spaces model meets local needs and aligns with peer-led co-design principles

Safe Spaces are filling a gap in the service system, with increasing demand

The number of guests attending Safe Spaces is continuing to rise. The strong uptake by guests is a demonstration that the service fills a key gap in the service system.

The peer perspective and leadership is valued across Safe Spaces

Peer leads report that the peer perspective is valued and forms part of joint decision making with clinicians, regardless of whether operations are managed by peers or clinicians. While there are some operational differences in how the Safe Spaces run and different understandings of what a peer-led service looks like, there is an overarching commitment to the peer-led approach.

Safe Spaces are providing a holistic service and are being flexible to meet guest needs through partnerships

The Safe Space model of care starts from the philosophy of "How can we help?" and "Do what works" as shown in their flexible approach, addressing peoples' holistic needs that might influence their distress (as well as directly addressing their distress).

This approach is supported by partnerships with Local Advisory Groups. The case study on the right highlights an example of how RAYS are working with local partners to deliver holistic supports for guests.

Some barriers exist which prevent guests from engaging with Safe Spaces

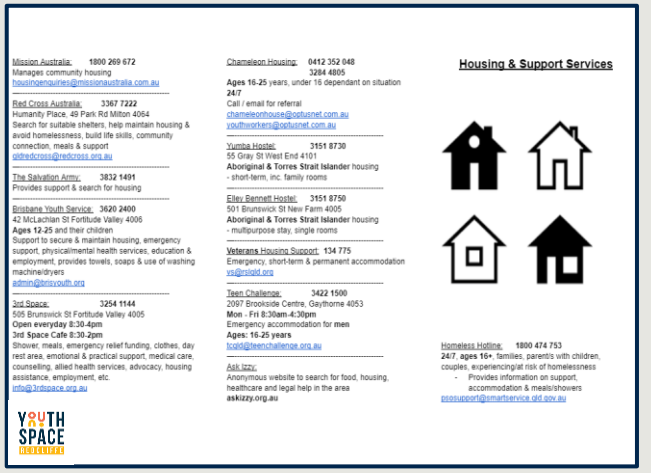
Although the model is overall appropriate and responsive to guest needs, there are reportedly some barriers to guest attendance and engagement. These include:

- Relatively short opening hours
- Due to the after-hours nature of the service, other services are often not available for referral when required
- Unavailability of transport to the Space, and to other services or hospital when appropriate

CASE STUDY | RAYS

Many guests are presenting to the Redcliffe Safe Space with food and housing insecurity. As a result RAYS has developed a series of pamphlets and other materials that detail information about service providers across a holistic range of needs including housing and food.

- **Housing and support:** The pamphlet (see below) contains information on local homelessness organisations including local hostels and Red Cross. Donated toiletries (toothbrush and soap) and on-site shower facilities are made available for guest use.
- **Food service:** RAYS has a partnership with the local breakfast club across the street where hungry guests can have a meal.



Housing & Support Services

Mission Australia: 1800 269 672
Manages community housing
housingenquiries@missionaustralia.com.au

Red Cross Australia: 3367 7222
Humanity Place, 49 Park Rd Milton 4064
Search for suitable shelters, help maintain housing & avoid homelessness, build life skills, community connection, meals & support
oldredcross@redcross.org.au

The Salvation Army: 3832 1491
Provides support & search for housing

Brisbane Youth Service: 3620 2400
42 McLachlan St Fortitude Valley 4006
Ages 12-25 and their children
Support to secure & maintain housing, emergency support, physical/mental health services, education & employment, provides towels, soaps & use of washing machine/dryers
admin@bnsyouth.org

3rd Space: 3254 1144
505 Brunswick St Fortitude Valley 4005
Open everyday 8:30-4pm
3rd Space Cafe 8:30-2pm
Shower, meals, emergency relief funding, clothes, day rest area, emotional & practical support, medical care, counselling, allied health services, advocacy, housing assistance, employment, etc.
info@3rdspace.org.au

Chameleon Housing: 0412 352 048
3284 4805
Ages 16-25 years, under 16 dependant on situation
24/7
Call / email for referral
chameleonhouse@optusnet.com.au
youthworkers@optusnet.com.au

Yumba Hostel: 3151 8730
55 Gray St West End 4101
Aboriginal & Torres Strait Islander housing
- short-term, inc. family rooms

Elley Bennett Hostel: 3151 8750
501 Brunswick St New Farm 4005
Aboriginal & Torres Strait Islander housing
- multipurpose stay, single rooms

Veterans Housing Support: 134 775
Emergency, short-term & permanent accommodation
vs@rslqld.org

Teen Challenge: 3422 1500
2097 Brookside Centre, Gaythorne 4053
Mon - Fri 8:30am-4:30pm
Emergency accommodation for **men**
Ages: 16-25 years
tcqld@teenchallenge.org.au

Ask Izzy:
Anonymous website to search for food, housing, healthcare and legal help in the area
askizzy.org.au

