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National Safe Spaces Network Scoping Study

Commonwealth Department of Health

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Executive summary

Over 3,000 Australians take their own lives each year, with every death by suicide representing a devastating loss to families and communities. The Australian Government has made reducing the number of Australians dying by suicide a national priority, with a new focus on community-based programs and initiatives which can better support people at risk. The need for different service types is underlined by the fact that up to 50 per cent of people who die by suicide do not contact currently available services before taking their own lives.

The Commonwealth Department of Health and Australia's National Suicide Prevention Adviser, Christine Morgan, are currently examining proposals which can enhance the supports available to people at risk of suicide. From March to September 2020, KPMG was engaged by the Department to undertake a scoping study on the proposal for a National Safe Spaces Network. The proposal has been developed by a consortium of national suicide prevention and lived experience organisations which includes Roses in the Ocean, Suicide Prevention Australia, Beyond Blue, Wesley Mission Queensland, the Australian Institute for Suicide Research and Prevention and Everymind. Representatives from several of these organisations were represented on the Expert Advisory Group which provided strategic input and expert advice for this scoping study.

The National Safe Spaces Network model seeks to address the fact that Australians experiencing suicidal distress and crisis currently have few places to turn other than hospital Emergency Departments. These facilities can be ill-suited to meeting the needs of people in distress, with long waiting times, constant bustling activity and variable treatment by clinical staff often acting to exacerbate an individual's sense of crisis. Lived experience advocates highlight the need for alternative spaces where people can seek help, be safe and access support from others who have survived their own experiences of suicidality in a calm, non-clinical environment.

The model proposes to establish a network of Safe Spaces providing support in different settings across five tiers that can meet people's changing needs over time:

- **Tier 5:** A residential safe house where people in crisis can stay for multiple days
- **Tier 4:** A safe alternative to emergency departments – such as Safe Haven Cafes
- **Tier 3:** A safe space to access psychosocial support and safety planning – such as Primary Health Network (PHN) commissioned services
- **Tier 2:** A safe space to talk to someone and access a referral – such as community centres or services that are already operational, with staff who have undertaken gatekeeper training in identifying and supporting people at risk of suicide
- **Tier 1:** A place to sit and feel safe in the company of other people – such as a library, coffee shop or hairdresser.

Importantly, all tiers of the model are intended to be led and delivered by people with lived experience and peer workers, giving people experiencing distress and crisis non-clinical service options.

In commissioning this scoping study, the Department sought to understand the feasibility of the proposed National Safe Spaces Network model for delivery in the current Australian service context. The project aimed to provide a holistic assessment of the concept of a National Safe Spaces Network, in a level of detail necessary to support informed decision-making by government.

Key findings

This scoping study indicates the National Safe Spaces Network proposal offers an innovative, evidence-based and person-centred approach to supporting people experiencing suicidal distress and crisis. If delivered as part of a broader spectrum of services capable of addressing both acute suicidal distress and its underlying drivers, the model has strong potential to strengthen supports for people at risk of suicide, working towards the goal of reducing its incidence over time.

Service need and demand

People with a lived experience of suicide and sector stakeholders strongly endorse the underlying premise of the National Safe Spaces Network proposal: that current service offerings are not well aligned with their needs and there is an urgent desire for alternatives.

Acute clinical care settings such as Emergency Departments are considered to increase distress rather than de-escalating it and are not perceived as accessible or engaging by many people at risk of suicide. There is strong demand for non-clinical alternatives which can:

- support person-centred care
- provide access to different levels of support depending on an individual's level of distress
- offer holistic supports addressing the underlying drivers of suicidal crisis
- help guests to navigate Australia's complex health service system.

These expressed needs are closely aligned with the intended philosophy and service offerings of the National Safe Spaces Network.

Analysis and mapping of the current service landscape indicates there are significant gaps in the availability of dedicated suicide prevention services, especially outside of the metropolitan areas located along Australia's east coast. Particular gaps exist in Western Australia, the Northern Territory and regional Queensland where rates of suicide and self-harm are significantly above the national average. Importantly, at the time of writing there are no existing suicide prevention services which currently provide equivalent offerings to the proposed Tier 5 residential Safe Spaces anywhere in Australia. Similarly, there are only a handful of existing or planned services which offer equivalent supports to Tier 4 emergency department alternatives for people in crisis.

State governments in New South Wales, Queensland and Western Australia are currently in the process of developing and rolling out a number of emergency department alternative services which have much in common with the proposed Tier 4 Safe Spaces. One Tier 5-equivalent service is also under development through the Suicide Prevention and Recovery Centre (SPARC) in Sydney, which has been established with seed funding from the Commonwealth. This focussed investment provides an opportunity to test the proposed model and collaborate with other levels of government and service providers in the delivery of a National Safe Spaces Network. These initiatives are also likely to generate a range of useful learnings on how practical delivery of this service model aligns with its core principles and intent.

However, in 2018-19 across Australia 79,455 people presented to Emergency Departments because of suicidal distress or attempting. The limited current scale of these state-based services and location only in selected communities is not expected to meet this level of demand. This means significant and wide-spread service gaps will remain. In the event the Commonwealth opted to pursue investment in the network, there would be benefit in this having a strong regional and remote service footprint, with Western Australia, the Northern Territory and regional Queensland being a priority for delivery of new services.

Proposed service model

Early and emerging evidence from comparable services operating internationally and within Australia points to the effectiveness of the proposed non-clinical, peer led approach in meeting the expressed needs of people experiencing suicidal crisis and supporting them to manage and reduce distress. There is also emerging evidence supporting underlying aspects of the Safe Spaces model in the context of suicide prevention, particularly brief contact interventions and peer-led supports. The scoping study did not identify any evidence indicating the proposed Safe Spaces model would increase risks to guests compared with other existing interventions or depart from currently established effective suicide prevention practices.

Some comparable services have explicitly targeted a reduction in Emergency Department presentations and demand for other clinical services by people at risk of suicide as a key intended outcome. Evidence on the impact of these services on broader system demand is currently inconclusive, with data and attribution challenges confounding clear findings. Some stakeholders, including members of the scoping study's Expert Advisory Group, also challenged the appropriateness of this metric in assessing the effectiveness of these services. Throughout this scoping study it was frequently emphasised that if the goal is reducing deaths by suicide, giving people at risk more service options and supporting them to access the right care pathways should be the focus. These are issues which would benefit from further consultation and co-design involving people with lived experience, to identify preferred target outcomes and appropriate metrics for monitoring effectiveness within a future National Safe Spaces Network.

There is broad support for Safe Spaces to be delivered as primarily non-clinical services, but stakeholders also identified possible roles for clinicians in assessing and providing referrals for guests who want clinical help, and potentially supporting lived experience peer workers through mentoring and professional development. The level of integration proposed tended to vary according to the stakeholder perspectives represented, with lived experience stakeholders generally favouring a model of clinical reach-back or support only when requested by frontline peer workers. Other stakeholders highlighted benefits in a mixed service delivery model involving both peer workers and mental health clinicians working collaboratively onsite to meet people's individual needs as they present. The relevance of clinical supports was also considered to vary by tier, with these being considered more necessary and important for the Tier 5 residential Safe Spaces and Tier 4 crisis services than the lower service tiers. The network's focus on tailored local service delivery means this is not necessarily a debate that needs to be resolved at a national, whole-of-network level. Rather, the network could be established with an overarching intent and philosophy of non-clinical support, with local communities then able to determine through co-design how much involvement – if any – they want from clinicians.

Stakeholders voiced concerns about the complexity of the proposed five-tiered approach and people's ability to effectively navigate to the right supports within this. The proposed settings for Tier 1 and 2 services are also considered to present a range of challenges in relation to their safety, accessibility and appropriateness for supporting people at risk of suicide. There would be value in undertaking further co-design with people with lived experience to explore whether and how consolidating the network into fewer tiers of physical locations augmented by online, phone and group-based peer supports may better achieve the intent of the model. For example:

- combining the services intended to be offered across Tiers 1 to 3 could deliver a single service with a particular focus on early intervention, service connection and support to avoid escalation into crisis.
- the currently proposed Tier 4 and 5 services would maintain their focus on supporting people experiencing acute crisis or following a suicide attempt, with an improved ability to maintain support as people's wellbeing improves through the lower tier service.

- peer support groups, support lines and online services could also then play a role in delivering the supports originally intended to be provided at Tiers 1 and 2. These services are not currently included in the model but could add significant value as part of a broader networked offering – particularly for people living in rural and regional areas.

The original five-tiered proposal was developed in close consultation with people with lived experience, so a proposed change of this kind would also need to be subject to further consultation and co-design.

Ensuring safe and high-quality support

Training and support for lived experience peer workers will be critical to the safe and successful delivery of the proposed peer-led model. While Australia's peer workforce is growing, there will be a need for further workforce development to support implementation of the proposed National Safe Spaces Network. Stakeholders frequently noted that having a lived experience of suicide provides valuable insights and perspectives, but supporting people in crisis also demands a broader skill set. Peer workers need to be specifically trained in empathetic listening and safe dialogue about suicide, trauma-informed practice, de-escalation techniques and other evidence-based suicide prevention practices. They also need ongoing professional support in the workplace to reduce the risk of vicarious trauma and re-escalation of their own distress or crisis.

The NSW Government's recent development of minimum training and support requirements for suicide prevention peer workers offers a well-considered initial model to follow. The NSW Ministry of Health has specified essential training requirements for both suicide prevention peer workers and managers supervising them, as well as essential components of professional support that must be provided. Discussions with key stakeholders indicate strong endorsement for this approach to suicide prevention peer workforce development and support. There is also an opportunity for the Commonwealth to lead broader workforce development through its ongoing work to develop the next National Mental Health Workforce Strategy and Peer Workforce Development Guidelines. Adopting the NSW approach across the proposed national network could support short-term workforce development while work on these broader strategic initiatives continues.

Existing national accreditation standards such as the National Standards for Mental Health and the Health and Community Standards are not likely to fully suit the requirements of the National Safe Spaces Network. In particular, achieving accreditation under these frameworks would likely be challenging for the proposed lower tier services because of the time and resources required to undertake this. However, Suicide Prevention Australia has recently released a set of Standards for Quality Improvement which provide a promising sector-specific accreditation approach. The development of these standards reflects the growing status of suicide prevention as a distinct service stream from other mental health and community services. The standards recognise that the features of quality care in a suicide prevention context may look different from those in clinical and other community-based environments – particularly in relation to aspects like the role of peer supports. They also provide for multiple levels of assurance depending on the nature of the organisation delivering services. This could support accreditation for lower tier services within the proposed network without imposing an unreasonable administrative burden. These new standards have been designed by Australia's suicide prevention peak body with the specific needs and service delivery requirements of suicide prevention in mind. In that context, they appear to provide a strong, practical option for accrediting services within a National Safe Spaces Network.

Roles for the Commonwealth and other partners

This scoping study has identified a number of potential roles the Commonwealth may opt to play in a future National Safe Spaces Network. These could include:

- leading the development and delivery of the network

- partnering with states and territories to do so
- setting national architecture and policy frameworks within which other partners and providers can deliver it
- funding discrete elements of the network through existing service channels such as Australia's Primary Health Networks without taking a role in broader network governance.

The optimum approach would need to be considered in the context of the Commonwealth's appetite and capacity for investment, the degree of interest from other required partners and the relative complexity of models integrating inputs by more or less actors. However, in relation to achieving a nationally consistent approach to the design and delivery of a network of Safe Spaces, stakeholders noted this may be a role that *only* the Commonwealth is able to effectively play. In a context where state governments and other partners are currently rolling out new services aligned with aspects of the Safe Spaces model at specific tiers, the window of opportunity to develop a nationally consistent approach is also likely to be relatively limited.

