Illawarra Shoalhaven Safe Space

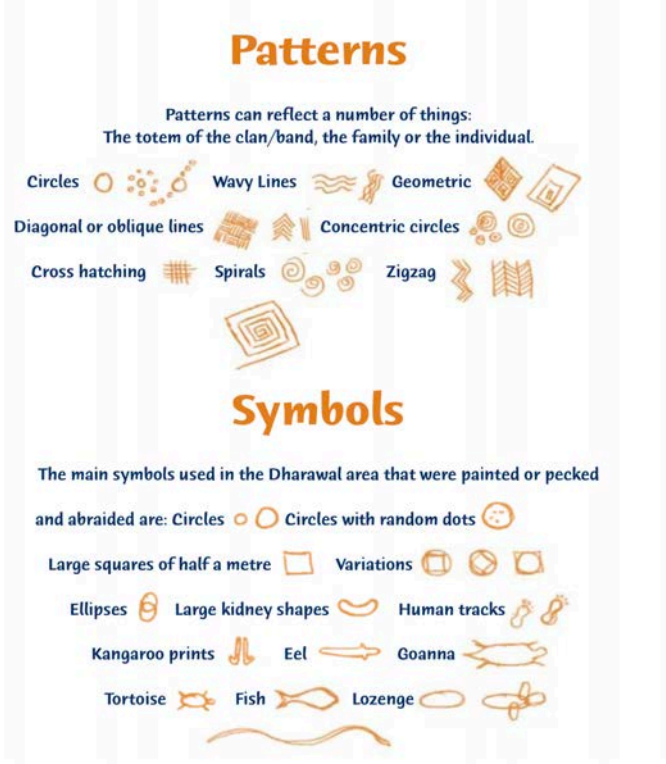
End-to-end co-design process

Summary

Roses in the Ocean

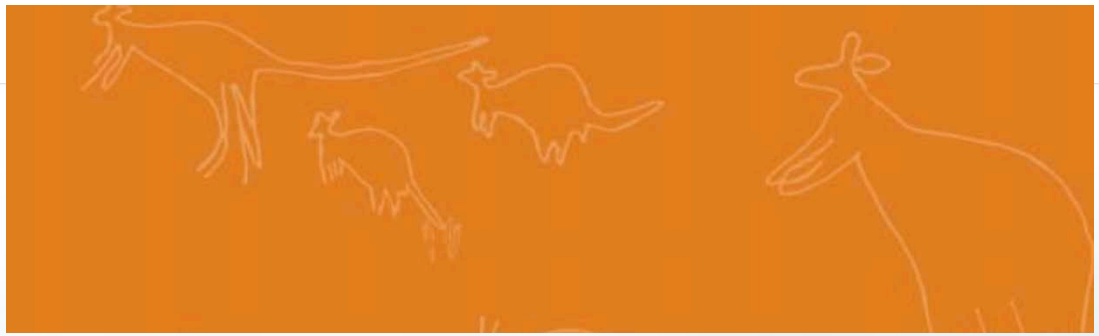
stemming the tide of suicide

Acknowledgement of Country



http://www.lesbursill.com/site/PDFs/_Dharawal_4Sep.pdf

We acknowledge the Dharawal people of the Illawarra Shoalhaven region, pay our respects to their elders past, present and emerging.



Acknowledgement of Lived Experience

We acknowledge those who have considered ending your life, and those who have attempted to do so.
We acknowledge your courage and tenacity to carry and move through the immense pain.

We acknowledge those who care for loved ones through suicidal crisis.
We acknowledge the fear and helplessness you experience, and your endless endeavors

to empower them to live.

We acknowledge those bereaved through suicide.
May your immeasurable loss define a legacy and a mission to discover healing and a new purpose.

We acknowledge all the magnificent lives we have lost to suicide and those who are struggling with life today.

Everyone's lived experience is unique.

Everyone's lived experience is valuable.

Everyone's live experience can make a difference.

Thank you

A heartfelt thanks to everyone who participated in the Safe Space co-design process in the Illawarra Shoalhaven region, with a special mention to:

- People with lived experience who so generously shared their uniquely valuable expertise in order to improve supports for others.
- David Alcorn and Johnny Pullman from the LHD for championing the Safe Space initiative.
- Alex Hains who was instrumental in getting the process up and running in the region.
- Emma Paterson who worked tirelessly, and with endless patience, behind the scenes.

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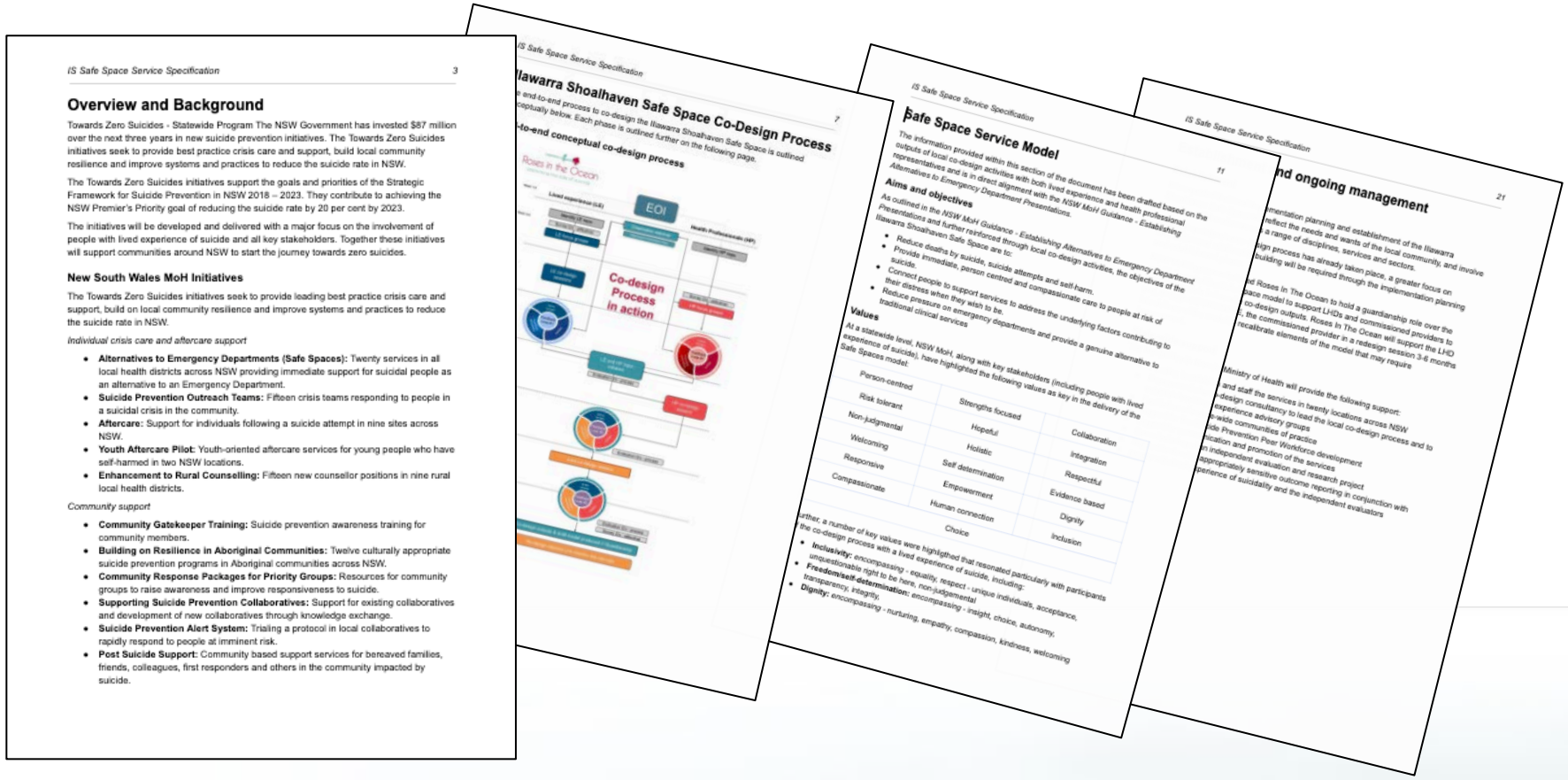
Outcome of co-design process

The key outcome of the co-design process was the development of an Illawarra Shoalhaven Safe Space service model document, structured in alignment with the commissioning requirements of COORDINARE (South Eastern NSW PHN).

COORDINARE will now take carriage of the commissioning process, to seek a service provider organisation to operationalise the Safe Spaces model in alignment with the co-design findings.

Service specification drafted and submitted to COORDINARE for commissioning.