Homeless Hotline: 1800 474 753
24/7, ages 16+, families, parent/s with children, couples, experiencing/at risk of homelessness
- Provides information on support, accommodation & meals/showers
pssupport@smartservice.qld.gov.au

YOUTH SPACE FOUNDATION

Repeat visitors constitute a significant proportion of service activity

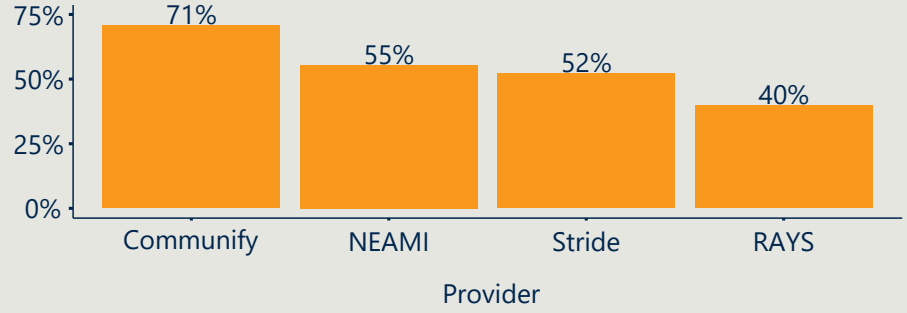
Repeat visitors constitute a significant and increasing proportion of service activity, however this is not leading to people being turned away

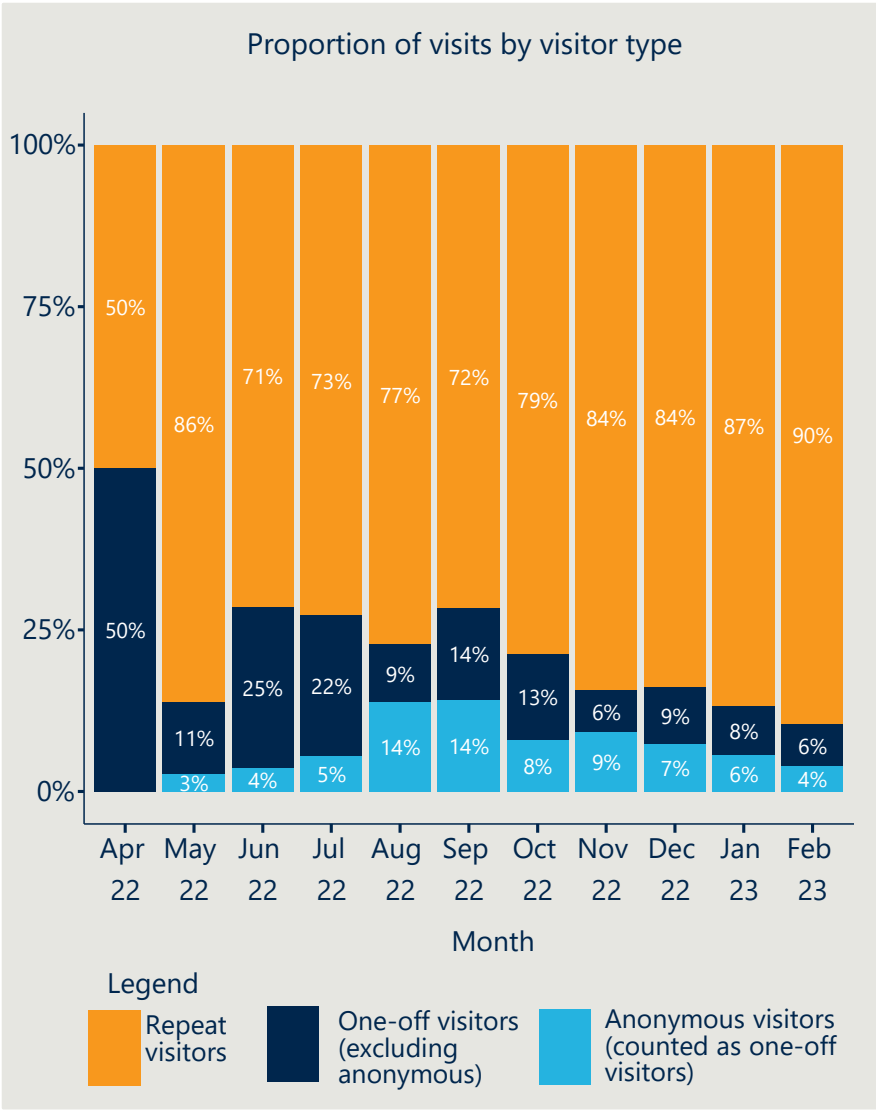
As shown in the graph to the right, the proportion of visits from repeat visitors has increased from 72% in September 2022 to 90% in February 2023. To some extent, this trend is to be expected as the service matures and there are fewer new people hearing about the service.