Governance and accreditation frameworks will provide the backbone for any future national network. In the absence of a national agency or organisation taking a coordinating role in this area, stakeholders consider delivery of a national network of services to a consistent standard to be unlikely. There is likely to be a need for both national, whole-of-network governance structures and service-level structures to support safe and high-quality service provision within the proposed network. Services such as headspace, Lifeline and the Royal Flying Doctor Service provide potential exemplar models to address these multi-level governance requirements, depending on decisions about the Commonwealth's preferred role. Regardless of the Commonwealth's level of involvement, stakeholders have a strong and unified view that people with lived experience should play a central role in the governance of the proposed national network at all levels – from whole-of-network oversight and coordination to leadership of local services.

While the National Safe Spaces Network model proposes multiple tiers of service, it is not intended that all tiers be delivered by a single agency or within a single community. Input from local communities is expected to drive prioritisation of specific tiers for delivery depending on local need. Implementation by a mix of funding and delivery partners may then be appropriate depending on the chosen tiers. Implementation of services at each agreed tier would need to be closely coordinated with state and territory governments and other service delivery stakeholders to ensure any future pilot or roll-out of the National Safe Spaces Network addresses priority service gaps and improves system navigation by users – rather than adding further complexity. If agreement to, and endorsement of, this model cannot be secured with jurisdictions, there is a risk that Safe Spaces would fail to meet the core expectations of stakeholders and intent of the model. This is because Safe Spaces would be unlikely to be able to establish close connections with other services and supports within the existing service landscape without cooperation from the states and territories.

Feasibility assessment

Based on the findings of this scoping study, KPMG assesses that the National Safe Spaces Network proposal outlines a service which is closely aligned with expressed and observed community need.

Its design reflects currently understood best practice in suicide prevention and there is early evidence to indicate the effectiveness of the proposed approach in improving the wellbeing of some people experiencing suicidal distress and crisis. Options and mitigations are available to address many of the challenges and risks highlighted by this scoping study, with co-design in partnership with people with lived experience providing an avenue to explore the next necessary layer of detailed service design.

Some aspects of the proposed model would require further detailed co-design with people with lived experience to develop these to a level of specificity that can facilitate full service costing and potential future implementation of a national network. These elements include:

- The intended target outcomes and priorities for measurement
- The appropriate number of service tiers and complementary roles for online, telephone and peer group supports
- The specific supports best provided at each tier of service to meet the needs of intended guests.

Because these elements relate to the design of services at individual tiers, this further co-design and model development could feasibly be undertaken in the context of a trial or pilot of Safe Spaces – with clear public communication about the approach.

Achieving a national network of the scale required to provide genuine alternative support pathways for people at risk of suicide would require gradual but focused effort and funding over an extended time horizon. This report provides a suggested implementation plan for further developing the proposed model to the point of a pilot service roll-out over 18 months. Ongoing development and delivery of the model would then need to be informed by decisions taken during this design period.

Contents

1. Project context

Suicide prevention is a national priority[1] Over 3,000 Australians take their own lives each year, with every death by suicide representing a devastating loss to families and communities. The Australian Government is now working towards Zero Suicides, a goal shared by state and territory governments and many individual communities across the country.

Targeting Zero Suicides recognises that no death by suicide should be treated as inevitable or unavoidable. It is an ambitious, long-term goal requiring coordinated action by many different partners. This will include expanding and strengthening existing services and scaling up promising new approaches which demonstrate effectiveness. There is also an important opportunity to involve the Australian community in new ways to better support loved ones, neighbours or colleagues who are at risk of suicide.

In 2019 the Australian Government appointed the nation's first National Suicide Prevention Adviser, Christine Morgan. The National Suicide Prevention Adviser is coordinating the development of person-centred and community-led solutions which can support people at risk of suicide, their families and friends along the continuum of suicidal behaviour. In close collaboration with lived experience representatives, service providers, experts and local communities, this work is driving an important shift towards whole-of-community responses that draw on the protective powers of community to support people in distress and help keep them alive.

In early 2020, KPMG was engaged by the Commonwealth Department of Health to undertake a scoping study on a proposal for a National Safe Spaces Network. The Safe Spaces model has been developed by people with lived experience of suicide, recognising that Australians experiencing suicidal crisis currently have few places to turn other than hospital Emergency Departments. These facilities can be ill-suited to meeting the needs of people in distress, with long waiting times, constant bustling activity and variable treatment by clinical staff often acting to exacerbate an individual's sense of crisis. Lived experience advocates highlight the need for alternative spaces where people experiencing distress can seek help, be safe and access support from others who have survived their own experiences of suicidality.

KPMG has been engaged to examine this model in detail, with a focus on the proposed delivery of a national network of Safe Spaces across Australia which would draw together existing government and community initiatives with potential new services. The work undertaken by KPMG in this scoping study will help inform deliberations by the Department, the National Suicide Prevention Adviser and the Australian Government on the role that a National Safe Spaces Network could play in reducing deaths by suicide.

1.1. The National Safe Spaces Network proposal – context

In November 2018 the Commonwealth Minister for Health, Greg Hunt, hosted a roundtable with lived experience representatives to explore alternatives to clinical care for people at risk of suicide. The roundtable was chaired by National Mental Health Commissioner Lucy Brogden, and drew together a range of national suicide prevention and lived experience organisations including Roses in the Ocean, Suicide Prevention Australia, Beyond Blue, Wesley Mission Queensland, the Australian Institute for Suicide Research and Prevention and Everymind, as well as representatives of Australia's state and territory governments and mental health commissions. The concept of a national network of Safe Spaces offering escalating levels of support for people experiencing distress and crisis through services spanning multiple tiers was discussed and developed through this roundtable.

The model was presented at both the national Suicide Prevention Summit and the meeting of the 5th National Mental Health and Suicide Prevention Plan Implementation Committee in December 2018. In both forums there was strong in-principle support for the Safe Spaces model as a more therapeutic approach to meeting the needs of people experiencing distress and crisis. The participating stakeholders expressed willingness to explore a national, networked approach to make Safe Spaces available within communities across Australia.

A consortium of lived experience and suicide prevention partners then developed the National Safe Spaces Network proposal for detailed consideration by the Commonwealth (see following section for details). While this proposal has been under consideration, a number of Australian state governments have announced plans to deliver services aligned with the Safe Spaces approach within their own jurisdictions.

In New South Wales, the State Government is currently in the process of rolling out 20 Safe Haven Cafes to provide an alternative to emergency departments for people in severe suicidal distress. The Queensland Government has also announced its intention to deliver eight Safe Haven Cafes across regional communities in that state, while the West Australian Government is preparing to open two Safe Haven Cafes in Perth and Kununurra before the end of 2020. These services are primarily modelled on existing services operating in the UK since 2014, and the St Vincent's Hospital Safe Haven Cafe in Melbourne which has been operating since 2018. These services share a common focus on offering people in crisis a safe place to turn where they can be supported by peer and lived experience workers to work through their distress. In this way, the work of these state governments is closely aligned with the intent of the Safe Spaces model. It also builds on diverse activities already delivered through local suicide prevention initiatives and collaborations in communities across Australia.

With the service landscape for suicide prevention evolving rapidly, it is particularly timely to explore the potential role of a National Safe Spaces Network in linking up and effectively connecting different services delivered by a variety of partners. In undertaking this scoping study, KPMG has explored both the specific model developed through the 2018 roundtable, and the broader implementation of Safe Spaces-type services across Australia. This approach has allowed for examination of the potential roles for different levels of government and partners in the delivery of Safe Spaces, along with considerations relevant to the delivery of a *national network* integrating many individual Safe Spaces at different stages of development.

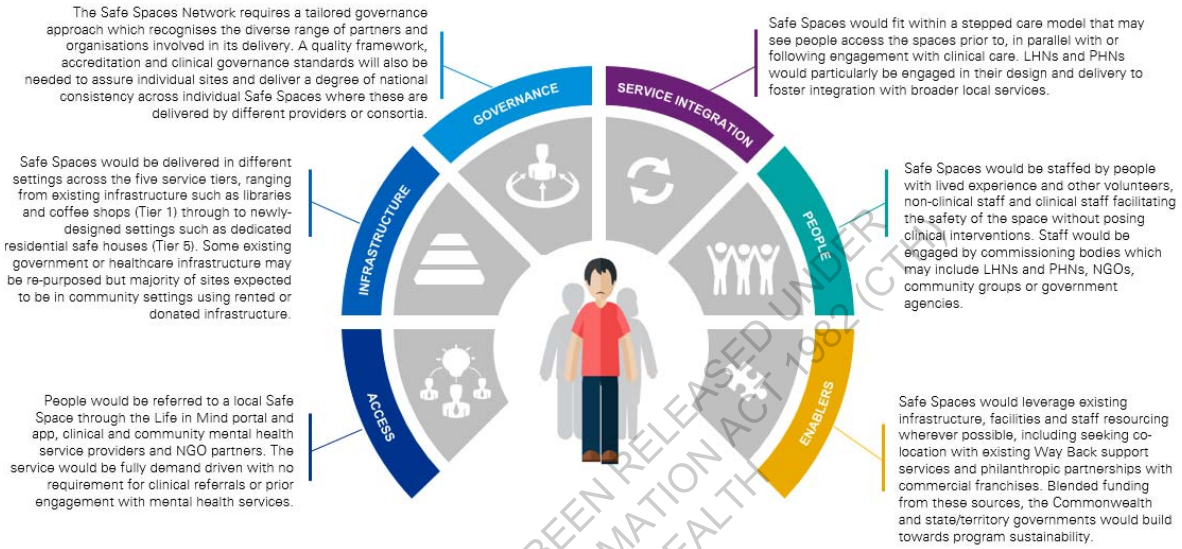
1.2. The National Safe Spaces Network – proposed model

The proposal for a National Safe Spaces Network[1] has been developed by a consortium of lived experience and suicide prevention groups. The consortium is made up of Roses in the Ocean, Wesley Mission Queensland, Beyond Blue, Australian Red Cross, Everymind and the Australian Institute for

[1] The detailed proposal document is included as Appendix A.

Suicide Research and Prevention. Suicide Prevention Australia also contributed to the development of the model as the national peak body for the suicide prevention sector. The voices and perspectives of people with lived experience have been central to the development of this proposal and the model it describes.

Figure 1: Safe Spaces proposed service model



Source: KPMG (2020) based on the National Safe Spaces Network proposal

Safe Spaces are conceived as places where people experiencing distress and crisis can seek support from peers with lived experience in a non-clinical environment. There is no single model for what constitutes a Safe Space; the ability for communities to develop spaces tailored to meet their local circumstances and needs is an important feature of the approach. What all Safe Spaces have in common is an ethos of warm, non-judgemental and person-centred support that responds to the individual needs of each person who seeks help. For some guests of Safe Spaces, this may mean having the opportunity to talk about what they are experiencing with others who have walked the same path. For others, it may simply mean being able to sit in a safe and soothing environment until their feeling of crisis passes. Safe Spaces are also envisaged as hubs for connecting people experiencing distress and crisis with services and supports that can help address their ongoing needs. This may include connecting guests with a range of supports from mental health or alcohol and other drug services, through to help with housing, finances, relationships and employment.

The Safe Spaces approach has informed the delivery of innovative services in a number of countries including the USA and UK – see *Section 4.3* for a discussion of international exemplar models. It also underpins several pilot or existing services delivered in Australia, such as the St Vincent's Hospital Safe Haven Café in Melbourne and the equivalent services under development by the New South Wales, Queensland and West Australian Governments; the Brisbane North Safe Spaces pilot; and the Suicide Prevention and Recovery Centre (SPARC) currently under development in Sydney.

The National Safe Spaces Network proposal has been developed to leverage this approach and make these services more available across Australia through the delivery of a coordinated national network of Safe Spaces. The proposal extends the concept of Safe Spaces by identifying five distinct tiers of service which could be drawn together into an integrated network. This approach recognises that experiences of distress and crisis are not static or 'one size fits all'. Different individuals can experience suicidality very differently, while a person's levels of distress can also fluctuate depending on a complex

interplay of factors in their lives. By delivering a range of supports of varying intensity within a single service framework, the National Safe Spaces Network is proposed to make it easier for guests to access the right kind of help and move between supports as their needs change.