IS Safe Space Service Specification 3

Overview and Background

Towards Zero Suicides - Statewide Program The NSW Government has invested $87 million over the next three years in new suicide prevention initiatives. The Towards Zero Suicides initiatives seek to provide best practice crisis care and support, build local community resilience and improve systems and practices to reduce the suicide rate in NSW.

The Towards Zero Suicides initiatives support the goals and priorities of the Strategic Framework for Suicide Prevention in NSW 2018 – 2023. They contribute to achieving the NSW Premier's Priority goal of reducing the suicide rate by 20 per cent by 2023.

The initiatives will be developed and delivered with a major focus on the involvement of people with lived experience of suicide and all key stakeholders. Together these initiatives will support communities around NSW to start the journey towards zero suicides.

New South Wales MoH Initiatives

The Towards Zero Suicides initiatives seek to provide leading best practice crisis care and support, build on local community resilience and improve systems and practices to reduce the suicide rate in NSW.

Individual crisis care and aftercare support

- **Alternatives to Emergency Departments (Safe Spaces):** Twenty services in all local health districts across NSW providing immediate support for suicidal people as an alternative to an Emergency Department.
- **Suicide Prevention Outreach Teams:** Fifteen crisis teams responding to people in a suicidal crisis in the community.
- **Aftercare:** Support for individuals following a suicide attempt in nine sites across NSW.
- **Youth Aftercare Pilot:** Youth-oriented aftercare services for young people who have self-harmed in two NSW locations.
- **Enhancement to Rural Counselling:** Fifteen new counsellor positions in nine rural local health districts.

Community support

- **Community Gatekeeper Training:** Suicide prevention awareness training for community members.
- **Building on Resilience in Aboriginal Communities:** Twelve culturally appropriate suicide prevention programs in Aboriginal communities across NSW.
- **Community Response Packages for Priority Groups:** Resources for community groups to raise awareness and improve responsiveness to suicide.
- **Supporting Suicide Prevention Collaboratives:** Support for existing collaboratives and development of new collaboratives through knowledge exchange.
- **Suicide Prevention Alert System:** Trialing a protocol in local collaboratives to rapidly respond to people at imminent risk.
- **Post Suicide Support:** Community based support services for bereaved families, friends, colleagues, first responders and others in the community impacted by suicide.

IS Safe Space Service Specification 7

llawarra Shoalhaven Safe Space Co-Design Process

e end-to-end process to co-design the Illawarra Shoalhaven Safe Space is outlined ceptually below. Each phase is outlined further on the following page.

-to-end conceptual co-design process

Roses in the Ocean

EOI

Co-design Process in action

IS Safe Space Service Specification 11

Safe Space Service Model

The information provided within this section of the document has been drafted based on the outputs of local co-design activities with both lived experience and health professional representatives and is in direct alignment with the *NSW MoH Guidance - Establishing Alternatives to Emergency Department Presentations*.

Aims and objectives

As outlined in the *NSW MoH Guidance - Establishing Alternatives to Emergency Department Presentations* and further reinforced through local co-design activities, the objectives of the Illawarra Shoalhaven Safe Space are to:

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

Values

At a statewide level, NSW MoH, along with key stakeholders (including people with lived experience of suicide), have highlighted the following values as key in the delivery of the Safe Spaces model:

Person-centred	Strengths focused	Collaboration
Risk tolerant	Hopeful	Integration
Non-judgmental	Holistic	Respectful
Welcoming	Self determination	Evidence based
Responsive	Empowerment	Dignity
Compassionate	Human connection	Inclusion
	Choice	

rther, a number of key values were highlighted that resonated particularly with participants the co-design process with a lived experience of suicide, including:

- **Inclusivity:** encompassing - equality, respect - unique individuals, acceptance, unquestionable right to be here, non-judgmental
- **Freedom/self-determination:** encompassing - insight, choice, autonomy, transparency, integrity
- **Dignity:** encompassing - nurturing, empathy, compassion, kindness, welcoming

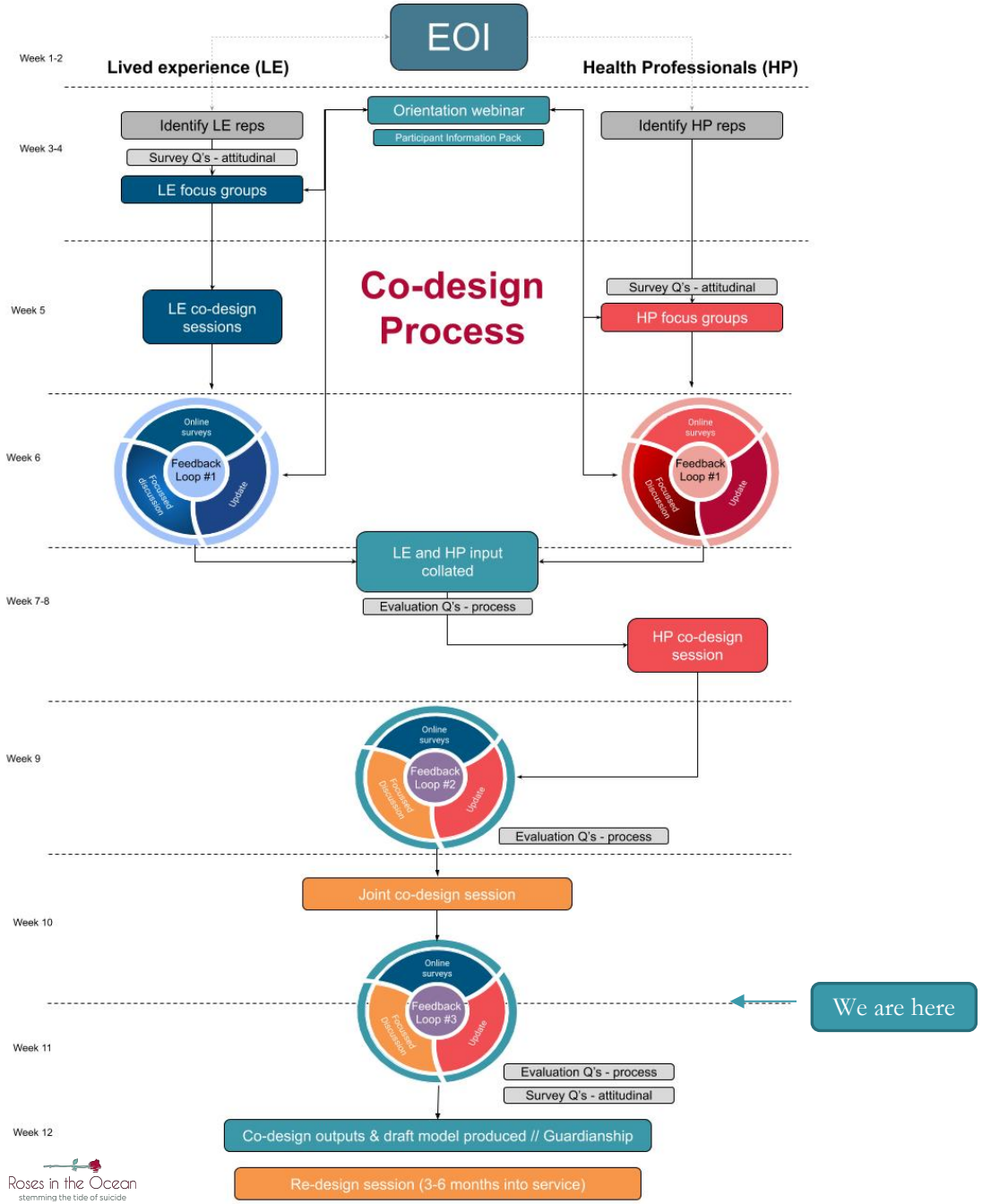
IS Safe Space Service Specification 21

nd ongoing management

mentation planning and establishment of the Illawarra reflect the needs and wants of the local community, and involve a range of disciplines, services and sectors.
ign process has already taken place, a greater focus on building will be required through the implementation planning

d Roses In The Ocean to hold a guardianship role over the ace model to support LHDs and commissioned providers to co-design outputs. Roses In The Ocean will support the LHD , the commissioned provider in a redesign session 3-6 months recalibrate elements of the model that may require

Ministry of Health will provide the following support:
and staff the services in twenty locations across NSW
-design consultancy to lead the local co-design process and to experience advisory groups
e-wide communities of practice
ide Prevention Peer Workforce development
ication and promotion of the services
n independent evaluation and research project
appropriately sensitive outcome reporting in conjunction with perience of suicidality and the independent evaluators



Overview of Summary Slide Deck

- The purpose of this summary slide deck is to capture all of the findings from the co-design process and document them in the same place.
- The end-to-end process to co-design the Illawarra Shoalhaven Safe Space is outlined conceptually in the diagram to the left.
- The summary slide deck is presented sequentially in line with the the order of workshops and feedback loops.