At this stage, capacity constraints are not leading to guests not being able to access Safe Spaces; only one instance of this is recorded in the data. This trend should be monitored and as discussed further on slide 22, a balance between supporting the needs of repeat visitors and maintaining capacity for visitors with one off acute distress needs will need to be maintained.

There is variation across providers in the amount of visits taken up by the six most frequently visiting guests (chart below)

This variation may reflect differences in help-seeking practices from the guests, but can also be influenced by provider practices. RAYS indicated actively managing Safe Space capacity by forming deep relationships with frequently visiting guests and having conversations about when the Safe Space is most helpful amidst their mix of supports.





Repeat visitors are a positive signal, highlighting the need for the Safe Space service and model

Providing support for repeat visitors was not a key feature of the Safe Space service design

The co-design process initially designed the Safe Space model for mostly one-off presentations rather than repeated visits. Providers have adapted systems and processes to support a level of continuity of care across visits, but have found it challenging to meet the wide variety of needs.

The fact that guests are returning indicates the Safe Space model is valued by guests and is filling a gap in the health and community service system

The service is filling a significant gap in the service system, beyond a one-off response to crisis. It's a positive sign that guests in distress feel safe and comfortable to access and engage with Safe Spaces. As shown in the image below, allowing guests to return to the Safe Space has enabled the avoidance of 176 visits emergency department admissions.

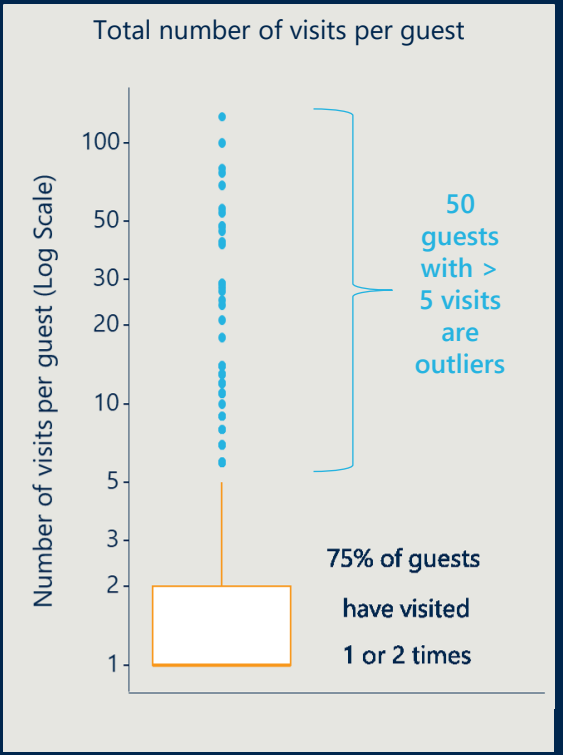
176
ED-RELATED ADMISSIONS AVOIDED

$1.46M
ED-RELATED COST AVOIDED

Note this is not total cost saved as it doesn't account for the operating costs of the safe space. See Appendix for overview of cost avoidance calculation method.

Characteristics of the most frequent guests

According to providers, many guests who are repeat visitors experience chronic distress due to structural disadvantage (e.g. financial hardship / homelessness), and a need for more intensive and longer-term skill building to support self-management of distress and loneliness. These guests often do not meet eligibility criteria for other support programs (e.g. NDIS psychosocial supports) or are not able to access other programs due to capacity constraints.



Insights on very frequent visitors (blue dots on chart)

- 50 guests have more than 5 visits which is significantly higher than the rest of the cohort.
- These guests make up 10% of all unique guests but they account for 67% of all visits.
- Similar distributions of demographic characteristics as the whole cohort.
- Duration of visits are significantly longer for these guests, with a median duration of 120 minutes, compared to 90 for other guests ($Z = -6.8$, $p < 0.001$).[1]

1 The difference in medians was tested using a Wilcoxon signed-rank test.

The model of care needs to adapt to accommodate repeat visitors and different presentations of distress

The Safe Space model should continue to support repeat visitors

Some stakeholders mentioned concern around repeat guests taking up capacity which could be used by people in 'genuinely' acute distress.

It is very difficult to establish any objective threshold for distress given the multitude of ways chronic acute distress can present. For example in complex PTSD, acute distress can be directed internally and present as a lack of emotion (due to psychological protective processes such as dissociation and compartmentalisation of emotions).

Introducing minimum distress thresholds creates risks of perpetuating service gaps for people who are not able to engage with other parts of the service system.

The Safe Space model should not rush repeat visitors

Recovery is often slow, non-linear and complex. One provider indicated some clients take years to address the intrinsic and extrinsic drivers of acute distress (examples of these are under the 'Long term improvement of distress drivers' heading in the diagram below).

Safe Spaces provide valuable supports for repeat visitors who may have atypical distress presentations and this should continue going forward.