The tiers of support recommended by the National Safe Spaces Network proposal are:

- **Tier 5:** A residential safe house where people in crisis can stay for multiple days
- **Tier 4:** A safe alternative to emergency departments – such as Safe Haven Cafes
- **Tier 3:** A safe space to access psychosocial support and safety planning – such as Primary Health Network (PHN) commissioned services
- **Tier 2:** A safe space to talk to someone and access a referral – such as community centres or services that are already operational, with staff who have undertaken gatekeeper training in identifying and supporting people at risk of suicide
- **Tier 1:** A place to sit and feel safe in the company of other people – such as a library, coffee shop or hairdresser.

Importantly, all tiers of the model are intended to be led and delivered by people with lived experience and peer workers, giving people experiencing distress and crisis non-clinical service options. As is discussed in *Section 4.1*, clinical supports delivered through hospitals and Australia's mental health sector currently represent the primary service channel for people experiencing distress and crisis. People with lived experience of suicide have articulated a strong desire for non-clinical alternatives, on the basis that a medical model of care often does not meet the holistic needs of people in crisis.

The different tiers of service within this model are not necessarily intended to be delivered by a single service provider in each location. Rather, it is envisaged that different partners – potentially including governments, PHNs, non-government organisations and other community-level groups – would develop their own Safe Spaces aligned to one or more of the service tiers. Multiple providers may then coordinate this activity to deliver the full spectrum of tiers within a particular community, city or region. Local communities may also determine they have a greater need for services aligned to some tiers than others, leading to a greater focus on investment in services at those tiers.

All of this activity is proposed to be coordinated and connected under the umbrella of the National Safe Spaces Network. The network would provide both a single recognisable 'brand' and quality assurance through service oversight. This national promotion and standard-setting function is considered important because a lack of community awareness of support options and how to seek help is an acknowledged barrier to people accessing the support they need when they are experiencing distress and crisis.

The National Safe Spaces Network proposal has been developed in a context of ongoing dialogue with the Australian Government about innovative approaches to supporting people at risk of suicide. For this reason, there are a range of aspects to the model which have not yet been defined or which require further detailed analysis. There is also a significant amount of work currently taking place across Australia at the state and territory level on the delivery of Safe Spaces-type services. Much of this work had not been announced or commenced when the proposal was initially developed. The Department has commissioned this scoping study as an opportunity to further develop the proposed model and test this with a broad range of stakeholders, taking into account emerging activity and the growing community appetite to try new things to reduce the number of Australians dying by suicide.

2. Project objectives and scope

In commissioning this scoping study, the Department sought to understand the feasibility of the proposed National Safe Spaces Network model for delivery in the current Australian service context. This required examination of a wide range of issues including: the service need and evidence base underlying the proposal, the service model, implementation and delivery considerations, options for governance and oversight, risks and mitigations, and levels of support for the approach among key stakeholders. Recognising that some aspects to the proposal required further development, the Department also sought analysis and advice on how the National Safe Spaces Network model could be expanded upon to facilitate detailed consideration by government.

This scoping study therefore goes beyond a direct analysis of the National Safe Spaces Network proposal as it was presented to government. Where KPMG's analysis identified a need for further information or model definition, the scoping study has sought to address this by looking to available evidence, data and expert input. Similarly, where the intent of the model or intended operation of its component parts needed clarification, KPMG has explored these issues in consultation with the scoping study's Expert Advisory Group and stakeholders to identify potential refinements. In this way, the project has aimed to provide a holistic assessment of the concept of a National Safe Spaces Network, in a level of detail necessary to support informed decision-making by government.

The Expert Advisory Group for the National Safe Spaces Network Scoping Study was made up of lived experience advocates, suicide prevention and mental health subject matter experts. Importantly, it also included representatives of the organisations responsible for Australia's two previous Safe Spaces pilots: St Vincent's Hospital Melbourne and Wesley Mission Queensland. The group was chaired by the Department with membership comprising:

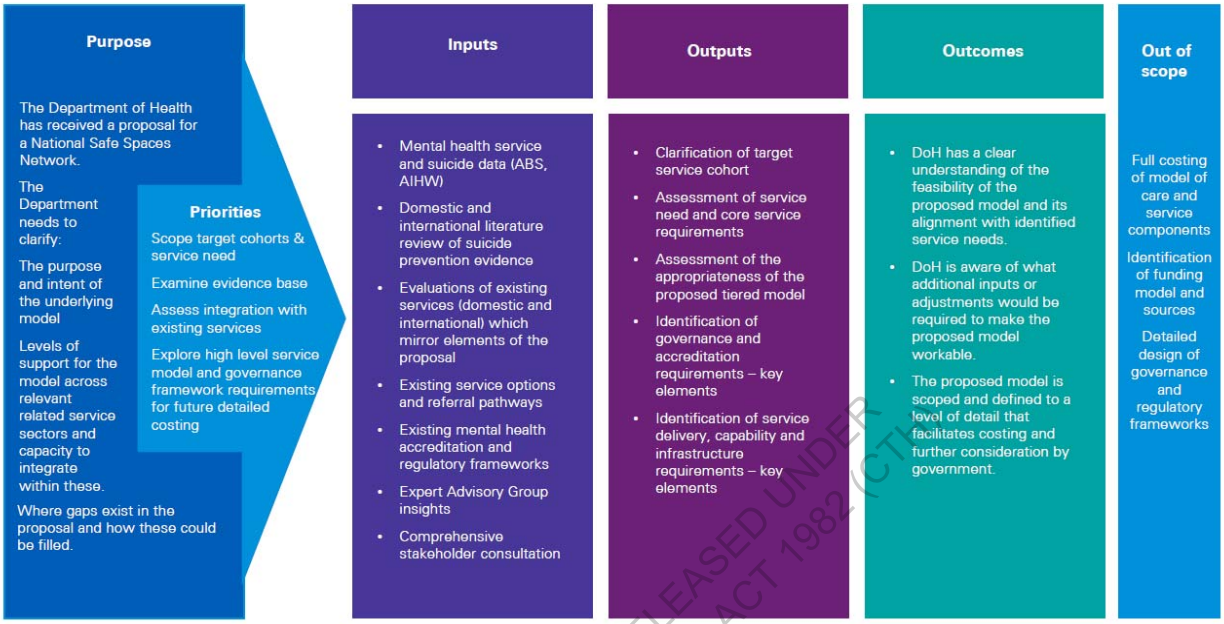
- Bronwen Edwards, Roses in the Ocean
- Georgie Harman, Beyond Blue
- Fran Timmins, St Vincent's Hospital Melbourne
- Kris Sargent, Wesley Mission Queensland
- Paul Martin, Brisbane North PHN
- Vicki McKenna, Kimberly Aboriginal Medical Service
- Jacinta Hawgood, Australian Institute for Suicide Research and Prevention
- Carrie Lumby Miller, Lived experience advocate.

KPMG acknowledges the significant contribution all members of the Expert Advisory Group made to the scoping study, and thanks them for the time, effort and thoughtful inputs provided over the life of this project.

2.1. Scope

To support delivery of the National Safe Spaces Network Scoping Study, KPMG developed a program logic model in consultation with the Department. As detailed in Figure 2, this mapped out the purpose and key lines of inquiry for the scoping study, along with the priority outcomes for this project.

Figure 2: Scoping study program logic



Source: KPMG (2020)

There are several important aspects of the National Safe Spaces Network proposal that would warrant close attention as part of further consideration of the model by government, but were beyond the scope of this specific project. First and foremost, KPMG undertook consultation with a wide range of key stakeholders spanning lived experience, suicide prevention, service delivery, government and community sector perspectives. However, detailed co-design of the National Safe Spaces Network model involving people with lived experience of suicide was beyond the scope of this project. It is anticipated that detailed co-design with lived experience representatives would be a priority for future stages of work if the Australian Government opted to pursue investment in this model. At various points this report proposes further engagement with people with lived experience of suicide based on feedback from the scoping study's consultation phase.

Second, this scoping study has not undertaken detailed costing of the National Safe Spaces Network model. KPMG has identified the major cost components of the model across each service tier and provided information on the indicative costs associated with these. Detailed costing of the model would depend on policy decisions about the number, location, staff and service mix of Safe Spaces within a national network, as well as the extent to which the network leveraged existing services versus seeking to establish new ones.

Finally, governance and accreditation are critical considerations for achieving national consistency of service delivery and quality of care across a National Safe Spaces Network delivered in diverse locations and through a potentially broad range of partners. This scoping study has examined the key considerations for governance and accreditation in the context of the proposed network and explored models that may be suitable for adaptation to its requirements. The development of detailed frameworks for governance and accreditation would represent a further stage of work requiring focused consultation with peak and professional bodies, people with lived experience and health regulatory agencies.

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4. Findings

This section presents the findings of KPMG's analysis across each of the domains within the Risk Assessment Framework. The findings presented here have been informed by a review of available documentary and data evidence, stakeholder consultation and inputs from the scoping study's Expert Advisory Group.

The proposal for a National Safe Spaces Network is complex, with this scoping study needing to explore a large number of varied lines of inquiry. In presenting the findings from this work, KPMG has focused on providing the information and insights which are considered most relevant to the Department's information needs when undertaking further consideration of the proposed model.

For this reason, the report does not explore in depth the causes and origins of suicidal behaviour, or the wide range of diverse perspectives on how this can most effectively be addressed. The report focuses on evidence and perspectives specifically related to the concept of a National Safe Spaces Network as one potential response to suicide. We acknowledge this would need to be one response among many delivered across the Australian community to effectively reduce the number of people dying by suicide.

4.1. Service need

The need for a National Safe Spaces Network can be examined through two lenses. The first relates to the demand for support and how this is distributed across the Australian population. The second relates to the current supply of services and whether the National Safe Spaces Network would be filling gaps or duplicating existing supports. This section explores the demand for support by examining the incidence of suicide across Australia, priority at-risk cohorts and the expressed needs of people with lived experience of suicidal crisis. We have also engaged with stakeholders to explore the service needs of people experiencing distress and crisis, and how the proposed model may address these. *Section 4.2: Current service landscape* then focuses on mapping existing services and supports for people at risk of suicide, to identify the availability and accessibility of these services along with service gaps and challenges highlighted by stakeholders.

Summary of findings – service need

- Around 3,000 Australians die by suicide each year, with an estimated 60,000 more people attempting it. Australia's suicide rate has not declined over the past 10 years despite focused efforts to improve support for people at risk.
- There are a number of cohorts who have a significantly higher risk of suicide, including people living in rural and regional communities, men, Aboriginal and Torres Strait Islander Australians, people from culturally and linguistically diverse communities and LGBTQI+ Australians. These cohorts may warrant focus as priority service cohorts for a National Safe Spaces Network.
- People with lived experience of suicide report that current service offerings are not well aligned with their needs. In particular, acute clinical care settings can increase distress rather than de-escalating this, and are not considered accessible or engaging by a large number of people at risk of suicide.
- People with lived experience and stakeholders across the service sector highlight a strong need for non-clinical service alternatives which support person-centred care, access to different levels of support depending on an individual's level of distress, holistic supports addressing the underlying drivers of suicidal crisis and support to navigate a complex service system.

The National Safe Spaces Network model is envisaged as an approach that can offer anyone who reaches out for help warm and non-judgemental support. The model intentionally avoids defining a 'target service cohort' in the way that many mental health and other human services do. In discussions with the Expert Advisory Group, this was put forward as a core strength of the approach because it works to avoid people 'falling through the cracks' on the basis of disconnected service criteria. KPMG acknowledges this intent and the value of having community supports which are genuinely accessible to anyone who may be experiencing distress and crisis.

In Australia, like other countries, suicide risk is not evenly distributed across the community. Examining current data and trends on the prevalence of suicide can provide an insight into which cohorts may have a particular need for support through a National Safe Spaces Network. In the event that the Australian Government opted to pursue investment in the proposed network, the question of whether to make some or all of these cohorts an explicit target for the network's services would be one for policymakers to consider.