Who participated in the process?

- 9 lived experience representatives in the focus groups
- 10 health professionals in the focus groups
- 67 respondents to feedback loop 1 survey (24 LE and 43 HP)
- 28 respondents to feedback loop 2 survey (13 LE and 15 HP)
- 29 respondents to feedback loop 3 survey (15 LE and 15 HP)

Roses in the Ocean
stemming the tide of suicide

Feedback Loop 1 – Lived Experience

Lived experience representatives participated in three online focus groups (2 hours each) where Roses in The Ocean facilitated conversations based around the experience of seeking help and support through the emergency department, exploring their feelings at each key touch point (finding, arriving, checking in, waiting, treatment, leaving), reasons behind why they felt that way, what needs they had at each stage.

Additionally, lived experience participants engaged in a 2 hour whole of group co-design session - a facilitated conversation regarding, values and principles of the Safe Space and bright ideas for what the Safe Space experience should look and feel like.

Co-design outputs from the lived experience focus groups were captured via a summary slide deck and presented back to the broader community via webinar. An opportunity was opened for anyone with a lived experience of suicide to participate in the process by sense checking the findings of the initial focus group and adding additional thoughts and insight via a survey.

Understanding your experience

Feelings, Needs, Ideas

- We walked through the experience of a person seeking help through ED (and for Health Professionals, the experience of supporting someone through the process) and explored their feelings, the reasons why they felt that way and what needs they had at each stage:

  finding, arriving, checking in, waiting, treatment, leaving

- The following slides highlight the key points of discussion and feedback from the first phase of co-design
- Everything that was shared in the conversations has been captured with the most common themes shown here

Finding

Feelings

Why were you feeling this way?

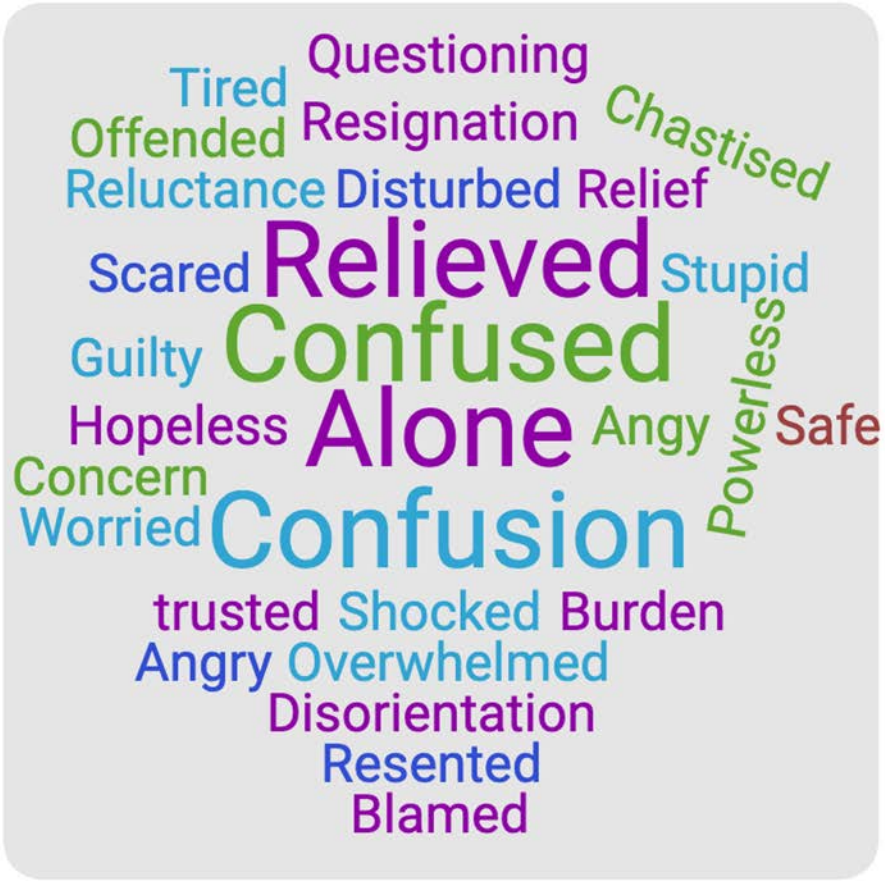
"Convincing friend to go and then getting there is like the amazing race"

"Its like I was following a magnificent script and then they throw you the same old thing time and time again, Ambulance and police rock up, you sit in the seat and it all happens, its surreal, you know what's going to happen"

Scared I would be arrested for committing a crime.

Arrival

Feelings



Why were you feeling this way?

"Other people start writing your life down as soon as you arrive and you know it's not true what they're writing but you're locked into that system with grand human emotions being viewed through narrow constrained and ultimately fiction through clinical lenses, whole journey based on that fiction"

"I felt relieved because I had a small bubble of hope that maybe I would find support, and then realised I was being treated like an imbecilic child and that quickly turned into growing concern for my safety."

Checking in

Feelings

Why were you feeling this way?

"There must be a better way to treat people with different needs. I wasn't bleeding, I hadn't stopped breathing, I wasn't having a heart attack, but my life was at just as high a risk as those that were triaged"

"Everyone's watching"

"Felt insignificant nobody understands"

"Lots of private questions in a public space"

Waiting

Feelings

Why were you feeling this way?

"Still hopeful I might find someone to support the process, wondering if all the gatekeepers were just the silly ones so keeping calm and waiting for someone with knowledge to support."

"Feel like I shouldn't be here and everyone is judging me."

"Unable to communicate my needs as nobody was listening"

Treatment

Feelings

Why were you feeling this way?

"Infuriated that there are so many people with kind hearts involved but they are a little skewed because everyone seemed to focus on sedating my physicality, and then leaving me to myself and own devices for the rest of my life"

"How can these people help my friend when they've only just met them?"

"I learnt early on that I am the expert in my mental health, I was angered as I was not asked what I thought I needed"

Leaving

Feelings

Why were you feeling this way?

"Lack of support and clear advice around the discharge process. Suddenness of discharge concerning. No time for recovery from hospital - back to school, work. I had to liaise with school, work out how that would look without advocacy to assist us. Convincing my son he was ready to go back to school and re engage."

"it's rarely over when you leave the ED"

"I don't feel safe I have nowhere to go or no support"

Generally

Feelings

Why were you feeling this way?

"It was like 10% of me stayed in the ED and the process, but 90% had to leave. I was physically there but -my spiritual self was gone because I told it to go away because it wasn't going to cope. I split myself because I needed to protect myself. Showing emotions wasn't going to help me get out."

"I felt blind fury, and annoyance beyond that that no one cared about my mental, emotional and spiritual tortured state and they just focused on sedating me and propping me upright so I could mimic a human in seated silence."

"Traumatised as care was imposed upon me"

Have not accessed ED or would never consider

"I wouldn't go back in the current circumstances but I would like to say that with changes underway I'd like to think it could be a safe place for me to go and embrace at another time. I need to feel assured that there is a recognition that when people are vulnerable they are the experts in their experience, and that people with lived experience are there to help them"

I haven't accessed supports via emergency departments because it has never occurred to me to do that. Why would a person considering killing themselves go to a place dedicated to saving the lives of people who are accidentally or inadvertently experiencing life-threatening situations?

"At the moment it is not a safe place for me but I'd like to look forward to a time when things are different. There is an inequity of power in the hospital. Others with physical needs are prioritised above my need - and yet my life is just as important and just as at risk - people need to be asked what they want and what they need."

"There are many people who care but their hands are tied by the system - time, resources, policies. They get burnt out and become victim of the system itself"

What needs should our safe space need to meet?

Needs

Practical Connection

- Food, drinks, warmth
- Access to the outdoors
- Safe environment
- Quality TV, magazines and entertainment
- Time and space
- Space for private conversations
- Administrative support

Emotional Connection

- Being in good company
- Being heard, eye contact
- Communal areas to connect with others
- Meaningful activities (art, craft, exercise)
- Empathetic staff
- Welcomed, hosted and respected
- Connection with skilled staff

Needs

Information Connection

- Process information (what's next?)
- Guidance on transition / exit (maintaining own health and where to access services)
- Information on what a person in crisis is feeling (for carer)

Other

- Mental health support
- Confidence in workers
- Avenues for creativity
- Human rights respected
- Autonomy as a person
- Expert in own journey

Co-designing our safe space

Values

- Equality
- Connection
- Respect – unique individuals, ‘being’with’
- Autonomy
- Co-passionate support
- Freedom – self reflection, insight, choice, own decisions
- Nurturing – empathy, kindness, love, fun
- Transparency
- Integrity
- Humility
- Authenticity
- Dignity
- Trust
- Non-judgmental
- Inclusion
- Team
- Acceptance
- Mutuality – kindness, spirit of mate-ship
- Ambiguity – observe holistic space
- Curiosity
- Deep listening
- Facilitated choice
- Unquestionable right to be here
- Flexible
- Welcoming

Principles

1. This is our place . . . Our place is YOUR place
2. We will welcome you as you are in a spirit of mutuality, unquestionable belonging and respectful acceptance
3. We will walk together amidst the freedom of autonomy, self reflection and choice.
4. We will offer co-passionate sharing of every person's journey
5. XXXXX
6. XXXXX

Your fabulous IDEAS to design the ISLHD safe space!