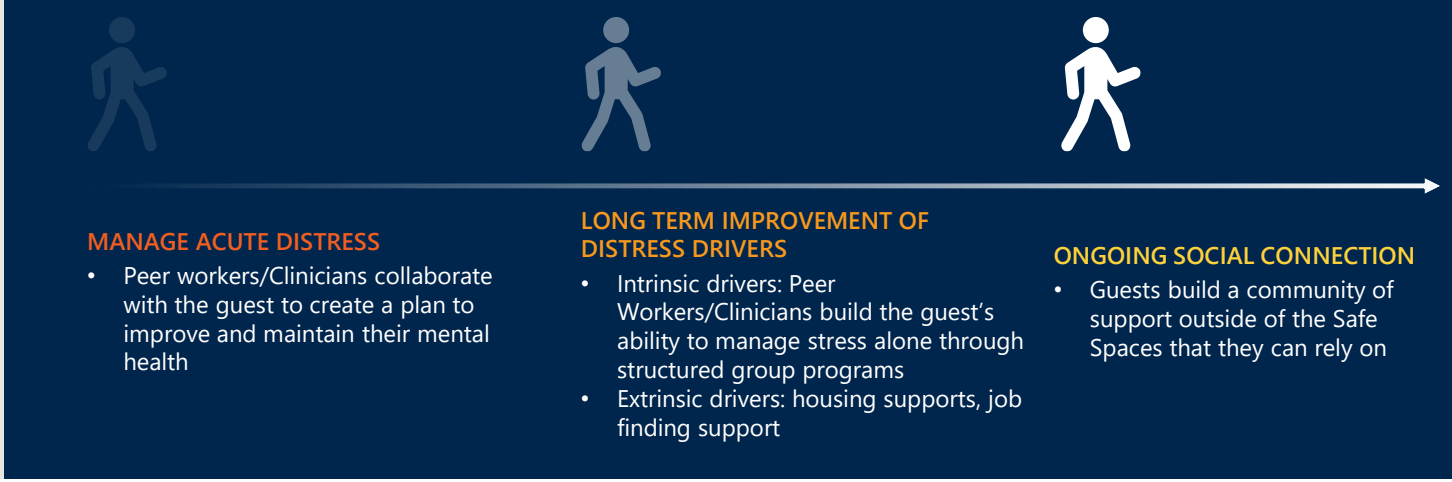
The Safe Space model of care should adapt to meet the needs of guests with chronic acute distress while maintaining capacity for new guests

Work is underway to develop appropriate support pathways for repeat visitors such as the 'support pathways', as explained in the Communify Case Study below and relationships with other service providers (such as housing providers) to address extrinsic drivers of stress (e.g. RAYS Case Study on page 20).

CASE STUDY | Communify

Support pathway: Communify is designing a 'support pathway' to assist repeat visitors to transition towards more tailored and appropriate support, such as structured groups for skill building and social connection.

The image on the right builds on Communify's work to conceptualise a potential future support pathway for repeat guests.



CASE STUDY | STRIDE

Repeat guest supported through acute distress amidst compounding challenges

Context & presenting issues

- A Māori woman presented to the Safe Space after being served with a Temporary Protection Order (TPO) against her for an allegation of domestic violence fuelled by alcohol misuse.
- At the time of presentation she was homeless living out of her car and unable to see her children.
- The guest described feeling stuck in cycles of domestic violence and retaliation.

Supports provided by the Safe Space

Across multiple visits, peer workers at the Safe Space:

- Provided distress management and co-regulation in the lead up to the court hearing.
- Supported the guest to access health and psychosocial support services including alcohol and drug services and anger management classes.
- Supported the guest to access broader community supports including domestic violence services, Women's Legal Services to support her through the legal process and financial supports for accommodation.

Outcomes

- The guest felt well supported in the lead up to the hearing, particularly as she could access the Safe Space multiple times in the lead up to the hearing.
- The guest was connected into practical supports which enabled her to begin addressing her multiple compounding challenges. Such improvements are required to lift the TPO.
- At the court hearing, the guest was permitted to return to her home and family.

Note: The displayed image is not of the client.

There is a need to crystalise guidance and messaging on the target cohort without creating rigid exclusion criteria

- Safe Spaces have a more holistic, safety-focussed conception of risk than traditional clinical mental health services, which promotes access to hard-to-reach groups.
- However clearer 'guard rails' around scope of practice and target cohort are needed, without introducing rigid exclusion criteria or unduly compromising the flexibility of the service.
- An emerging consensus of when the Safe Spaces are not able to support people is presented below.
- Some key activities underway to refine are presented in case studies on the right.

Safe Spaces are not able to support people who currently...

REQUIRE MEDICAL TREATMENT

For example:

- People who require urgent medical treatment (e.g. suturing, x-ray, or emergency treatment).
- People who are currently experiencing acute and severe psychosis.
- People who are currently overdosing.

ARE UNABLE OR UNWILLING TO ENGAGE WITH PEER WORKERS

For example:

- Extreme hunger or sleep deprivation making conversations difficult.
- Severe intoxication with alcohol or drugs leading to an inability to converse with peer workers.