Who is at risk of suicide?

Data on the prevalence of suicide and attempted self-harm in Australia must be approached with some caution. There are a number of factors which make it challenging to generate an accurate statistical picture of how many people die by suicide, and who they are.

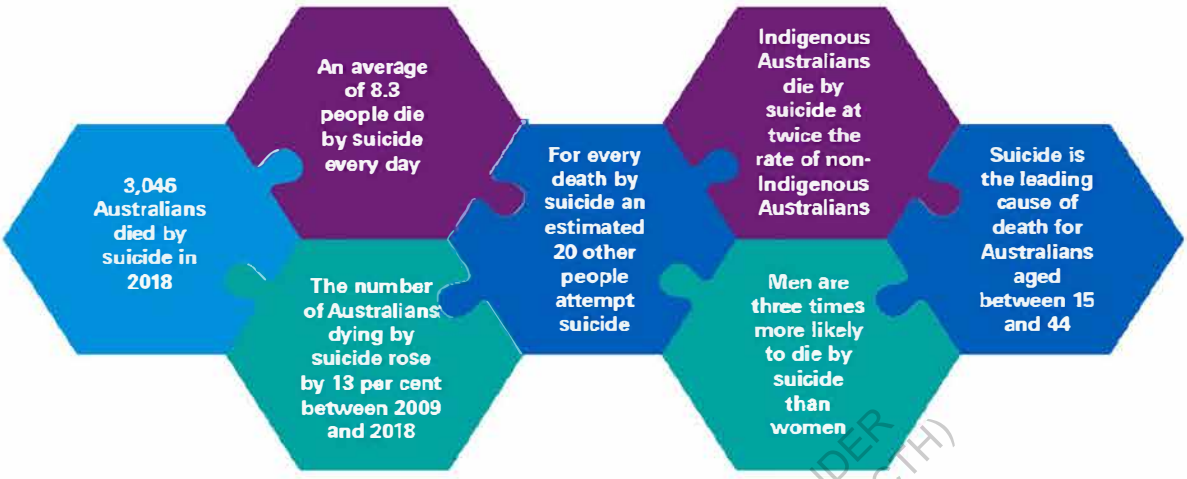
The primary public data set on suicide comes from the Australian Bureau of Statistics' annual *Causes of Death* collection, which provides a consistent annual record of suicide deaths back to 1993. However, in Australia a varying range of state and territory authorities are involved in the investigation, certification and collection of data about deaths. This can include police, forensic medical staff, coroners and state and territory registry offices – all of whom are collecting data in different ways and for different legal purposes. As De Leo et al have noted, this leads to significant variance in whether the cause of death is reported as suicide, with official suicide data potentially underreporting the actual incidence by up to 16 per cent[2]

Further, Australia's National Suicide Prevention Adviser Christine Morgan has highlighted that there is very significant social stigma associated with suicide. People who have attempted to take their own lives often face a combination of personal shame, societal stigma and structural stigma in the form of discrimination[3] This stigma can be particularly strong in Aboriginal and Torres Strait Islander, culturally and linguistically diverse and religious communities[4] It can also be a challenge in close-knit rural and regional communities[5] This stigma can further obscure accurate reporting of deaths by suicide and suicide attempts because families and individuals may not wish to have this recorded.

Community awareness and understanding about suicide is progressively evolving, as part of a larger shift in how mental ill-health and psychological wellbeing are perceived. While this is helping to make deaths by suicide and suicide attempting more visible, it also raises further challenges in comparing current suicide data with that collected in the past to gain an understanding of population-level trends. There is an ongoing debate about the extent to which apparent increases in the suicide rate over the past 10 years reflect a genuine rise in suicide deaths compared with increased reporting of such deaths.

With these caveats in mind, Figure 4 provides key statistics on the current prevalence of suicide in Australia using the latest available data.

Figure 4: Key statistics on suicide prevalence



Source: Australian Bureau of Statistics, Causes of Death, Australia (2019)

Australia's current suicide incidence of 12.1 deaths per 100,000 people places us near the middle of the pack for OECD countries, alongside nations such as Canada and Austria[6] The Australian Government's target of working towards Zero Suicides aims to progressively lower this rate over time[7] While around 3,000 people die by suicide each year, the potential pool of people who are at risk is far greater. Extrapolating from the World Health Organisation's estimate that for every death by suicide 20 other people will attempt it, this would mean approximately 60,920 Australians a year are at serious risk. This figure does not include people who may experience suicidal thoughts or be on a trajectory towards suicide without making a direct attempt. It is important to consider this broader cohort when designing suicide prevention services because they may benefit most from early intervention to prevent escalation to extreme distress and attempting suicide.

People living in non-metropolitan areas die by suicide at a much higher rate than Australians living in capital cities, as Table 3 below highlights.

Table 3: Metropolitan and non-metropolitan suicide rates

Region of usual residence	Standardised death rate per 100,000 people (2018)
Greater Sydney	9.2
Rest of NSW	15.1
Greater Melbourne	8.1
Rest of Vic	12.6
Greater Brisbane	13.8
Rest of QLD	17.6
Greater Adelaide	11.5
Rest of SA	13.4
Greater Perth	13.0

Region of usual residence	Standardised death rate per 100,000 people (2018)
Rest of WA	20.1
Greater Hobart	12.2
Rest of Tas	16.4
Greater Darwin	14.2
Rest of NT	27.1
Australian Capital Territory	11.0
Greater capital cities total	**10.3**
Rest of states total	**15.9**
Australia	**12.1**

Source: Australian Bureau of Statistics (2019)

This also highlights the significant disparities in suicide rates across Australia's states and territories. This reflects differences in the availability and accessibility of services across different communities, as well as differences in the share of population comprised of higher risk groups.

In addition to these regional variations, it is well understood that some cohorts within the Australian community have a significantly higher risk of suicide and attempted self-harm than others. The following sections briefly summarise available data and evidence on these cohorts and the potential drivers of their higher risks.

Men

Men are much more likely to die by suicide than women, with a rate of 18.7 deaths per 100,000 people compared with 5.8 deaths per 100,000 people[8] This relationship is consistent across all age groups, although there is variation in the extent of this gender gap over the life cycle.

Suicide risk begins rising from men aged 15 to 24, with the prevalence peaking at 27.5 deaths per 100,000 men aged 45 to 54 before beginning to decline again. However, there is also a significant jump in suicides by men aged 85 and over, with the incidence being 32.9 deaths per 100,000 men in 2018[9] The reasons for men's higher suicide risk are complex and are an area of ongoing research inquiry. Significant factors are believed to include a reduced willingness to reach out for help compared with women due to social gender norms, expectations and stigma, and the selection of more lethal means when attempting suicide[10]

It should be noted, however, that in the past decade suicide rates for young women aged between 10 and 24 appear to have been rising while rates for young men the same age have been relatively static[11] This is believed to be linked to the increased selection of more lethal means of suicide by young women, with deaths by hanging particularly increasing for both men and women. This emerging trend is under examination by experts and researchers, but represents a potential shift in the established gender dynamics of suicide which should be considered in future service planning.

Aboriginal and Torres Strait Islander Australians

Indigenous Australians are significantly overrepresented in suicide deaths. In 2018 suicide was the fifth leading cause of death for this community; at 24.1 per 100,000 people the suicide rate for Indigenous Australians is twice as high as for non-Indigenous Australians[12] It is likely that even these estimates represent an underreporting of Indigenous deaths by suicide, given both cultural stigma associated with suicide and data reporting challenges in regional and remote communities[13] Troublingly, the gap between Indigenous and non-Indigenous Australians in suicide prevalence is highest among younger age groups. Indigenous people aged 1 to 14 are eight times more likely to die by suicide than non-Indigenous people of the same age, five times more likely in the 15 to 24 age bracket and nearly four times as likely between the ages of 25 and 34[14]

There is a significant body of research dedicated to understanding the complex causes of suicide among Indigenous Australians. While it is important to acknowledge the great diversity of Indigenous communities across the country, common factors which are believed to contribute to the increased prevalence of suicide within these communities include:

- Intergenerational trauma linked to both the history of dispossession and dislocation of Indigenous communities and the forced removal of children from their families
- Ongoing experiences of racism and discrimination
- Lack of access to culturally safe and appropriate services, including mental health services
- Grief from the premature deaths of family, community members and friends
- Socioeconomic disadvantage and the stressors associated with homelessness, limited employment prospects, poverty and a lack of access to broader social services[15]

Some of these are complex structural factors requiring actions far beyond the health and human services system to properly address. But others are crucial considerations when exploring who may need to use the supports intended to be provided through a National Safe Spaces Network, and how well these may align with their needs.

Culturally and linguistically diverse communities

Australians from culturally and linguistically diverse backgrounds are believed to be another cohort at higher risk of suicide. When considering this group, it is important to note that national data sources such as the Australian Bureau of Statistics' *Causes of Death* data set do not include data on the ethnicity or cultural background of people who die by suicide. Combined with cultural and religious stigma associated with suicide in some communities, this makes it difficult to determine the current prevalence of suicide among Australians in this cohort.

However, there are a number of reasons why culturally and linguistically diverse Australians are believed to be at higher risk. This includes separation from family and support networks who may be living in another country; stressors associated with migration including changes in earnings and social status; experiences of discrimination and social exclusion; and a lack of access to services and supports because of language or cultural barriers[16] Further, migrants coming to Australia from countries affected by conflict or through difficult refugee pathways may have experienced significant trauma which can be compounded by these other stressors.

Anecdotal and location-specific data collection supports the priority needs of culturally and linguistically diverse communities. For example, in recent years there has been a focus on the mental health needs of South Sudanese refugee communities in Melbourne's Dandenong region, following a significant rise in suicides among young people in this community[17] As with Indigenous Australians, understanding the complex risk factors and specific service needs of culturally and linguistically diverse communities will

be important for assessing the appropriateness of the National Safe Spaces Network model to meet these.

Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) Australians

LGBTQI+ Australians represent the final cohort identified by experts and data reporting as a priority for suicide intervention. As with culturally and linguistically diverse communities, the Australian Bureau of Statistics data does not provide comprehensive reporting on the sexual or gender identity of people who die by suicide. But surveys conducted within the LGBTQI+ community point to very high levels of suicidal distress and suicide attempting, particularly among young people who are still developing an understanding of their sexual or gender identity.

Research by the National LGBTI Health Alliance found that gay and lesbian young people aged between 16 and 27 were five times more likely to attempt suicide than other Australians, while transgender people aged over 18 were nearly 11 times more likely to do so[18] Around one in seven LGBTQI+ Australians report having had thoughts of suicide in the past two weeks, with this rising to around one in five among LGBTQI+ people aged between 14 and 21. Among young people who had experienced verbal abuse relating to their sexual or gender identity, 30 per cent reported having thoughts of suicide, while 60 per cent of people who had experienced physical abuse reported doing so[19]

LGBTQI+ Australians can face particular challenges in accessing all forms of health and mental health care, particularly those who are gender diverse. The National LGBTI Health Alliance Survey found anticipated discrimination was one of the major reasons for people in this cohort not seeking help with thoughts of suicide or other mental health challenges[20] The Royal Australian and New Zealand College of Psychiatrists has also highlighted entrenched mistrust of medical and mental health professionals as a barrier to seeking help, because LGBTQI+ people have 'historically been criminalised, pathologised and invisibilised by the legal and medical institutions'[21] These experiences have prompted the development of specialist health and mental health services focused on the needs of LGBTQI+ Australians, which can be a preferred point of service for this cohort compared with mainstream services.

Other at-risk groups

There are three further groups which emerge in analysis of available data and literature as having a higher risk of suicide compared with the general population. These groups differ from the cohorts identified above in that they do not necessarily share common characteristics or demographic features – they may live anywhere around Australia and be drawn from any segment of the community.