- Not on hospital grounds, and not in hospital
- Central & accessible, safe to access
- Totally opposite to ED
- NON-clinical
- Lived Exp of suicide Peer Support workforce
- Management of service NOT by clinician
- Collaboration & integration with health system when we need it
- Soft furnishing, nice lighting, prints on wall,
- Welcomed to space when you arrive
- Seamless way to feel information into another place the person needs to access
- Opening times – to be discussed
- Oriented into the safe space by welcoming
- Essential kitchen table for tea coffee scones
- Computer if someone needs to access it, phone chargers
- Something to do. Colouring, self guided activities,
- Freedom to interact or not – on your terms
- Option to go for a walk with peer worker
- Simple way to collect info – give person or family member a book they could start writing, drawing their story in so they don't have to keep sharing – author their own story or co-authored with a LE Peer worker and family members

Your fabulous IDEAS to design the ISLHD safe space!

- Mural walls
- Artwork that changes with sunlight
- Resident dog
- Imagery in information pack
- Physical space – no reception desk but a kitchen table, look like you're walking into a kitchen space. Welcoming. Real pot plants.
- Seating set up really important – coffee tables next, diagonal facing chairs, a corner bean bag with sensory; group casual space; no direct focus on TV in central area
- Colour of walls really important – not white and not super bright
- Consider aesthetics and functionally
- Kitchen – able to bake fresh baked goods
- Techniques to help people feel grounded – sensory modulation
- Peers with a lived experience of suicidality
- Clinical manager should be non-medical – social worker/ psychologist - ideally with their own lived experience

Co-Design Feedback Loop 1

24 Lived Experience respondents

Lived Experience Feedback Loop 1

The vast majority of Lived Experience respondents **agreed** that the slides presented **accurately reflected** their experiences. Points of interest include:

- More work needs to be done on understanding what we all mean by ‘clinical’ and ‘non-clinical’ to ensure desired workforce is engaged
- Some uncertainty around safe space principles – may need further work
- Utilisation of technology (for personal use as well as across the safe space e.g. entering information on iPads)
- Reiteration that staff working in the safe space should have a lived experience of suicidal crisis / ideation and supporting others to find support
- Cultural and gender/sexuality inclusive care must be considered

Feedback Loop 1 – Health Professionals

Health professionals also participated in three online focus groups (2 hours each) where Roses in The Ocean walked through the experience of being a Health Professional supporting someone through the process of finding and accessing support through the emergency department (finding, arriving, checking in, waiting, treatment, leaving), and explored their feelings, the reasons why they felt that way and what needs they had at each stage.

Co-design outputs from the health professionals focus groups were captured via a summary slide deck and presented back to a broader audience of health professionals via webinar. An opportunity was opened for health professionals in the Illawarra Shoalhaven region to sense check the findings of the initial focus group and add additional thoughts and insight via a survey.

Feelings, Needs, Ideas

- We walked through the experience of a person seeking help through ED (and for Health Professionals, the experience of supporting someone through the process) and explored their feelings, the reasons why they felt that way and what needs they had at each stage:

  finding, arriving, checking in, waiting, treatment, leaving

- The following slides highlight the key points of discussion and feedback from the first phase of co-design
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Understanding your experience

Finding

Within public health system

- Frustration with lack of options
- Acknowledge that ED isn’t ideal in many cases
- Sad, disappointing and distressing for patients
- Powerless, existing systems and processes dictate how/where patients are referred
- Have to meet duty of care and legal obligations

Outside public health system

- Anxious around what might happen when someone at-risk sent to ED
- Reluctance to send to ED
- Support through development mgmt plans
- Difficult to balance worrying to someone's life and getting them support
- ED is the only option that you’ve got in a time of crisis
- Angry, unheard, disappointed, frustrated

It's a mixture of feelings because I know I'm doing the right thing from a legal perspective but for the consumer I feel sad and disappointed, and I know that it doesn't really encompass best practice

It's very hard because the reason for referral is you're worried for their life. It's not that you think ED is going to be helpful, but there is nothing else that can be offered that is going to fill that gap.

You're doing this because you have no other options, and you're doing all that you can.

Frustrating to know you are not doing the best thing - but there are no other options available

Sometimes you have amazing people in these roles but they seem powerless as well. Its clear the system isn't working so how can we work together to make it work

Arrival

Within public health system

- Consumer usually has had previous bad experiences with ED
- Frustration, anxious, sad – you know it is going to be tough for them
- Trust or rapport for consumer gets eroded by long delays, physical environment
- Variable staff attitudes toward consumers, families and/or carers
- Triage system is challenging

Outside public health system

- ‘Us vs. them’ power struggle
- Snookered, you’re behind the 8 ball
- Peer workers not viewed on same level as other clinical staff
- Many things add up to to a good or bad experience (e.g. environment, triage nurse, waiting room)
- High patient volume add to stress of hospital staff to remember they are treating ‘people’
- Privacy and confidentiality an issue

Feel disappointed. I carry a lot of frustration about the way the service runs & the way the system is. It eats away at that hope that things are going to get better and are moving in the right direction. Just feel disappointed. I walk away and shake my head.

Consumer usually has had a bad experience in the past so the ED is the last place they want to go to so they already feel anxious about going. And then when they arrive they know they're going to be treated differently, disrespected in some regard.

Who is on triage can make a big difference.

When you do go up to the ED you're put in the red chair, and everyone is sitting there looking at you, people are distressed and angry

Sad - you see where you're taking them is not helping them in any way, shape or form, and they're going to be in there for hours before they get help.

Checking in

Within public health system

- Angry – discrimination against mental health patients, repeat presenters
- Frustration and variability in mental health triage process
- Lack of respect for Peer Workers
- Limited communication between ambulance and hospital
- Clients struggle with transition through the system

Outside public health system

- Feels a bit ‘them and us’, stigma due to mental health issues.
- Long waits, even after calling ahead
- “Am I in the right place? Am I bad enough? Am I going to get any help here?”
- Variability in service quality – depends on who is doing the assessment
- Frustration with escalation processes, loss of control.

We do feel like we're a part of a wider service, but when we have a client who doesn't transition through the system well you realise you're not all on the same page

Sometimes I get an awesome triage, the Nurse has engaged really well with the person & got a lot of info that I'm not going to have to get them to repeat. Other times I get "mental health presentation" which is an indicator of their attitude. When I see this I know how the person has been treated

Angry - it makes me feel a sense of discrimination for the patient, mental health in general & for my profession

People just want someone to listen to them, just to be heard & validated. it doesn't take a lot of training or expertise to be able to do that

Feels a bit "them & us" - there is stigma around "one of yours" (the mentals)

Waiting

Within public health system

- Frustration, pressure, worried.
- Knowing service does not ultimately support the person
- Long waiting times, particularly for frequent presenters
- Many people are triaged and leave before being assessed
- Hit and miss – sometimes ‘who you know’ helps

Outside public health system

- Long waiting times for things that could’ve been solved elsewhere
- ”The hospital is not a place for mental health and wellbeing”
- Some people say what they need to say to go home
- Support you get is so inconsistent
- Feelings of hopelessness emerge
- There are good people but bad experiences are due to build up of a number of things

Ultimately there are lots of pressures that are beyond anyone's control, there could be 5 other mental health cases they need to see. So in the end it may not come down to the skills of the clinician, it is out of their control

I've supported people and we've waited for 5 hours. If they had been assessed earlier we could've found out it wasn't a big issue and it could've been resolved earlier.

I feel stretched thin and trying to keep together a service that does not ultimately support the person

Where you're positioned, the mental health room, you are on show. If things do escalate you are on show, there is no private place for us to take you

People don't know what to expect and as you go through it, it feels more hopeless

Treatment

Within public health system

- Burdened by decision to admit against someone's wishes
- Pressure, time, duty of care
- Making people wait feels wrong
- Community management usually possible with confidence in family and support service
- Comprehensive assessments helpful (family/carers, consumer and supports)

Outside public health system

- No confidence in acute services
- Hit and miss, variability
- By the time it gets to this point people will say anything to go home
- Difficult to run through high volume of information whilst in distress
- People need to feel like they’ve been heard.