Key features:

- People are welcome to return to the space once medical needs are met or they are able and willing to engage with peer workers.
- Safe Spaces have differing resources available to them and so their ability to support guests will vary. For example RAYS has access to meals and as such they may be more capable of supporting guests experiencing extreme hunger than other providers.
- The examples provided are not rigid exclusion criteria and need to be considered on a case by case basis between Safe Space staff and the potential guest.

CASE STUDY | Network

Wesley Mission Queensland (WMQ) has led a range of activities to harmonise practice across sites, including an Alcohol and Other Drug (AOD) audit

The AOD audit found inconsistency across the Spaces in the circumstances under which providers would allow guests with AOD needs to enter the Safe Space.

WMQ are now working with PHN and the Safe Space sites to ensure consistency of AOD practice, to promote staff and guest safety and to maximise the inclusion of guests who would benefit from the Safe Spaces.

CASE STUDY | Communify

Communify is leading the development of risk management tools

The risk management tool facilitates a holistic screening of suitability for Safe Spaces.

- A number of protective and risk factors for safety; and
- A 'red flag' checklist that triggers immediate clinical intervention and referral to hospital.

4. Outcomes and Impact

Most guests (86%) showed an improvement in distress from their Safe Space visit

The Subjective Units of Distress Scale (SUDS) is a tool for measuring the intensity of a person's distress. Providers are capturing SUDS data for guests when they arrive and when they leave. The key metric we are examining here is the improvement in distress level between the start and the end of the visit. SUDS improvement scores fall into one of the following three categories:

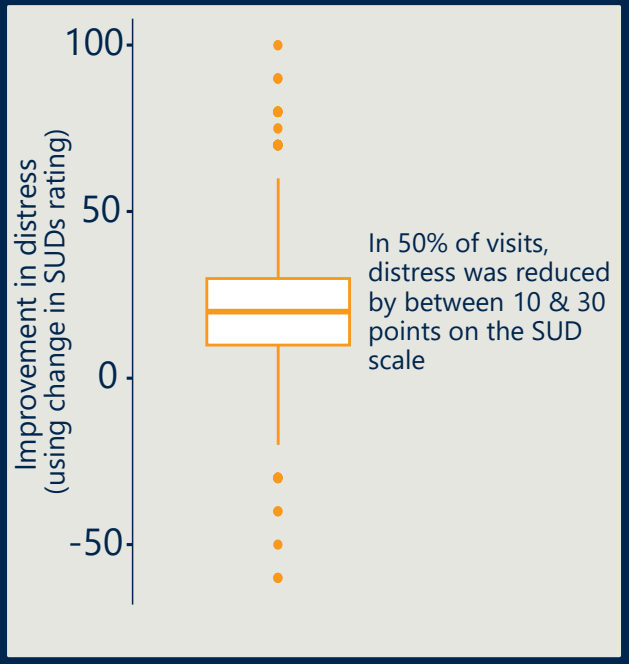
- **Improved distress**: scores over 0 refer to reduced distress over the visit
- **Unchanged distress**: scores equal to 0 mean the distress level remained level over the visit
- **Worsened distress**: scores below 0 refer to increased distress over the visit – providers reported that a small number of guests' anxiety would increase as the Safe Space was closing as it has become their key place of support (for example some homeless guests).

NUMBER OF VISITS WITH VALID SUDS SCORES	1577
PERCENT OF VISITS WITH VALID SUDS SCORES	83%
MEDIAN IMPROVEMENT IN DISTRESS RATING	20

CHANGES TO GUEST SUDS RATING UPON DEPARTURE

86%	12%	1%
IMPROVED DISTRESS	UNCHANGED DISTRESS	WORSENED DISTRESS

Boxplot of distribution of SUDS improvement scores across visits (n= 1,577)



Key insights:[1]

- Aboriginal and/or Torres Strait Islander guests were 50% less likely than other guests to show improved distress (p =0.002)
- Visits which included distress management were 12% more likely to show overall improved distress (p = 0.03)
- Improvement in SUDS score varied significantly by gender. Compared to female guests
  - Male guests' distress rating improved 6.4 points **less** (p<0.001)
  - Non-binary guests' distress rating improved 6.3 points **more** (p=0.007)

1. See Appendix for further technical details on the statistical analysis performed in the key insights column of this page

Peer work is intensive and workforce structures need to accommodate for this

To prevent burnout Safe Spaces should create opportunities for full-time work recognising the significant out of shift training and support required as well as opportunities for regular leave to take breaks

Peer work in a walk-in space is challenging and intense work, with distinct challenges from clinical work

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 and only spends around one hour with a client once or twice a week (this varies depending on the client's needs). The boundaries of a clinicians' roles are typically well defined by professional codes of practice and ethics and clinicians undergo extensive and rigorous training to understand these boundaries.

On the other hand, 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.