The first is people who have made a previous suicide attempt. The risk of suicide in this group has consistently been found to be markedly higher than in the general population[22] One international meta-analysis estimated one in 25 people who present to hospital for self-harm will die by suicide within the next five years[23] Recognising this significantly higher risk, aftercare supports which seek to assertively engage people upon discharge from hospital after a suicide attempt have become an increasing focus of service delivery in recent years.

The second group is people with a mental illness, who may have a suicide rate up to seven times higher than the general population[24] Australian Bureau of Statistics data indicates that among people who died by suicide in 2018 with an identified co-morbid illness, mood disorders were the most common – being present in 43.9 per cent of suicides[25] Anxiety and stress-related disorders were also co-morbid in 17.6 per cent of suicides, while schizophrenia and other delusional disorders were identified as co-morbid in

6.5 per cent of suicides[2] Internationally, a meta-analysis of studies examining the link between suicide and mental illness has suggested a very significant majority of people dying by suicide had been diagnosed with a mental illness prior to their death[26] However, this is disputed by other experts who emphasise the complex environmental and social origins of suicide[27] It should also be noted that people with a mental illness who die by suicide represent only a small share of the total population with a mental illness[28]

The extent of overlap between people with a mental illness and those experiencing suicidal distress and crisis is a contentious area. KPMG has identified a wide range of perspectives on this through the data and evidence review and stakeholder consultations. It is not possible to definitively identify the share of people with a mental illness who experience suicidal distress and crisis, or their prevalence within the overall community of people who are at risk of suicide. It is also important to acknowledge that people can experience suicidal distress and crisis for a wide range of reasons and with no underlying mental health condition. But it should be noted that in some potentially significant share of cases, people experiencing suicidal distress and crisis will have a co-morbid mental illness. Recognising this is important for considering the holistic needs of people who may engage with a National Safe Spaces Network.

The third and final group emerging in this analysis is people who have never accessed services or disclosed their suicidality prior to making a suicide attempt. In conducting research and stakeholder consultation for this project, KPMG regularly heard the figure quoted that approximately 50 per cent of people who die by suicide have never accessed *any* form of support prior their death. While the source of this statistic is unclear, there is jurisdiction-specific research examining prior contact with mental health services in a number of Australian states. Analysis by the Western Australian Department of Health found that 43 per cent of people who died by suicide had previously contacted mental health services, but only half of this group had sought help directly before their death[29] Research conducted in Queensland comparing help-seeking by Indigenous and non-Indigenous people experiencing suicidal crisis found 43 per cent of non-Indigenous people had been in prior contact with health services compared with just 24 per cent of Indigenous people[30] Analysis by Orygen in Victoria also identified that more than 50 per cent of people who die by suicide have had contact with health services in the six weeks prior to their death[31]

These findings point to the existence of a significant group of people who are at risk of suicide but are not connected with the traditional supports provided through the health and mental health systems. It is not known whether these people access other community-based or informal supports, but they would appear to be a further group with significant and potentially unmet needs for support. This group is clearly a focus of current analysis for a number of agencies and service providers. Several of the stakeholders consulted for this scoping study mentioned having work underway to better understand who its members are and why they do not currently engage with services.

This discussion of available evidence on the prevalence and distribution of suicide in Australia highlights a priority need for services and supports addressing the risk of suicide among the following groups:

- People living in rural and regional communities
- Men
- Indigenous Australians
- People from culturally and linguistically diverse communities

[2] These percentages should not be summed because individuals who die by suicide may have had one or more co-morbid mental health conditions. The Australian Bureau of Statistics data does not provide any mechanism for distinguishing single co-morbidities from multiple ones.

- LGBTQI+ Australians
- People who have previously made a suicide attempt
- People with a mental illness
- People experiencing distress and crisis who are not currently connected to services.

These groups would therefore also represent obvious priorities for service by a National Safe Spaces Network. However, the discussion above has highlighted the complex range of factors that may affect the willingness or ability of people in each of these priority cohorts to engage with this support. Recognising that these cohorts currently have suicide risks significantly above the general population, it is important to consider how the model aligns with their specific needs and preferences. This point is explored further throughout the report.

Expressed need – people with lived experience

Having explored the available data on the scale of service demand and identified high-risk cohorts, it is also important to consider the expressed needs of people with lived experience of suicide. Expressed need reflects the perspectives of a community or cohort about the need for intervention and current gaps or shortfalls in available service offerings. It is an important input for human services design because it can help ensure services are aligned with the perceived needs of their intended users.

To understand the expressed needs of people with lived experience of suicide, KPMG has reviewed a wide range of submissions and reports prepared by lived experience advocacy groups to bodies such as the Productivity Commission, the New South Wales Parliament and the Royal Commission into Victoria's Mental Health System. The needs and priorities identified through this review were then tested and validated with lived experience stakeholders through the consultation phase.

One point that came through clearly and strongly in this analysis is that people with lived experience of suicide believe there is a significant gap in specialised services for people experiencing suicidal distress and crisis. This gap means that presenting to an Emergency Department is often the only immediately-accessible service option – particularly after business hours and on weekends. While helplines and local support services may be an available as an initial point of contact, these services will generally refer people to Emergency Departments if they disclose suicidal ideation or attempted self-harm[32]

People with lived experience emphasise that Emergency Departments are ill-suited to their needs for a number of reasons. The following concerns are consistently raised in submissions and reports on this topic. First, the physical environment of Emergency Departments is not therapeutic, with bright lights, noise and bustling activity increasing discomfort and sense of unease[33] This is true for most visitors, but can be particularly problematic for people in crisis because it can lead to an escalation in their distress. This can sometimes lead to an adverse reaction from staff who perceive these people as difficult or disruptive. People with lived experience report that too often this results in distressed people being restrained – whether through physical or chemical means[34] These experiences can be deeply traumatising in ways that create barriers to future help-seeking[35]

When people experiencing distress and crisis do access Emergency Departments, they commonly report not being taken seriously by staff, or treated as if they are taking up resources intended for other, more 'worthy' patients[36] This is reinforced by findings from a 2018 study by the Australasian College for Emergency Services, which examined the experiences of people presenting to Emergency Departments for acute mental health crises. The report found these people waited longer to be assessed and treated than people with physical conditions, were significantly less likely to be seen within clinically recommended timeframes, and had an average length of stay of 11.5 hours compared with seven hours for other visitors[37]

Linked to this point, the report found people presenting with an acute mental health crisis were also twice as likely as other visitors to leave an Emergency Department before their treatment and care was concluded. People with lived experience highlight this as a particular problem because failing to secure help when it is sought can leave people in crisis feeling rejected and isolated, increasing their risk of suicide or self-harm[38] When people reach out for help but do not find it, this can also discourage further engagement with both the clinical system and other possible support channels[39]

The use of Emergency Departments as a primary source of care and support is linked to perceived gaps in the accessibility and affordability of other service options. As one person with lived experience explained in their submission to the Victorian Royal Commission:

> *"I'm on the Medicare subsidised psychologist visits and I'm still out of pocket $87 a visit. That is an astronomical cost! To walk into a doctor, say 'I contemplated suicide last night and I need help' and then have to tee up a time with a heavily booked psych during work hours at that cost. It's hard"*[40]

People with lived experience consistently report facing long waits to access specialised support services such as psychologist appointments[41] These access issues are particularly challenging in rural and regional areas where seeking help may involve both a long wait for an appointment and travelling some distance to attend it[42] Both the Productivity Commission and the Victorian Royal Commission have acknowledged that access to timely, appropriate and affordable care is a problem across Australia's mental health system. However, KPMG's consultations suggest people with lived experience perceive these challenges to be particularly acute in relation to services specifically focused on suicide prevention and support. One reason for this is that when services are available, they are often located within – or pre-suppose engagement with – mental health services. This reduces their accessibility for people who are experiencing distress and crisis for other reasons. Another reason cited by lived experience representatives is that there is only an emerging understanding that people at risk of suicide can have distinct service needs from the broader mental health consumer community. As a result, the number and diversity of specialised services addressing these needs does not yet meet demand.

These lived experience perspectives support the position advanced by the National Safe Spaces Network proposal – that people at risk of suicide experience significant gaps in the availability and accessibility of services that meet their needs. They also endorse the strong call for alternatives to Emergency Departments to provide support in times of distress and crisis.

When considering what these alternatives may look like, it should be noted that the primary public work and advocacy on this issue by lived experience representatives has been undertaken by the proponents of the National Safe Spaces Network proposal. Roses in the Ocean, along with Beyond Blue and Suicide Prevention Australia, have been active participants in past public inquiries and consistently advocated for the kind of supports intended to be delivered through the proposal examined by this scoping study.

Beyond specific advocacy, available research and consultative work with people with lived experience indicates desirable features of alternative service offerings would include[43]

- Services being available outside of standard working hours, and preferably 24/7
- Services offering both a sanctuary and an active source of support and links to other services
- Services being staffed by peer workers – including peer workers with lived experience
- Services having capacity to protect the privacy and dignity of users

- Services providing follow-up contact and support following initial engagement by users
- Services offering users the chance to be listened to in a non-judgemental way
- Services offering compassionate and person-centred care
- Services engaging friends, families and other personal or community networks in the care and support of users.

The specific alignment of the proposed Safe Spaces model with the expressed needs of people with lived experience is explored further below in discussing feedback from KPMG's consultation with stakeholders. However, the commonly highlighted features listed above sketch out a model of care that has much in common with the proposed network. In the event that the Commonwealth opted to pursue investment in this model, further detailed co-design with people with lived experience would be beneficial to ensure this meets their needs at both a principles level, and in practice and delivery.

KPMG also sought feedback on the needs of people experiencing distress and crisis directly through stakeholder consultations, which included people with lived experience and broader partners across the service system. These consultations emphasised that there is no 'one size fits all' solution to service delivery for people experiencing suicidal distress and crisis. Stakeholders consistently highlighted the diverse range of causes that can underlie suicidality, ranging from life events and trauma to mental and physical illness. In that context, it is not possible to definitively categorise what all people at risk of suicide need or the services that will support them most effectively – this will be different from person to person and situation to situation. However, stakeholders identified a number of common aspects which are important in the design and delivery of suicide prevention services, which are discussed below. These can be conceptualised as enablers to care that meets people's individual needs, whatever these may be.

A person-centred approach

Stakeholders highlighted that each individual experiencing suicidality has different needs. For example, some people simply want to talk to someone who understands their situation, while others are seeking more structured support such as safety planning and connections to services which can address the underlying drivers of their crisis. Similarly, people who seek support may have a diagnosed mental health condition, be experiencing distress because of life stressors – or both. Stakeholders highlighted that services need to be flexible and adaptable enough to respond to the specific needs of each person who accesses them, acknowledging and responding to service users as individuals. Some lived experience stakeholders mentioned that this is a current weakness of existing clinical services. These services are perceived to focus on diagnosis and categorisation of people into recognised service groupings, rather than responding to people as individuals with unique needs.

Notably, stakeholders also highlighted that the same person's needs can change based on their situation and circumstances. Often, people's experience of suicidal crisis can wax and wane; this makes it important to offer a range of supports at different levels of intensity to cater for these changing needs. This point is discussed further below under the linked theme of access to different levels of care.

Stakeholders indicated that to achieve this person-centred approach, the involvement of people with lived experience in service design and delivery is key. There is also an important role for ongoing feedback from service users to ensure that services continually place their needs at the centre of their delivery and do not fall into unhelpfully standardised models of care over time. These was a general view that Safe Spaces have the potential to offer a more person-centred approach than current service options because they are focused on peer support which does not seek to impose particular treatments or outcomes.

Access to different levels of care

A stepped care approach was noted as important by many stakeholders to ensure people experiencing suicidality can access care that meets their level of need at different times. It was highlighted that most of the existing options only provide acute care for people who are very distressed, and don't provide an opportunity for people who are on a suicidal trajectory to reduce and manage their distress. Stakeholders emphasised that people would benefit from the availability of a range of different services providing support at different levels of intensity so that they can move between these depending on their needs. This was considered to be important both for helping prevent people from escalating to acute crisis, and for helping them recover after a suicide attempt. This was frequently linked to the above theme about person-centred care in that stakeholders indicated there need to be services available which can 'meet people where they are' at different levels of need.