By the time it gets to this point, they'll say anything just to go home because they just want to get out of there - people know what to say to just go home. The window of opportunity to help someone may have closed by the time they are seen

Soul destroying – I've had people say I need to go there because I feel unsafe, but when they get there & realise what it is, they think I've got to get out of here because it feels unsafe

Burdened by decision to admit someone against their wishes.

When you're scheduling someone, you are removing their human rights. You have to be very mindful to think about what it will feel like for that person. It's a HUGE decision to make and it shouldn't be made lightly

Heavy responsibility about having to make hard decisions

Leaving

Within public health system

- Frustrated – you know person will be discharged and you'll be called back to get them
- Discharged to a waiting list of private psychologist – no better.

Outside public health system

- Huge black spot – people are waiting for next step in time of crisis
- Difficult for person to retain information and use at later time
- Discharge planning needs to be improved
- Need more communication – don't know what's happening

We've had patients discharged with a plan to go to a private psych with a waiting time as well, when still in suicidal crisis. We feel this is a mismatch from what the person needs and when they need it.

Frustrating when you take someone to hospital, and you know they're going to be discharged and you know you're going to be called back to them - it's a never-ending cycle. That person is not getting the help they need, there is something missing in the process

Black spot - when people are waiting for next step are suicidal

Often, we'll get them PJs or something (for stay in Shellharbour), and then only to hear on Monday when we get to work that they were just released with nothing & no way to get home

Need more communication as often we don't know what's happening

What is needed?

What's missing from the services available in our region?

- Communication with ambulance service (increase investment)
- Other places to take people other than ED
- Flexibility to enable time to plan with person for best option
- Improved protocols (ambulance and services hands are tied)
- Empathic, in-person services
- Support for people with chronic trauma and borderline personality disorder
- Safe, secure space where peopled are welcomed (meeting the person where they're at)
- A place that understands people
- Increase hope by linking with a better service response
- Clarity on options and processes

What do you need to feel comfortable with supporting people to access a safe space?

- Building relationships with the service
- All health professionals working at the service to undergo peer worker training
- Strong endorsement from ISLHD
- Understanding what the service offers and clear purposes (e.g. age cohorts)
- How safe space would approach Borderline Personality Disorders and trauma
- Address risk, duty of care, accountability, legal obligations (taking someone to the Safe Space is appropriate and legally viable).
- Skilled workforce to enable escalation when required
- Anticipate people will need a clinician on staff to feel comfortable in referring
- Ensure state level policies and procedures reflect ‘current state’

Feedback From Co-Design Loop 1

Health Professionals (43 survey respondents)

Question: Do the slides presented accurately reflect your experiences?

The vast majority of Health Professionals agreed that the slides presented reflected their experiences.

There were however a small number of outlying comments stating that:

- Opinions from outside of public health being inaccurate and unrealistic
- Things were actually worse in reality

Resoundingly, people are telling us that the current crisis support services (e.g. ED) are not ideal for people experiencing suicidality. What would you suggest an alternative support should look like?

- Safe and welcoming environment
- Quiet – less sensory stimulation
- Open 24 hours
- All public is aware to go there
- Acute treatment team to provide services in homes of patients
- Hub with SP clinicians
- Less clinical and more relaxed (for low-risk clients)
- Access to a range of health professionals and clinicians
- Access to allied health services
- A dedicated mental health facility
- Dedicated crisis centers
- Mix of clinicians and peer workers

Health professionals have flagged a number of things that would help them feel comfortable to support a person accessing a non-clinical Safe Space. What would you like to add?

- Peer worker training and mentoring
- Manage entirely at the safe space with no pathway to ED
- Skilled and experienced clinical staff
- Clear agreement between government and NGO outlining critical incident process
- Clear guidelines on referral criteria and accessibility
- Broad referral criteria
- Targeted peer support
- Highly capable Peer Workers
- Clear ‘step-up’ pathway to ED
- Culturally inclusive care

Collation of Lived Experience and Health Professional input

Survey results from both feedback loops (lived experience and health professionals) were collated, forming a foundational base of knowledge for the subsequent phases of the co-design process.

Health professional co-design session and feedback loop 2

The intent of the health professionals co-design session compared the co-design outputs of lived experience participants and health professionals with each other and the NSW MoH guidance documentation. Roses in The Ocean facilitated targeted conversations at the co-design session, structured around elements of the service model where:

- ***Good alignment** existed between NSW MoH guidance document, Lived Experience participants and health professionals*
- ***Some divergence** existed between NSW MoH guidance document, Lived Experience participants and health professionals prior to the session*
- ***Further discussion** was required to reach agreement between NSW MoH guidance document, Lived Experience participants and Health Professionals.*

Feedback Loop 2 opened another opportunity for lived experience representatives and health professionals to sense check the outputs of the health professionals co-design session

Safe Space elements

Agreed through alignment

- **Values:** what will safe space hold itself to?
- **Outward connections and partnerships:** Where will safe space connect people to, when and why?
- **Physical environment & accessibility:** what does the safe space look and feel like? How do people access it?
- **Workforce development and support:** how will staff capability be developed over time

HP co-design Session

- **Location of safe space:** where will the safe space be established?
- **Connection pathways to safe space:** how will people access the safe space?
- **Staffing:** who will deliver support at the safe space?

To be discussed

- **Service model:** what support will people received at the safe space?
- **Reporting:** how will we know that the Safe Space is meeting the needs of the community
- **Communication and engagement:** how will we communicate about Safe Spaces to the sector and the community?
- **Governance:** who will be involved in overseeing clinical and operational aspects of the safe space?

Before we co-design…

- **Green text** = alignment between MoH, LE and HP
- **Orange text** = further discussion to explore divergence
- **Red text** = out-of-scope according to NSW MoH guidelines

What has been agreed on so far?

Values, outward connections and partnerships, physical environment and accessibility, workforce development and support.

Good alignment between NSW MoH guidance document, Lived Experience participants and health professionals.

Values to inform the model

Needs refinement but good in-principle alignment

NSW MoH Guidance

- Person-centred
- Risk tolerant
- Non-judgmental
- Welcoming
- Responsive
- Compassionate
- Strengths focused
- Hopeful
- Holistic
- Self determination
- Empowerment
- Human connection
- Collaboration
- Integration
- Respectful
- Evidence based
- Dignity
- Inclusion
- Choice

LE co-design process

- Equality
- Connection
- Respect – unique individuals, 'being'with'
- Autonomy
- Co-passionate support
- Freedom – self reflection, insight, choice, own decisions
- Nurturing – empathy, kindness, love, fun
- Transparency
- Integrity
- Humility
- Authenticity
- Dignity
- Trust and acceptance
- Non-judgmental
- Inclusion
- Team
- Mutuality – kindness, spirit of mate-ship
- Ambiguity – observe holistic space
- Curiosity
- Deep listening
- Facilitated choice
- Unquestionable right to be here
- Flexible
- Welcoming

Outward connections and partnerships

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
People can access information and warm referral re: a broad range of community based health and social services. Clear protocols will be in place to support staff to make decisions about safety and access. This includes having the capacity to respond to drug and alcohol issues and provide access to medical or other support, where this is needed. People will be actively supported to determine for themselves how best to stay safe and supported to access additional services of their choice. Guests that present with clear and immediate risks will be connected with other, more appropriate services.	**Guidance on transition / exit (maintaining own health and where to access services)** **Collaboration & integration with health system when we need it.**	**Skilled workforce to enable escalation when required.** **Building relationships with the service to understand how to coordinate / integrate.** **Clear 'step-up' to ED.**

Physical environment & accessibility

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
There is no requirement for people to present to an emergency department prior to accessing the service. The service can be located on or off hospital/health grounds, but is within proximity to the Emergency Department, not requiring people to travel a long distance. Ideally, as a non-clinical service, the service will represent a genuine alternative to accessing the hospital. The Safe Space is accessible outside of business hours. The environment is welcoming, safe and calm. This includes cultural, spiritual and emotional safety, and the provision of trauma informed care.	**Open after hours to access support when needed.** **Safe and welcoming space as well as aesthetically pleasing, functional and warm.**	**Safe, secure space where peopled are welcomed (meeting the person where they're at).** **Ability to support in the after hours.** **Safe and welcoming environment.** **Open 24 hours**