Burnout is a prominent risk in peer workers and the risk is exacerbated by inadequate training and supports, not feeling connected in the role and job insecurity

Burnout is characterised by emotional exhaustion, depersonalisation and a diminished sense of personal accomplishment – has been identified as an issue which impacts a higher proportion of peer workers than other healthcare professionals, with the implications of burnout including increased staff turnover and absences as well as poorer job performance.[1]

Research suggests that key drivers of burnout include:[2-3]

- **inadequate training and supports:** lack of role clarity, insufficient role specific training and support before and during the role, not having access to regular supervision and debriefing.
- **not feeling connected in the role:** limited opportunity to connect with other peer workers.
- **job insecurity:** underemployment (not receiving full time hours in one job) means that workers need to juggle multiple roles; roles not including time for the training and supports required to do peer work well; limited ability to take leave and breaks due to capacity constraints.

1. Maslach C, Schaufeli WB, Leiter MP. Job burnout. Annu Rev Psychol. 2001;52:397–422. doi: 10.1146/annurev.psych.52.1.397.
2. 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;
3. Meredith LS, Bouskill K, Chang J, Larkin J, Motala A, Hempel S. Predictors of burnout among US healthcare providers: a systematic review. BMJ open. 2022 Aug 1;12(8):e054243.

Expanded and standardised training and supports which recognised the intensity for peer workers are required

Training and supports for peer workers have varied considerably

Initial training for peer workers varied considerably across providers. The duration, intensity and format of training differed significantly across providers from online training modules to multi-day face to face education. Some providers delivered more limited training (e.g. one-two days with some online modules) whereas other providers have more extensive training programs (see NEAMI's case study to the right). There has been feedback that some training (e.g., ASSIST training) has been less aligned with the program's approach.

All providers deliver debriefing after shifts and regular check-ins in so that peer workers forum to discuss their experiences to ensure that the emotional impact was not carried home with them. However, access to one-to-one supervision sessions varied significantly across practices.

Rigorous and consistent peer work training and supports are essential to prevent burnout and support high quality and safe services

- The PHN should work with providers to establish a consistent, relevant set of peer worker training, that meet the needs of both staff and Safe Space guests. A range of training modules has been suggested by providers including Vicarious trauma; De-escalation; Suicide Narrative; Intentional Peer Support and the Power Threat Meaning Framework.
- The PHN should also work with providers to establish a consistent, relevant set of clinician training, that meet the needs of both staff and Safe Space guests. This should aim to help them better bring a peer approach to clinical practice.
- Opportunities for continuous improvement and on the job learning should be a standard feature of the peer work role. Regular individual supervision and debriefing is an essential part of the support system for peer workers. Regular opportunities for peer workers to connect and share practice across providers would also be helpful given then the evidence around the link between burnout and job connection.
- Contracting and salary arrangements for peer workers should reflect the high intensity and skilled nature of the work and the significant out of shift time required for trainings and other supports (e.g. debriefing, supervision, opportunities to connect with other peer workers).
- The PHN might also consider providing greater guidance around the recruitment of staff for the Safe Spaces, including considering a values-based approach.

CASE STUDY | NEAMI

NEAMI has developed a unique regimen of training and continuous improvement approach to best support its peer workers.

Initial training

Training consists of an intensive face to face training lasting six days on how to effectively leverage peer experience and share stories.

Regular shift rhythm

Continuous improvement and wellbeing is built into NEAMI's operating rhythm:

- Pre-shift – Before the shift, the team does a check in to hand anything over from previous shifts and to chat through any key practice improvements.
- Post close – After the shift, the team spend 30 minutes debriefing so that staff can work through any issues that came up on the shift and can "leave work at work".

Continuous improvement

- Structured group reflection – Twice a week, peers spend 30 minutes recording their reflections to refine their individual practices.
- Individual supervision session – Monthly one on one mentoring/coaching sessions to privately discuss practice without the risk of being judged.

Clearer guidance is required for operations managers and team leaders

Operations managers would benefit from a deeper understanding of the peer role to enable better organisational support

- Some operations managers indicated it would be helpful to have a deeper understanding of scope, benefits & challenges associated with the peer worker role.

Team leaders would benefit from further opportunities to connect and share learnings with each other and the PHN

- While the existing operations managers' forum is working well, team leaders would also benefit from a forum where they can share practices and to provide any feedback to the PHN on key challenges.

Service guidelines should be produced to provide further guidance on for operations manager and team leaders

- Currently there is limited guidance available for operations managers and team leaders to support them in their roles. Providers indicated that at this stage of the pilot, service guidelines would provide greater consistency across the Safe Spaces and provide the documentation required to advocate within their organisations to enable the Safe Spaces model to run as intended.
- The service guidelines should be based on an emerging consensus of the minimum requirements and expectations of Safe Space activities. They should aim to strike the balance between providing guiding principles alongside sufficient detail, examples and case studies, to support providers to 'work in the grey' and deliver the Safe Space model in their service delivery context. They should be clear about any non-negotiable features of the Safe Spaces model without being overly prescriptive.
- Potential content themes for the service design guidelines (derived from interviews and other service guidelines) are presented in the case study to the right.