Lived experience stakeholders also pointed out that people's journeys through these different levels of care would not always be linear, as distress can peak and wane in unpredictable ways. In this context, it was highlighted that services offering different supports need to be well connected to ensure people do not fall through the cracks between them.

The tiered model of care proposed for the National Safe Spaces Network was considered to be in alignment with this need for different levels of care. However, a number of stakeholders also balanced this with an acknowledgement that having too many options can increase service complexity and confusion about where people should go.

This feedback is discussed further in *Section 4.6*. Expressed demand among stakeholders appeared to be strongest for the Tier 4 and 5 services. However, it was also frequently noted that there is a gap in services equivalent to the proposed lower tiers of the Safe Spaces model which can help prevent people escalating into more acute crisis.

Holistic support that addresses underlying drivers of distress

Stakeholders commonly drew attention to the fact that there are multiple factors which can interact to influence a person's experience of suicidal crisis. Lived experience and suicide prevention stakeholders in particular noted that services should consider a person's holistic needs to deliver supports that address these underlying drivers – not just help them manage their distress in the moment. Common factors identified as contributing to suicidal distress included financial stress, family and relationship breakdowns, domestic and family violence, homelessness and housing issues, and drug and alcohol dependency. There was strong consensus that effective care should include helping people access services that can assist with these underlying stressors. Stakeholders acknowledged that it will not be possible for suicide prevention services to comprehensively address all of these needs because these often require different, more specialised knowledge and information. But there was a strong view that suicide prevention services should help connect people with appropriate services by helping them to identify what their needs are and then providing warm referrals and support to engage.

Stakeholders also highlighted the importance of involving families, carers and friends in the support process as part of a holistic approach to care. It was frequently mentioned that these support networks are essential in delivering ongoing support outside of a person's interactions with services. Closely involving them in what happens during service visits can support continuity of care and better communication about that person's needs. Again, this need was often raised as a contrast to current service delivery models which are premised on principles of privacy and non-disclosure to other people beyond the individual receiving care.

Guidance with service navigation and access

One of the most common challenges stakeholders identified with the current service system is its complexity. Stakeholders consistently described a fragmented and disconnected system where some services are duplicated or overlap, while others are missing or difficult to access because of service criteria, cost or waiting times. In this context, stakeholders frequently identified a need for support to navigate this system and access the right services. It was regularly pointed out that even professionals operating within the service system can find it challenging to be across all of the service options and how people can access these. For people in crisis and loved ones looking to support them – who may never have previously interacted with this system – this challenge is multiplied many times over.

Support to navigate to the right services and access these in a timely way was a clear need emerging from the consultations, with stakeholders generally agreeing that a National Safe Spaces Network would be well-positioned to play this role. Many stakeholders emphasised the potential value of Safe Spaces as community hubs or coordinating points for suicide prevention services in their local communities, providing a 'single front door' or first point of contact for people who don't know where to go.

There are two final and related points which were particularly raised by lived experience stakeholders in relation to the needs of people at risk of suicide and the alignment of a National Safe Spaces Network with these. These stakeholders frequently discussed i) the importance of giving people options and ii) allowing them to remain in control of their situation while seeking help. These issues are related in that at the moment, people experiencing distress and crisis often do not feel as though they have any option but to seek help through an Emergency Department or acute clinical service. However, when they do, this often results in other people taking control of their situation and making decisions about what happens next – for example, through involuntary admission to hospital, treatment with medication or other clinical interventions. This was reported to be very distressing and disempowering for people in crisis. The fear of this happening was described to be a barrier to help-seeking for many people, particularly those who have had a prior adverse experience with the clinical system.

Lived experience stakeholders reported a strong desire for more diverse service options, so that people can choose which type of service to engage with depending on their needs and prior experiences. There was clear agreement that a National Safe Spaces Network would support this objective by allowing people to decide whether they wish to seek peer support or pursue a clinical service channel.

Similarly, the peer-led aspect of Safe Spaces is considered an important factor in allowing people to remain in control of their own situation when accessing these services, as peers with lived experience are seen as less likely to impose treatments or solutions. The consultations highlighted deep levels of distrust with clinical services among some people with lived experience of suicide. In this context, Safe Spaces were seen as offering a welcome alternative to a disempowering clinical service system. This is an important factor to consider when designing services that can better support people at risk of suicide, particularly in relation to the integration of these services with more traditional clinical supports.

Service need – conclusions

Reviewing documents, data, and stakeholder inputs highlights a clear need for more diverse approaches to supporting people at risk of suicide – particularly for the high-risk cohorts identified. There are a many Australians who are at risk of, or attempt, suicide each year but current service options often do not provide support which aligns with their needs. Sometimes, they fail to engage the people who need them most at all.

Exploring the perspectives of people with lived experience indicates that Australia's current service options are considered to be overly focused on acute clinical interventions, with limited options for early intervention or management of people who may be on a suicidal trajectory. These services are also often difficult to access because of cost, selection criteria and long waiting times. Both people with lived experience and broader stakeholders across the service system acknowledge a need and desire for a different approach. The common features of this new approach would include:

- being more focused on the individual and their unique needs, addressing the whole picture of a person's experience of suicidality – not just their acute symptoms
- helping people in crisis navigate a complex service system to get the help they need.
- more closely involving families, communities and peer workers with lived experience of suicide.

These aspects closely reflect the underlying principles and drivers of the National Safe Spaces Network proposal, indicating strong alignment between the proposed model and the service needs identified through this scoping study.

4.2. Current service landscape

The second important lens to consider in assessing the need for a National Safe Spaces Network is the current availability of comparable services and suicide prevention supports more generally. It is clear from the discussion in the previous section that stakeholders and people with lived experience perceive significant unmet needs. Exploring the number and type of services currently offered across Australia is important for assessing priorities to address these and how the proposed network may contribute to doing so.

Summary of findings

- There is a very small, but rapidly growing, number of existing services providing comparable supports to those intended to be offered through the National Safe Spaces Network. Even taking into account the currently planned roll-out of these services in New South Wales, Queensland and Western Australia, significant and wide-spread service gaps are likely to remain.
- Beyond the Safe Spaces model, there are a range of existing services which focus on addressing the needs of people experiencing suicidal distress and crisis. These services are moderately accessible in metropolitan areas along Australia's east coast, but there are limited service offerings in regional and remote communities. Particular gaps exist in Western Australia, the Northern Territory and regional Queensland where rates of suicide and self-harm are significantly above the national average.
- In the event the Commonwealth opted to pursue investment in the National Safe Spaces Network, service mapping indicates there would be benefit in the network having a strong regional and remote service footprint, with the three states mentioned above being a priority for delivery of new services.
- There are a larger number of mental health and alcohol and other drug services available across Australian compared with suicide-specific services. However, as with dedicated suicide support services, availability varies significantly and is particularly sparse in remote parts of Australia. This should mean effective partnerships and referral relationships to and from Safe Spaces are possible in many locations but would need to be closely scoped and considered where services are less available.

In relation to the availability of suicide prevention services, stakeholders consulted for this scoping study commonly identified a number of significant practical gaps. The most frequently raised included:

- **Lack of after-hours services and supports** – Current supports and services for people experiencing distress and crisis tend to operate during business hours. This was highlighted by stakeholders as a major gap as people may experience crisis at any time of day – particularly late at night and on weekends. Other key services that may be related to the underlying drivers of suicidal crisis also generally operate to standard business hours, such as mental health, housing and welfare services. This often leaves people in crisis with few alternatives other than to attend an Emergency Department, because they are open and staffed 24 hours a day, seven days a week.
- **Lack of alternatives to clinical services** – While many stakeholders acknowledged that clinical care can play an important role in helping some people manage their suicidality and underlying drivers of crisis, it was also commonly recognised that many find the clinical model of care ill-suited to their needs in times of crisis, as discussed in the previous section. Stakeholders frequently

described a gap in the availability of services based more on warm, empathetic interactions with staff who will take the time to listen to what the person in distress is experiencing.

- **Lack of non-acute supports** – The term 'missing middle' was frequently used by stakeholders to describe a gap in services between the limited supports offered by services like Lifeline and the acute interventions provided by the clinical system. Stakeholders described a need for services which can support people who are experiencing higher levels of distress and may be on a suicidal trajectory but are not yet at the point of active suicidal ideation or attempting. This was identified as a significant gap in the current service landscape, as the service mapping discussed later in this section largely confirms.
- **Lack of adequately trained personnel** – Stakeholders reported that there is a misconception staff who work in health or mental health settings are trained and experienced at dealing with people experiencing suicidal crisis. In fact, it was noted that health and community sector workers who come into contact with people in crisis in these settings often lack the core skills to engage in an empathetic and supportive way. This leads to inappropriate responses which can range from dismissive to 'hitting the panic button' by engaging clinical and emergency supports against a person's wishes. Another key skill that was highlighted as missing from current clinical and community services personnel was the ability to correctly refer people to appropriate services that can help with either their suicidality or its underlying drivers.
- **Lack of accessible specialist suicide prevention services** – It was commonly highlighted that services specifically addressing the needs of people experiencing suicidal crisis tend to be available only in metropolitan areas or larger regional communities. Stakeholders also noted that access is generally better in high socio-economic areas than in lower socio-economic areas where people may be at particular risk of suicidality due to life stressors and wellbeing challenges. Even among more populated regions, specialist services are generally not available in every area and are frequently offered as an adjunct to mental health services rather than being provided as standalone services. Many stakeholders drew attention to the fact that providing supports through mental health services can create a barrier to access for people whose suicidality is not underpinned by a diagnosed mental health condition, or who feel stigmatised by connection to the mental health system.
- **Lack of aftercare and follow-up after a suicide attempt** – Stakeholders commonly highlighted gaps in the care and support provided to people who have made a suicide attempt following their discharge from hospital or another care venue. It was reported that people are often discharged without being put in touch with appropriate support services, or with limited knowledge of the supports that are available to them. The Way Back Support Service was regularly cited as an important service innovation in this area, but some stakeholders noted the currently limited reach and availability of this service compared with the scale of need.
- **Lack of appropriate services for vulnerable communities** – Vulnerable populations such as Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, people living in rural and remote communities and LGBTQI+ Australians have unique needs in relation to suicide services and supports. There was a clear consensus that these needs are not currently being met by available services, resulting in low levels of access and uptake. Stakeholders highlighted that there is a particular gap in the delivery of culturally safe and appropriate services and the staffing of existing services with culturally competent personnel.

In addition to these specific gaps, stakeholders highlighted the complexity of the current service landscape as an overarching problem that makes it difficult for people experiencing distress and crisis to find the help they need. Challenges in navigating the system can lead to people experiencing service gaps even where supports are notionally available. This has also been a strong theme emerging from both the Productivity Commission's inquiry and the Royal Commission into Victoria's Mental Health System. The latter's Interim Report noted: *"A lack of coordination between governments has led to an uncoordinated and fragmented set of programs and policies on suicide prevention. This has resulted in a patchwork of solutions and duplication of effort"*[44] This point is underlined by the service mapping

presented at Figure 5 (p.29) which points to significant overlapping of services in some areas with relatively low suicide rates and large service gaps in areas with much higher suicide rates. System complexity is often a feature of Australia's federated service landscape. However, stakeholders indicated this challenge is particularly acute in relation to suicide prevention services at the present time of recent attempts by all levels of government to rapidly scale up delivery of these services with limited coordination. This point was often raised in the context of discussing how a National Safe Spaces Network could integrate with the current service landscape. Stakeholders consistently expressed the view that delivery of the network would need to be carefully coordinated with state governments and other partners to ensure it filled gaps rather than adding complexity where services already exist.