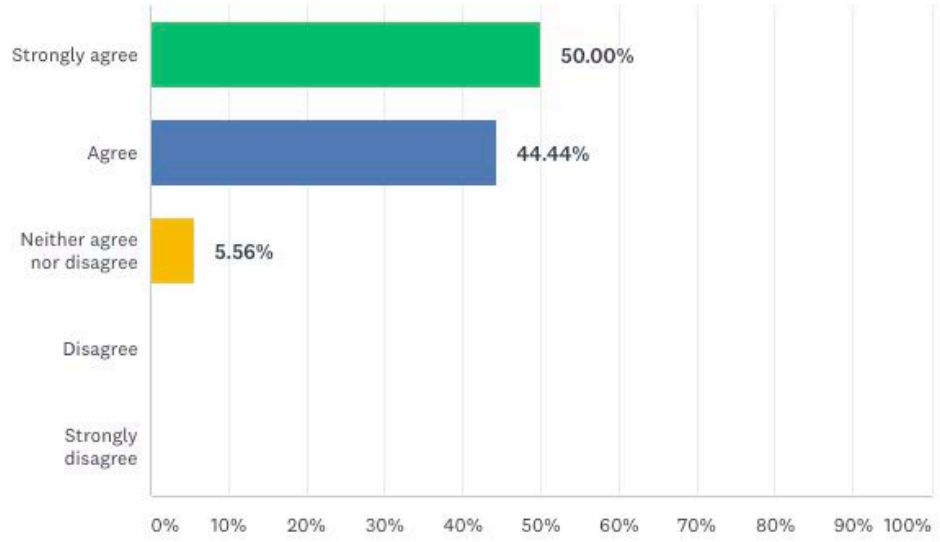
Out of scope and above resource allocation

Workforce development and support

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
Ongoing training, supervision, individual mentoring and group reflection to support SP Peer Workers MoH Guidance doc provides skill development/ training requirements for SP Peer Workers State-wide SP Peer Workforce Community of Practice is established	**Highly capable lived experience of suicide SP Peer Support workforce.** **Ongoing connection with skilled staff.**	**SP Peer worker training and mentoring.** **All health professionals working at the service to undergo peer worker training.**

Feedback Loop 2: Values, outward connections, physical environment and accessibility

To what degree to you endorse the slides above (52 to 56)?



Notes

- 18 answered (6 skipped)
- 94.44% (17 people) of those who answered agreed or strongly agreed

Feedback Loop 2: Values, outward connections, physical environment and accessibility

Do you have anything further to add regarding the slides above, prior to finalization?

- Add ‘culturally sensitive’ to Values
- Desire for Safe Space to be open 24/7 (but acknowledgement of resource constraints)
- Explore other alternatives to ‘step up’ to ED e.g. accessing clinicians (if needed) through inreach/outreach
- Clear management strategies for people who are highly intoxicated or presenting with aggressive behaviours, including the safety of other guests

What was discussed at the Health Professional co-design session?

Location of Safe Space, Connection Pathways to Safe Space, Staffing.

Some divergence between NSW MoH guidance document, Lived Experience participants and health professionals prior to the session.

In-principle agreement reached by end of co-design session.

Location of Safe Space

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
Safe Space can be located on or off hospital grounds (but within proximity). Scoping of potential sites for the Safe Spaces can progress independently of the local co-design process	**Preference for to be located off hospital grounds (but within walking distance).** **Centrally located.** **Easy and safe access.**	**For discussion.**

Location of Safe Space

On or off hospital grounds

- Consensus reached for Safe Space to be off hospital grounds but located nearby
- Health Professionals acknowledged the wishes of lived experience participants and genuinely want to meet their needs

Physical location

- Two locations were suggested by the group:
  - Wollongong (highest number of consumers)
  - Nowra (an area of high need)
- Pro's and con's for both locations (e.g. proximity to mental health services)
- An argument could be made to locate the safe space at either location.

Connection pathways to Safe Space

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
No requirement to present to ED prior to accessing the Safe Space. No expectation of a clinical referral pathway from ED to the Safe Space Guests attending the Safe Space not required to undertake any assessments / meet eligibility criteria. Safe Space promoted in local community (MoH to support promotion of Safe Spaces)	**Can be recommended by ED to visit.** **Free to visit Safe Space when needed.** **Innovate ways to collect information about guests on arrival other than standardized assessment tools.**	**Address risk, duty of care, accountability, legal obligations (taking someone to the Safe Space is appropriate and legally viable).** **Clear guidelines on referral criteria and accessibility** **Ensure state level policies and procedures reflect 'current state'** **How safe space would approach Borderline Personality Disorders and trauma**

Connection Pathways to Safe Space

What was discussed?

- Broad support for no expectation of clinical referral or attendance at ED prior accessing Safe Space
- Acknowledgement that it does present challenges with how the system is currently set up (not insurmountable)
- Consensus that Safe Space isn't being developed to change how the LHD operates

What is required to progress?

- Transfer of care protocols refined and/or education of LHD ED staff required (both regarding what the Safe Space offers but also how this meets LHD obligations)
- Safe Space to be offered as a genuine support option
- Good strong relationships required between Safe Space and LHD (ED particularly).

Staffing

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
Non-clinical SP Peer Workforce The service is staffed by Suicide Prevention Peer Workers with a lived experience of suicidal crisis and recovery Recruitment and training of SP Peer Workforce undertaken in line with the NSW MoH SP Peer Workforce Guideline	**Lived experience of suicide Peer Support workforce** **Management of service not by clinician.** **Clinical manager should be non-medical e.g. social worker/ psychologist - ideally with their own lived experience**	**Anticipate people will need a clinician on staff to feel comfortable in referring from ED** Out of scope **Highly capable Peer Workers** **Less clinical and more relaxed (for low-risk clients)** **Mix of clinicians and peer workers** **Skilled and experienced clinical staff / mix of clinicians and peer workers / access to allied health services**

Staffing

What was discussed?

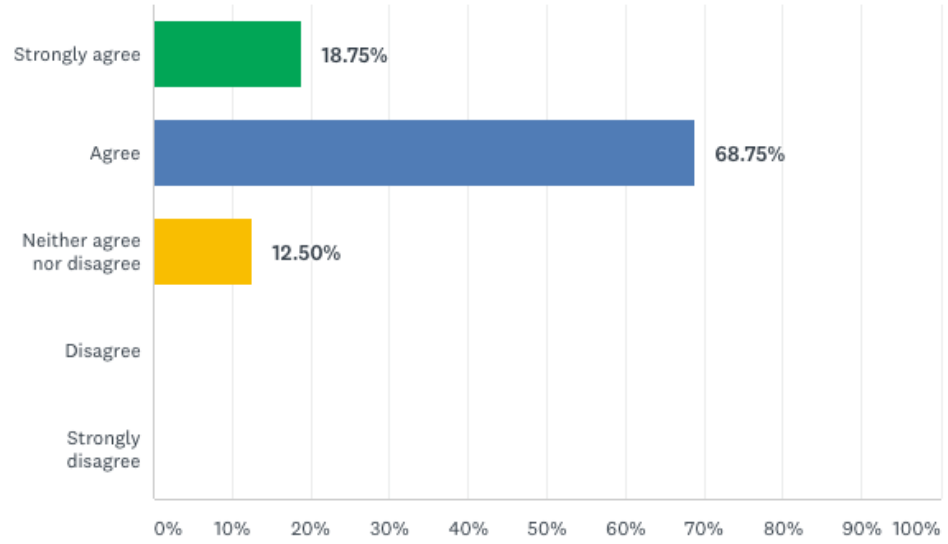
- Acknowledgement of the genuine requirement for all staff to have lived experience (identified positions)
- Preference for peer workers (no clinical staff required)
- May be worth ‘identifying’ positions to ensure mix of cultures, sexuality/gender to meet the needs of local community
- If necessary, to bring external people to safe space to co-facilitate groups they will be from Allied Health if necessary

Feedback Loop 2 Questions

- To what degree to you endorse the slides above?
- Do you have anything further to add regarding the slides above, prior to finalization?

Feedback Loop 2: Location, connection pathways to Safe Space and staffing

To what degree to you endorse the slides above?



Notes

- 16 answered (8 skipped)
- 87.5% (14 people) of those who answered agreed or strongly agreed
- 2 neither agreed or disagreed

Feedback Loop 2: Location, connection pathways to Safe Space and staffing

Do you have anything further to add regarding the slides above, prior to finalization?