SAFE SPACE SERVICE GUIDELINES | EXAMPLE CONTENTS

1. Introduction to the guidelines - *sets the scene for the document*
- Purpose of the guidelines
- Background on the development of Safe Spaces

2. Design of the Safe Space - *explains the underpinning theory*
- Purpose and overview of Safe Spaces
- Key features of the model of care including supporting theory & practice frameworks (i.e. from peer work)
- Key differences from typical clinical services.

3. Stages of a Safe Space shift - *gives practical resources and examples about running a Safe Space shift*
- Pre-shift preparation
- Greeting and screening guests
- Supporting guests – including new & returning guests
- Guest follow ups
- Referral pathways (in and out)
- Post shift debrief
- Data collection and quality assurance.

4. What is required to deliver Safe Spaces? - *provides an overview of the activities needed to deliver Safe Spaces*
- Roles within providers to deliver Safe Spaces
- Recruiting peer workers
- Training and supporting peer workers
- Ensuring the quality and safety of Safe Spaces
- Communicating the purpose and benefits of Safe Spaces externally.

5. Improvement and Sustainability

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What is working well

Key successes and enablers of the Safe Spaces have been outlined throughout this report. The below summarises key identified things that are working well, as well as where further information can be found.

1	Safe Spaces are clearly meeting unmet needs and have become a trusted location for acute distress management as indicated by ongoing demand	pages 12-14 & 20
2	Strong co-design process with adaptation in the implementation to the needs seen on the ground	page 20
3	Commitment to the holistic service model and peer led approach starting from the philosophy of "How can we help?" and "Do what works" distinguishes the Safe Spaces	page 20, 24
4	Clear communication and collaborative governance approach to work through challenges and ambiguities of designing and implementing a service where there is no roadmap	page 15
5	Commitment to sharing and resolving challenges to drive positive collective outcomes	page 15
6	The Network and integration initiatives are gaining momentum due to dedicated efforts	page 17-18
7	Guests are seeing improved distress outcomes from their visit to the Safe Space	page 24, 27
8	Provider flexibility in implementing a continuously improving service which is very different to traditional clinical services	pages 15, 20, 24 & 30

Key recommendations

Below an overarching recommendation and four recommendations about key themes about the Safe Spaces are provided.

Overarching: Iteratively develop Safe Space service guidelines to promote consistency over time

1 Workforce and training

Consider approaches to expand and pool training resources across all levels as the Safe Spaces mature

See pages 28-30

1a. Develop a minimum standard set of training for peer workers, clinicians, team leaders and operational managers.

1b. Ensure every peer worker has access to debriefing after every shift and regular individual supervision.

1c. Consider approaches to pooling resources across the Safe Space sites and developing more opportunities for full time work (e.g. service coordinator roles and casual workforce pool).

1d. Build opportunities for the progression of peer workers, including by ensuring all Safe Space sites have a peer practice lead.

2 Quality and safety

Improve consistency in quality and safety, and develop longer-term models of care for repeat guests

See pages 20-25 & 30

2a. Agree on clearer messaging on who the Safe Spaces is set up to support for without compromising the open door policy which has enabled access for hard to reach groups.

2b. Agree on overarching quality and safety & practice governance frameworks.

2c. Develop models of care for repeat visitors balancing the need to support individuals with chronic distress and the need to ensure Safe Spaces continue to have capacity to see new guests.

3 Governance

Refine governance structures to promote interaction and sharing of insights across all roles

See pages 15, 28-30

3a. Establish separate forums for peer workers, team leads and operational managers across Safe Spaces to connect and share learnings.

3b. Ensure team leaders have avenues to share enablers, barriers and feedback to the PHN to guide continuous improvement.

3c. Maintain open and collaborative approach to collectively identifying and solving problems as they arise

4 Network

Maintain the strong progress to date

See pages 16-17

4a. Continue to support the Network's stakeholder engagement and integration efforts.

Note: Progress for the next phase of the integration work, formalising partnerships and implementing initiatives, may occur at a slower pace due to the extensive stakeholder engagement required.