Some stakeholders also highlighted an important distinction between services being *available* and being *accessible*. A service may be available in the sense that it is open, has staff present to help and is located in a place people can easily get to. But if this service is not presented in a way that engages with the needs of potential users, or does not offer an environment that feels psychologically safe, it may still not be accessible. This is a particularly relevant consideration for people from vulnerable communities and men, who have different patterns of service engagement than other members of the community[45] This was also a topic of some discussion within the Expert Advisory Group, in the context of recognising that clinical and mental health services which may currently be *available* to people at risk of suicide are not *accessible* to them because of the factors discussed in *Section 4.1*. This caveat is important when considering the current options identified in the discussion and mapping of existing services that follows.

Existing comparable services

There are a small number of services currently operating in Australia which are aligned with the Safe Spaces approach or deliver aspects of its intended model at particular tiers. These services are operating independently of each other, without the overarching national strategy or coordinated approach intended for the national network. Each is briefly described below along with the relevant tier they align with in the proposed model for the National Safe Spaces Network.

More detailed information on the models of each of these services is discussed in *Section 4.6: Service Model* and *Appendix E: Summary of existing exemplar services*

Table 4: Comparable existing services

Service	Location	Tier equivalent	Service notes
St Vincent's Safe Haven Cafe	Melbourne, VIC	Tier 4	After-hours drop in centre located on the grounds of St Vincent's hospital, offering people in crisis a safe place to turn where they can be supported by peer and lived experience team members. It is designed to provide a non-clinical alternative to treatment in the St Vincent's Hospital Emergency Department.
Alternatives to Emergency Departments	Various locations, NSW; QLD; WA	Tier 4	The NSW State Government is currently in the process of rolling out 20 services across the state. These will be based in the community rather than being co-located on hospital campuses, but the intent and model of care is expected to be broadly the same as the existing Victorian Safe Haven Café. The Queensland Government is also in the process of delivering eight Safe Haven Cafés across regional communities, while the Western Australian Government is preparing to open two Safe Haven Cafés in Perth and Kununurra before the end of 2020.

Service	Location	Tier equivalent	Service notes
Brisbane North Safe Spaces	Brisbane, QLD	Tier 3 and 4	Services operated as a pilot in 2019. Similar to Safe Haven Cafés, the Brisbane North Safe Spaces adopted a drop-in model and provided a safe, non-clinical alternative to ED. Staff included a mix of peers and trained mental health workers who were available to work one-on-one with guests.
Living EDge	Brisbane, QLD	Tier 4	An alternative space at Redland Hospital for people experiencing suicidal distress. Located near the Redland Hospital Emergency Department, Living EDge provides a calming space where people at risk of suicide can talk to peer support workers, participate in relaxing activities that ease distress and arrange ongoing guidance and support.
The Way Back Support Service	25 sites nationally	Not directly comparable but includes elements of supports intended to be offered across Tiers 3 and 4	An assertive outreach program that provides non-clinical psychosocial support to people for three months following a suicide attempt or suicidal crisis. The program delivers a person-centred model of care which includes safety planning, links to community services for ongoing support, practical assistance to respond directly to the needs of an individual client, and where required, clinical care.
Lifeline Centres	41 sites nationally	Not directly comparable but includes elements of supports intended to be offered across Tiers 1 to 4	Lifeline delivers volunteer-led telephone crisis support via a network of 41 Lifeline Centres across Australia. Around half of these centres also provide face-to-face counselling and other suicide prevention or bereavement services. Service offerings vary between sites, but can include bereavement support groups, financial counselling, and support with problem gambling.
Suicide Prevention and Recovery Centre (SPARC)	Sydney, NSW	Tier 5	Currently under development, SPARC is will provide non-clinical residential support and care for people experiencing suicidal crisis. The service will be available for a five day/four night stay for up to four guests at one time, with an option to return for additional stays.

With the exception of The Way Back Support Service and Lifeline's Connect Centres, each of these services are still in planning or have been operating for only a handful of years. The services which are most directly analogous to the Safe Spaces model are also currently operating at relatively small scale in discrete communities. This indicates that in terms of services directly reflecting those proposed through the National Safe Spaces Network, there is very limited availability across Australia at present.

To analyse the broader service landscape and other forms of support which may be available, KPMG has undertaken detailed mapping of existing suicide prevention, mental health and alcohol and other drug services in operation across the country. We recognise that not all of these services will be directly relevant to the needs of a person experiencing distress and crisis, given the wide range of drivers which can underlie suicidality. However, understanding what is currently available in each of these areas is important for identifying service gaps as well as considering the range of service connection points a National Safe Spaces Network may need to engage with.

National service mapping

The National Safe Spaces Network would need to be delivered within a service landscape that features a range of existing services and supports. Most relevantly, this includes government funded and non-government suicide, mental health and alcohol and other drug support services, as well as broader social, relationship and wellbeing supports. The number, range and availability of these services varies significantly across Australia. Mapping existing services is important to explore this variation and understand which regions or communities may be priorities for any future investment.

To explore this, KPMG has mapped more than 2,000 physical service locations across Australia, spanning suicide prevention, mental health, alcohol and other drug services. This service mapping is based on a desktop review of publicly available information as well as the websites for:

- 31 Primary Health Networks (PHNs) across Australia
- State and territory government health departments and health services
- Individual Aboriginal Community Controlled Health Services across Australia
- Large mental health and suicide prevention service providers (e.g. Lifeline, Beyond Blue and headspace)
- Online directories of health services that are government funded.

The detailed methodology for the service mapping as well as results for each state and territory is provided at *Appendix C: Service mapping methodology*.

For the purposes of KPMG's analysis, service mapping has been separately undertaken for suicide prevention services and general mental health and/or alcohol and other drug services. This distinction in service type is intended to highlight the differences in the availability of suicide prevention services compared with mental health and alcohol and other drug services. It also recognises that while there is likely to be some overlap between the target cohorts for these services, they are not equivalent.

Dedicated suicide prevention services

Because the causes of distress and crisis are complex and multifaceted, there are a wide range of suicide prevention programs and services delivered in Australia. Some of these have a direct focus on acute crisis intervention, while others seek to address known risk factors and support people in managing their wellbeing[46] For the purposes of KPMG's analysis, the following were identified as suicide-specific support services:

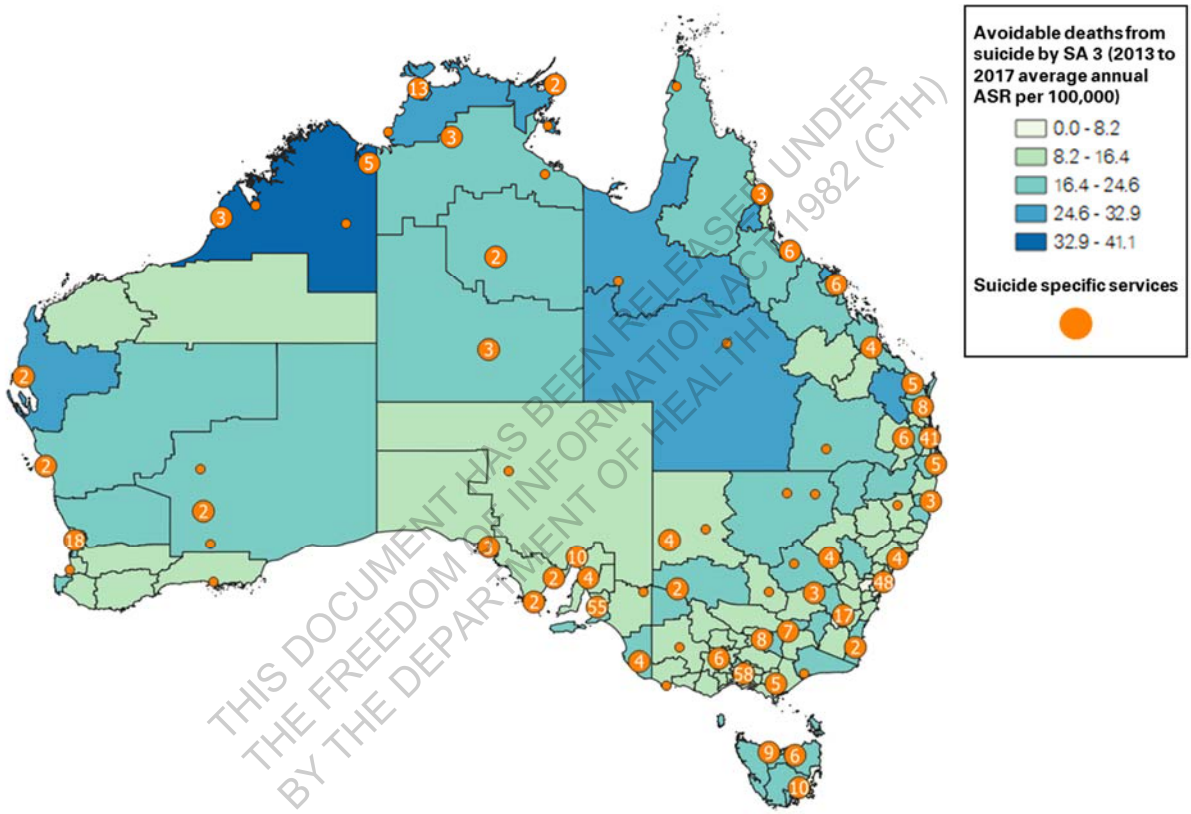
- Residential safe houses specifically for people experiencing suicidal distress and crisis
- Alternatives to emergency departments (e.g. Safe Haven Cafes)
- Aftercare services offering support following a suicide attempt (e.g. The Way Back Support Service)
- Psychosocial supports and counselling services specifically for people experiencing suicidal distress and crisis
- Safe places for people experiencing suicidal distress and crisis to seek assistance and access referrals (e.g. Lifeline Crisis Centres)
- Suicide prevention networks and suicide bereavement groups
- Suicide gatekeeper training services (e.g. providers delivering Applied Suicide Intervention Skills Training).

Figure 5 maps the specific locations of these services against the average age-standardised suicide rate for each SA3 region in Australia[47] Mapping these two variables together provides an indication of the

population need in each region for suicide prevention services, assisting in the identification of current supply gaps.[3]

This mapping clearly demonstrates that there are a limited number of suicide-specific support services overall in Australia relative to population need. The majority of existing services are located in metropolitan areas along the eastern coastline of Australia. In comparison, there are far fewer services in regional and remote areas particularly in Western Australia, the Northern Territory and Queensland. This lack of services is considered to be an important factor underpinning the significantly higher rates of suicide and self-harm in these communities[48]

Figure 5: Locations of identified suicide prevention services relative to rate of average annual avoidable deaths from suicide by SA3 (2013 to 2017, ASR per 100,000)

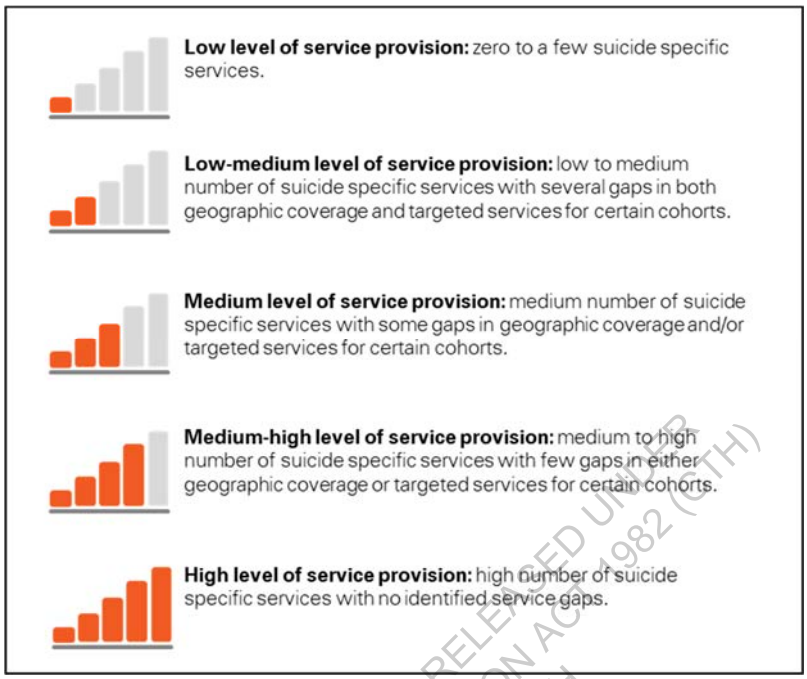


Source: Public Health Information Unit, Torrens University Australia (2020); KPMG (2020)

Based on this mapping of suicide-specific support services, KPMG has undertaken a high-level and qualitative assessment of the level of service provision across Australia. Identified services were classified by their level of remoteness[49] and rated against the criteria in Figure 6. This process considered the number of different types of suicide prevention services, relative to need, to identify the current availability of different types of support.