- Connection guidelines to be kept simple (individual or family identified that attending safe space will support them to lower their risk + not at immediate risk)
- Develop strong and productive relationships with LHD staff, police and ambulance to enhance connections to Safe Space
- Support for peer workers is critical to avoid burnout (clinical supervision and self care)
- Further consideration given to mix of peer workers and clinical staff (ensuring access to clinical support if needed)
- Some concern around Safe Space as a genuine ‘alternate to ED’ without any onsite clinical support
- Some concern about the Safe Space model becoming ‘too clinical’ and that Peer Workers are more than capable of meeting the needs of guests.

What remains to be discussed and determined through Feedback Loop 2 and at co-design session 3…

Service model, information gathering & reporting, external communication, governance.

Further discussion required to reach agreement between NSW MoH guidance document, Lived Experience participants and Health Professionals.

Service model

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
Family and friends are involved, wherever possible and in alignment with the wishes of the person using the service The service is connected closely, or jointly delivered with community organisations, including other support services and local businesses. Clinical services are not provided. What is delivered in the service must be non-clinical. However, there is a clinical governance structure which provides a clear process to actively support the Suicide Prevention Peer Workers to identify in partnership with the person using the service, when and how additional clinical supports may be needed and accessed to best meet the individual needs and wants of the person.	**Non-clinical** **Collaboration & integration with health system when we need it.** **Linking in with a broad range of social and community services.** **Provision of support groups (educational and peer connection)**	**Understanding what the service offers and clear purpose (e.g. age cohorts)** **Other services suggested for region:** **Hub with SP clinicians** **Acute treatment team to provide services in homes of patients** **A dedicated mental health facility** **Dedicated crisis centers**

Feedback Loop 2: Service Model Questions

In addition to linkage to other services, support (practical and emotional) and access to groups, are there any other specific services that Safe Space guests should receive?

- Advocacy and linkage to a broad range of services (including LHD)
- Follow up contact (phone, text)
- Practical supports (e.g. taxi vouchers)
- Safety planning
- Access to welcoming physical environment

Feedback Loop 2: Service Model Questions

What is the minimum service response that all Safe Space guests will receive on accessing the Safe Space?

- Greeted by a team member
- Safety, validation and support
- An active listening and empathetic response
- No judgement or pressure to receive a ‘service’, access to the space with the opportunity to engage with a range of supports

Feedback Loop 2: Service Model Questions

What role do you see the safe space playing in supporting the natural supports of guests of the service? (A natural support may be a carer, family member, friend, worker from another service etc,)

- Allowing opportunities for respite
- Referrals and information (carer specific
- Level of involvement determined by the guest
- Support specific for a carer (acknowledging different focus)

Feedback Loop 2: Service Model Questions

How will the service specifically address the needs of Aboriginal people, People from the LGBTQI+ community, Men, Young people and Older people?

- Employing a mix of diverse staff
- Partnership with relevant organisations
- Engagement with specific communities about how best to meet their needs
- Training for staff in cultural awareness

Information gathering & Reporting

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
Develop appropriately sensitive outcome reporting in conjunction with people with lived experience of suicidality Outcome reporting is non-intrusive and does not present a barrier to people accessing the Safe Space. Outcome reporting to the Ministry of Health includes indicators of consumer experience, staffing, number of people using the Safe Space, issues, incidents, governance, partnerships, as well as and broad expenditure reporting. There is accountability and transparency about how effective the Safe Space is and whether it is meeting community expectations.	**Innovate ways to collect information about guests on arrival other than standardized assessment tools.**	For discussion.

Feedback Loop 2: Information Gathering and Reporting Questions

How will outcome data be collected and reported? For example, consumer experience, staffing, number of people using the service, issues, incidents, governance, partnerships, referrals, expenditure reporting?

- Allow for written, spoken or pictorial data
- Co-designed with guests – what is most meaningful?
- Potential to use iPad survey to collect information
- Web-based tools
- Opportunity for feedback / engagement post Safe Space visit

Feedback Loop 2: External Communication Questions

How will Emergency Department staff be supported with information and education about the service? Posters/ leaflets/ visits/ meetings/ peer worker in situ?

- Strong partnership between LHD and Safe Space
- Attendance at staff meetings to educate staff about the service
- Effective printed material in high access areas
- Peer worker available (either in situ or able to attend ED as required)

Feedback Loop 2: External Communication Questions

How will the service be promoted in the community, other health services and community organisations?

- Interagency meetings (through flyers etc)
- Social media, local media, pop up stalls and community events
- Partnerships with local government, service providers.

Feedback Loop 2: External Communication Questions

What support does the district need from the Ministry around communication/ promotion?

- State-wide and/or local communication
- Ensure promotional costs are funded
- Communication with services about role and function of Safe Space

Feedback Loop 2: External Communication Questions

What partnerships will support local connections for guests?

- Partnerships with organisations to meet the needs of culturally diverse guests
- Partnerships with organisations to meet the broad social determinants of health (housing, employment etc)
- Close working relationship with local services (mental health specific but also community and social services)

Feedback Loop 2: External Communication Questions

Are there media opportunities to promote the safe space?

- Peer workers in newspapers and radio
- Utilisation of local radio / ABC radio
- Active promotion of electronic media / digital media
- Link in with key dates on the mental calendar (e.g. mental health week)

Governance – (waiting for LHD/PHN guidance)

NSW MoH Guidance Document	LE co-design perspective	HP co-design perspective
Clear governance and reporting lines within the health service, to provide oversight and support. Clinical governance structure which provides a clear process to actively support SP Peer Workers when and how additional clinical supports may be needed. Ongoing opportunities for lived experience involvement (include communication channel for guest feedback) Transparent about all policies and procedures	**Ongoing involvement in shaping the design of the safe space.** **Being aware of protocols and procedures, nothing a secret.**	**Clear agreement between government and NGO outlining critical incident process and referral pathways (in and out).** **Understand process and protocols for clinical risk / risk management.** **Role in operational governance yet to be discussed.**

Feedback Loop 2: Governance Questions

What will operational governance look like for the Safe Space site?

- Local steering committee
- Ensure mix of peer workers and lived experience
- Team leader / manager reportable to the governance structure
- Inclusion of professional stakeholders where needed

Feedback Loop 2: Governance Questions

What will clinical governance look like for the Safe Space site?

- Access to clinical information.
- Minimal clinical governance required, not a clinical service.
- Mental health clinician who is designated consultant to the Safe Space staff – engage with each other through regular meetings
- No clinical governance required

Joint co-design session and feedback loop 3

The joint co-design sessions consisted of equal representation from both lived experience and health professional participants. The session consisted of a series of small and whole-of-group activities centred around five scenarios that are likely to be encountered by the Safe Space. The intent of the session was to bring to life the operational and practical aspects of how the Safe Space would respond to a variety of real-to-life situations.

Feedback loop 3 opened further opportunities for both lived experience and health professional participants to sense check the outputs of the joint co-design session and add further insights that may not have been captured. This was achieved through a live webinar and online survey.

Scenario 1:

Chantelle is a 17 year-old teenage girl who arrives at the safe space experiencing suicidal thoughts. It is the first time she has ever reached out for help and she is frightened by what she is experiencing. She doesn't know where else to go.

It is 8pm – just thirty minutes before closing time.

Responding to Scenario 1

- Provide a welcoming and non-judgmental environment
- Acknowledge and communicate how safe space can assist someone under the age of 18
- Enquire around parents and trusted person
- Use flexibility in hours (someone always rostered on past closing time) to link with an appropriate service or support
- Meet her practical needs e.g. facilitating links to transport
- Reinforce she is welcome back any time as this is her space and offer the opportunity for a follow up call
- Likelihood of this situation could be prevented with operating hours from 10am – 10pm
- Follow up with Chantelle the next day

Responding to Scenario 1

"Has she looked at headspace or other services relevant for young people? Have a look with her but also reinforce that this is her space, she is welcome to come back anytime, reassure her."

"Operating hours of 10am – 10pm would ideal. Would be great to set up the expectation that these are the hours"

"Flexibility around closing times is needed. At each shift if someone can stay and support someone longer that would be ideal."

Scenario 1 - feedback Loop 3 ‘do you have anything further to add?’

- Reinforce the benefit of having appropriate resources at hand e.g. flyer with relevant services
- Ensure mix of peer workers to meet needs of clients
- Staff have good knowledge of referral pathways
- Welcome her and enquire around coping strategies she has previously used.
- Flexibility in service hours – even if it means providing the service when it continues past normal hours
- Safe Space needs to be open later e.g. until 11pm (when people are lonely and isolated)
- Utilise and leverage natural supports (if possible)
- Caution around family dynamics, ensuring Safe Space doesn’t become contentious with support networks

Scenario 2:

A young man, David, arrives at the safe space. He is accompanied by a lady of similar age who he doesn't introduce. David appears a little agitated with the woman but seems happy to have arrived at the safe space. He accepts a cup of tea from one of the staff, and while he's chatting quietly with them, he keeps glancing towards the woman. You discover she is David's sister and is really keen to stay with him in the safe space and is clearly very concerned about her brother.