Future focus areas for the evaluation

SAFE SPACES

- Understanding guest perspectives / support person perspectives with a stronger focus on outcomes
- Understanding peer worker and clinician perspectives (who are not in leadership roles)
- Monitoring changes in model of care
- Deeper analysis on understanding emergency department admissions avoided
- Sustainability of the Safe Space model under Head to Health

NETWORK

- Continue to monitor implementation progress
- Establish network data collection once formal partnerships are established
- Consider perspectives of network partners

Appendix

Methodology for estimating the total cost savings due to emergency department presentations avoided 1/2

There are two key components of the estimated cost savings:

- 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 are presented in the table below:

Parameter	Value	Source
Cost per mental health ED presentation[1]	$944.7	Weighted average cost of mental health emergency presentations in Australia FY19-20 See next slide for calculation.
Proportion of mental health ED presentations that result in an admitted inpatient stay[2]	39.3%	Proportion of mental health ED presentations that separate into an admitted inpatient stay in Queensland FY 19-20
Average cost of mental health inpatient admission[1]	$18,758	Average cost of admitted mental health phase in Queensland FY19-20
Total average cost saving per ED presentation avoided	$8,316.6	Cost of ED presentation + Average proportional inpatient costs Cost of ED presentation: 1 (ED presentation) x $944.7 (Cost of mental health ED presentation) = $944.7 Average proportional inpatient costs: 1 (ED presentation) x Proportion of mental health ED presentations that result in an admitted inpatient stay (39.3%) x average cost of mental health inpatient admission = 7,371.9

1.Independent Hospital Pricing Authority. National Hospital Cost Data Collection Report: Public Sector, Round 24 Financial Year 2019-20 Appendix. 2021. Accessible here
2.Mental health services in Australia, Emergency department mental health services - Australian Institute of Health and Welfare [Internet]. Australian Institute of Health and Welfare. 2022 [cited 17 June 2022]. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services

Methodology for estimating the total cost savings due to emergency department presentations avoided 2/2

This slide shows the how the cost per mental health ED presentation[1]

Presentation category	Australian Emergency Care Classification code and description	Number of separations	Proportion of presentation category	Cost	Weighted average Mental Health ED presentation cost
Mental health ED	E1990A Mental, behavioural and neurodevelopment disorders, other Complexity level A	91,404	38.5%	$1,218	$944.7 Calculation: ($1218 x 38.5%) + ($895 x 33.2%) + ($631 x 28.3%)
	E1990B Mental, behavioural and neurodevelopment disorders, other Complexity level B	78,909	33.2%	$895	
	E1990C Mental, behavioural and neurodevelopment disorders, other Complexity level C	67,128	28.3%	$631	
	TOTAL	237,441	100%		

1.Independent Hospital Pricing Authority. National Hospital Cost Data Collection Report: Public Sector, Round 24 Financial Year 2019-20 Appendix. 2021.

Additional detail on statistical analysis performed for key insights column on page 27

Key insights (from page 27)

- Aboriginal and/or Torres Strait Islander guests were 50% less likely than other guests to show improved distress (p =0.002) – see dot point 1
- Visits which included distress management were 12% more likely to show overall improved distress (p = 0.03) – see dot point 2
- Improvement in SUDS score varied significantly by gender. Compared to female guests – see dot point 3
  - Male guests' distress rating improved 6.4 points **less** (p<0.001)
  - Non-binary guests' distress rating improved a 6.3 points **more** (p=0.007)

This section provides technical details of the statistical analysis performed on the SUDS scores on page 27 in the interests of transparency. For ease of reference, we have reproduced the key insights from page 27 in the blue column on the left.

1. The odds ratio for the likelihood of improvement in distress for Aboriginal and/or Torres Strait Islander guests compared to other guests was calculated using a logistic regression. The overall model was statistically significant X2 (2, N = 1,577) = 8.69, p = 0.003. The odds ratio for Aboriginal and/or Torres Strait Islander status is 0.5 (95% CI 0.32, 0.78) meaning that the Aboriginal and/or Torres Strait Islander guests are 50% less likely than other guests to show improved distress but the likelihood could vary between 22% and 68%.

2. The risk ratio for the likelihood of improvement of distress for visits where distress management was provided was calculated using a robust Poisson regression. The overall model was statistically significant X2 (1, N = 1,577) = 4.71, p = 0.03. The risk ratio for use of distress management is 1.12 (95% CI 1.01, 1.25) meaning that visits using distress management were 12% more likely to show improved distress, but the likelihood could vary between 1% and 25%.

3. The relationship between improvement in SUDS score and gender was investigated using a linear regression model with female guests as the reference level. The overall model was statistically significant R^2 =0.03, F(2, 1386)=28.1, p<0.001.
   a. The effect estimate for male guests was -6.4 points (95% CI -7.8 points, -4.2 points) meaning that compared to female guests male guests showed on average a 6.4 points lower improvement in their SUDS score between the start and the end of the visit however this this could range between 7.8 points and 4.2 points lower than female guests.
   b. The effect estimate for non-binary guests was 6.3 points (95% CI 1.7 points, 10.7 points) meaning that compared to female guests non-binary guests showed on average a 6.3 points higher improvement in their SUDS score between the start and the end of the visit. However this this could range between 1.7 points and 10.7 points higher than female guests.

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We are inspired and determined to improve people's lives in significant ways. When our strengths complement yours and we think big together, we can transform businesses, governments, and communities. We realise a bigger idea of success.

700	70	5
PEOPLE	PRINCIPALS	COUNTRIES