Responding to Scenario 2

- Understand David's desire (and consent) to involve his sister – with the freedom to change his mind at any point
- Ensure Safe Space can also meet carer specific needs (including appropriate resources)
- Respond to the needs of individual and carer confidentially if needed in physical spaces that allow for private conversations.
- Diversity of peer workers needed to handle a number of situations (e.g. carer/individual focused, gender/sexuality, cultural background).
- Actively work with David to engage with natural supports as a protective factor

Responding to Scenario 2

"I feel it would be really important for Safe Space to be inclusive of the sister if David wants them there. If the person wants the carer there safe space needs to include carer."

"Emphasise and encourage benefits of natural supports - important for safe space to support the natural support systems. There is balance between giving a person what they need and supporting those who may be in support roles for years to come."

Scenario 2- feedback Loop 3 ‘do you have anything further to add?’

- Many respondents agreed favourably with what was suggested.
- Allowing for others to be present is essential – few people will access the space alone so staff need to be trained in handling similar situations
- Welcoming David’s friend or family member and building their capacity
- Reiteration that the space needs to be more than just a single room. Need to consider privacy of multiple people
- Providing of carer specific support and resources need to be made available.

Scenario 3:

Leanne walks into the safe space and says hi to the peer worker who greets her. She knows the safe space well, having visited for a few weeks in a row. She says it is a place where she can relax for a while, knowing that she is safe from self harming while she is here, and it helps her get through her week. Tonight she asks if there is anything different she can do while she is at the safe space.

Responding to Scenario 3

- Ask Leanne what she'd like to do, opening an opportunity for Leanne to contribute to available activities at the Safe Space (e.g. art, journaling)
- Role of the peer worker is non-clinical and to facilitate inclusion and connection
- Guests are not only participants, but they directly contribute to the service ('our place is your place')
- Ensure that Leanne is welcomed and comfortable within the Safe Space
- Facilitate person-centred and self-directed support

Responding to Scenario 3

"Guests are not only participants, but directly contribute to the Safe Space. This speaks to the principles of mutuality and that *our place is your place*."

Scenario 3 - feedback Loop 3 ‘do you have anything further to add?’

- The majority of respondents expressed positive sentiment to what was summarized
- Reiterate a focus on self-determination and self-directed learning
- Budgeting and resourcing considerations to be made re: possible activities
- Some comments regarding too much emphasis put on the guest to come up with ideas and perhaps Safe Space should be equipped with diversional resources and equipment.
- Emphasis on reducing the ‘us and them’ divide
- Clarity needed regarding whether the space is open to everyone or people at risk of suicide

Scenario 4:

David turns up at the Safe Space for the first time. He seems quite agitated and distracted. He had heard about the Safe Space from a community services worker who supports him in a program for people with "complex and enduring mental illness". He tells the SP Peer Worker that his neighbor is trying to control his thoughts through a chip he has planted in his television. David says he can't handle the torment of this any more, and feels that killing himself is the only way to get relief from it.

Responding to Scenario 4

- Safe Space staff to meet 'David' – not David's diagnosis
- No clinical evaluation at the Safe Space – people are not assessed for their symptoms or risk in the traditional sense. Whatever support that is needed should be decided in collaboration with David
- Safe Space staff to follow processes and protocols, having options to seek further advice if needed.
- Safe Space is not an automatic route to ED.
- Safe Space staff to focus on being with David in distress and discomfort instead of delving into 'risk' and mental illness diagnosis.
- Identify partnerships with David for the type of care that he needs and wants (existing support groups, clinical support if needed/desired, other natural supports)
- David could walk in highly distressed and walk out calm – attend to suffering not the symptoms.

Responding to Scenario 4

"It is 'David' walking through the door, not his diagnosis. You talk to David, understand what he wants, needs."

"Whatever happens, anything that happens must be done with the person. If they need extra help, it is built into the model that there is clear pathway to more help."

"There is no assessment at the safe space. We must deal with the person - ask questions to gauge what the situation is. You can go up ladder if you need to, but the person walking through the door is the most important thing."

Scenario 4 Feedback Loop 3 ‘do you have anything further to add?’

- Reinforcement that the needs of David can be met by Peer Workers in the Safe Space
- Wording around ‘going up the ladder’ needs to be more reflective that Safe Space is an alternate to ED not the bottom rung of stepped care.
- Thought needs to be put toward minimising noise and keeping a peaceful environment
- Potential for David to re-engage with the services he is already linked with e.g. advocacy
- Good opportunity to link to existing peer support groups
- Be constantly curious about his resources as well as his distress
- Provide support in a time of fear

Scenario 5:

Amanda is a 20 year old woman with a history of past suicide attempts who comes to the Safe Space extremely distressed. She says that her life is not worth living, that she has tried everything to stop feeling this way. She tells the SP Peer Worker that she has been on dozens of different medications, tried therapy for childhood trauma, done everything the psychologist told her – "nothing ever works" and she has "run out of options". When the worker asks her if she has plans to kill herself, she tells them that she has bought medication off the internet and is just waiting for her mum and dad to leave her alone so she can take it. Her history of previous attempts is known to one of the Safe Space Peer Workers, who had previously supported her in ED.

Responding to Scenario 5

- Respect and acknowledge that Amanda has chose to come to the Safe Space for support (a protective factor). There is still time to “escalate” if needed.
- Peer workers are skilled in sharing their stories of their own suicidality and trauma in order to “normalize” why someone might be feeling suicidal.
- Peer workers could work collaboratively with Amanda’s family to dispose of medication at home – preventing a trip to the ED.
- Skilled peer workers are be able to build relationships of mutual trust and respect which can itself become a protective factor.
- Safe Space staff may have to work with Amanda to collaboratively identify the need to access ED. A predetermined process would work best, including agreement on pathway to ED and timely ED access for guests of the Safe Space.
- Process to also include capacity for active support from the Peer Worker to walk alongside Amanda to navigate the hospital system and accompany Amanda at all stages in the process, including staying with her in ED.
- Clarity gained around legal ramifications (if any) if someone were to take their life after accessing Safe Space.
- Debriefing offered to Peer Worker to ensure they are supported after a death.

Responding to Scenario 5

"The beauty of the safe space is that the peer workers can talk about their experiences and can be alternative to traumatic places. The safe space is HOPE for change and that in itself can provide hope."

"Safe Space peer worker should accompany Amanda to the next level of support. There needs to be a clear pathway that is quick and easy for the individual and peer worker be seen by the ED if needed."

Next iteration of values to inform the model

NSW MoH Guidance

- Person-centred
- Risk tolerant
- Non-judgmental
- Welcoming
- Responsive
- Compassionate
- Strengths focused
- Hopeful
- Holistic
- Self determination
- Empowerment
- Human connection
- Collaboration
- Integration
- Respectful
- Evidence based
- Dignity
- Inclusion
- Choice

LE co-design process

Inclusivity

- Equality
- Respect – unique individuals,
- Acceptance
- Unquestionable right to be here
- Non-judgemental

Freedom/self-determination

- Insight
- Choice
- Autonomy
- Transparency
- Integrity

Dignity

- Nurturing
- Empathy
- Compassion
- Kindness
- Welcoming

Curiosity

- Deep listening
- Flexible
- Ambiguity
- Humility

Mutuality

- Spirit of mateship
- Co-passionate support
- Connection
- Authenticity
- ‘being’with’

Next iteration of principles

1. This is our place . . . Our place is YOUR place
2. We will welcome you as you are in a spirit of mutuality, unquestionable belonging and respectful acceptance
3. We will walk together amidst the freedom of autonomy, self-reflection and choice.
4. We will offer co-passionate sharing of every person's journey
5. We value every person's lived experience and recognize each person as the expert in their own lives

Feedback Loop 3 ‘do you have anything further to add?’

- Many respondents agreed with how scenario 5 was responded to
- Work collaboratively with the Assertive Outreach team as a priority (over ACT or ED).
- Tension still remains between responses that advocate for clear ‘escalation pathways’ and capability to deescalate situations within the Safe Space itself
- Ability for peer workers to advocate for Amanda re: ongoing support

“Holding space. Unrelenting care and compassion with safe limits (e.g. closing time). Have space for danger and despair, and walk together to get the help needed to keep Amanda alive. Be there tomorrow if she returns. Be there to witness growth and change. Share stories of hope, life and joy when Amanda is ready. And the same applies to Peer Workers. Breathing space, reflection, time away from the space e.g. retreats built into the model. Give the best care and support to the Peer Workers as a model for guests”