[3] Note that the age standardised rate of suicide is used in this instance as a proxy for service need, but the type and size of need can vary independent of recorded instances of suicide.

Figure 6: Assessment criteria for level of provision of suicide prevention services



Source: KPMG (2020)

The results of this assessment are presented in Table 5 overleaf. This indicates there are no categories of dedicated suicide prevention services which have medium-high or high levels of service delivery across metropolitan, regional or remote Australia. Services offering psychosocial supports, suicide prevention networks and bereavement support groups, and suicide gatekeeper training services all have medium levels of service provision in major cities. Support networks and bereavement groups also have a medium level of reach in regional areas. Beyond this, all remaining types of services were found to have lower levels of availability, with no residential safe houses and only a handful of safe alternatives to Emergency Departments currently available. As noted in *Section 4.1*, a number of these services are currently under development in New South Wales, Queensland and Western Australia. However, the relatively small scale of intended delivery is unlikely to meet the extent of demand discussed in the previous section.

This analysis highlights that there are significant and extensive gaps in the current supply of suicide-specific services across the spectrum of supports intended to be delivered by the National Safe Spaces Network.

Table 5: Assessment of the provision of suicide prevention services across Australia

	Major cities	Inner and outer regional	Remote and very remote
Residential safe houses for people experiencing suicidality	0 services identified	0 services identified	0 services identified
Alternatives to emergency departments	7 services identified	0 services identified	0 services identified
Aftercare following a suicide attempt	24 services identified	22 services identified	1 service identified
Psychosocial supports for people experiencing suicidality	84 services identified	54 services identified	8 services identified
Safe places for people experiencing suicidality to access referrals	14 services identified	11 services identified	1 service identified
Suicide prevention networks and bereavement groups	76 services identified	70 services identified	34 services identified
Suicide gatekeeper training services	43 services identified	30 services identified	6 services identified

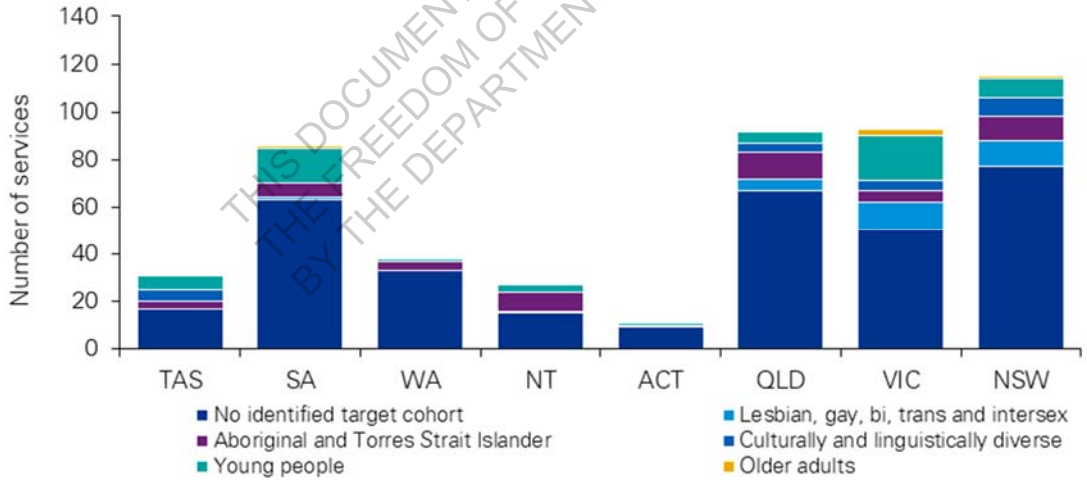
Source: KPMG (2020)

As part of this service mapping, KPMG also examined the target cohorts of each suicide-specific service. Identified target cohorts included:

- Aboriginal and Torres Strait Islander communities
- LGBTQI+ Australians
- Culturally and linguistically diverse communities
- Young people
- Older adults.[4]

As shown in Figure 7, the majority of suicide-specific services across Australia do not have a specific target cohort or community. This aligns with a population-wide approach to suicide prevention. As every Australian may have need for suicide prevention services at some point in time, it is important that services are accessible to a broad general audience. However, given the significantly higher suicide risk experienced by the cohorts discussed in *Section 4.1*, it is also important to ensure appropriate services are available which can meet more specialised needs. Figure 7 indicates that only a small proportion of suicide-specific services across Australia are targeted to high risk communities. The extent of service targeting varies significantly across Australia, with the more populous states providing a larger range of specialist services than smaller ones. Services addressing the needs of young people were the most commonly identified, representing almost 12 per cent of all dedicated suicide prevention services. There are also a number of services focused on supporting Aboriginal and Torres Strait Islander people, with 9.5 per cent of services having a specific focus on these communities. Services supporting LGBTQI+ Australians (6.3 per cent), culturally and linguistically diverse communities (4.3 per cent) and older adults (1 per cent) made up a smaller share of these specialist supports.

Figure 7: Identified target cohorts for suicide prevention services



Source: KPMG (2020)

This analysis indicates there are also significant gaps in suicide-specific services addressing the needs of high-risk cohorts. While the National Safe Spaces Network model is not specifically targeted to any individual cohort,

[4] Note: Services with more than one target cohort have been recorded for the purposes of this analysis. As such, some individual services may be counted more than once in the figure to account for the provision of services for more than one target cohort.

the proposal envisages that dedicated Safe Spaces may be established within the broader network to meet the needs of these communities. This is explored further in *Section 4.8: Implementation considerations*.

Mapping of mental health, alcohol and other drug services

People's experience of suicidal distress and crisis can be driven by a wide range of factors. Where mental health or alcohol and other drug misuse issues are a factor in this, it will be important for the National Safe Spaces Network to be able to connect with appropriate services and refer their guests to these. The nature of relationships between Safe Spaces and these broader existing services is discussed in detail in *Section 4.6*. In this section, KPMG has focused on mapping dedicated mental health and alcohol and other drug services to identify how available these currently are to support effective service connections when needed.

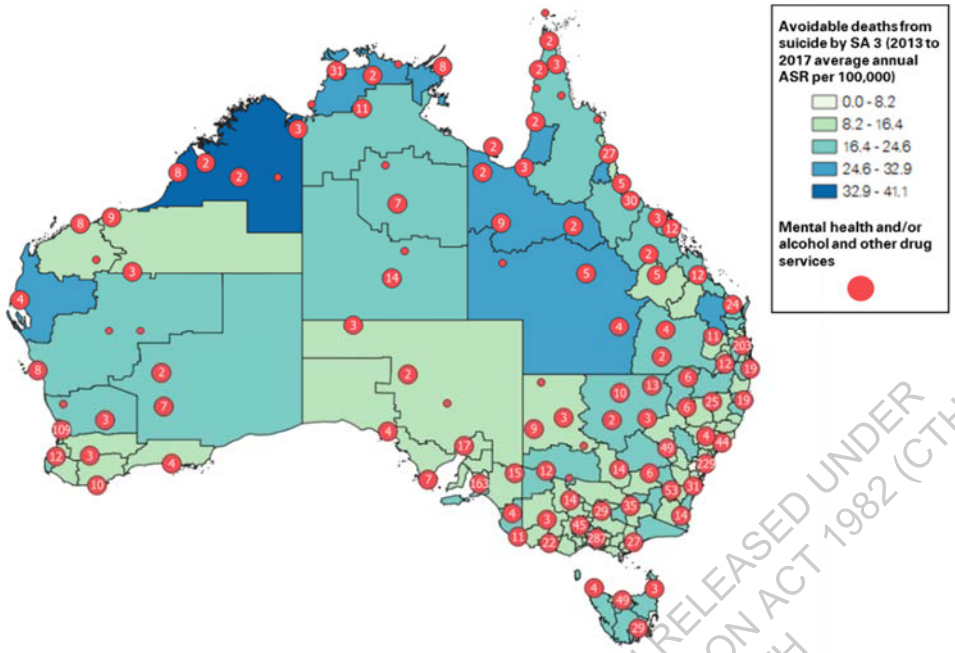
For the purposes of this analysis, the following services were identified as mental health and/or alcohol and other drug services:

- Residential services and supports for people experiencing mental health and/or alcohol and other drug concerns (e.g. Step Up Step Down services, Prevention and Recovery services, and residential alcohol treatment centres)
- Psychosocial support and counselling for people experiencing mental health concerns and/or alcohol and other drug concerns (headspace, Wellways, Neami, Lives Lived Well and Salvation Army)
- Social and emotional wellbeing services and supports for Aboriginal and Torres Strait Islander people.

In line with the approach taken for suicide-specific support services, Figure 8 maps the locations of mental health and alcohol and other drug services against average age-standardised suicide rates[50] This indicates these services are significantly more available than those providing dedicated suicide prevention services but the supply still varies widely across Australia. The majority of services are concentrated in Australia's capital cities and inner regional towns, with service gaps increasing with remoteness. Service gaps are seen to be particularly pronounced in the Northern Territory as well as in areas of regional Queensland, South Australia and Western Australia.

These observations coincide with the recent draft findings of the Productivity Commission, which found many people with moderate and higher intensity mental health needs live in regional and remote parts of Australia and do not have ready access to affordable, culturally appropriate and timely services and supports[51] People living regional and remote areas are also more likely to face barriers to access, such as stigma, isolation and travel costs, exacerbating challenges in seeking help in times of high personal distress[52]

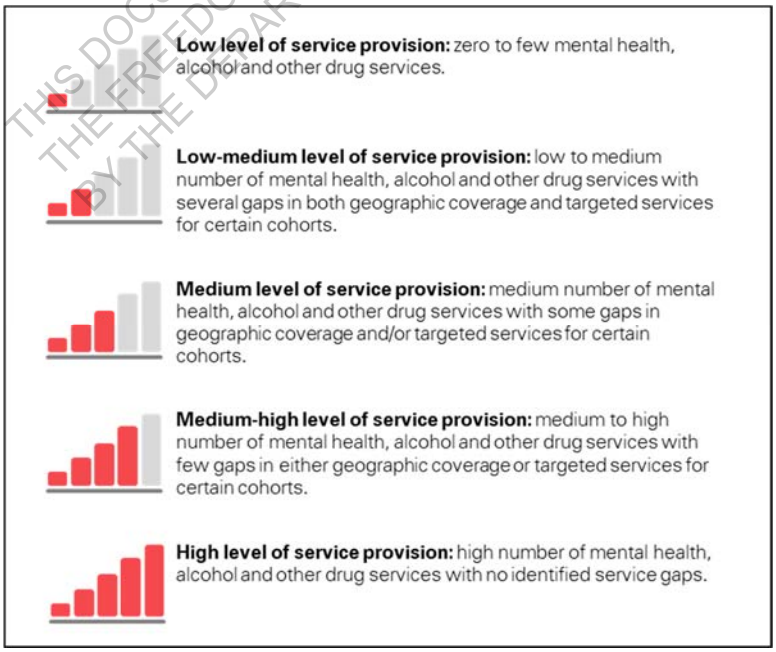
Figure 8: Locations of identified mental health, alcohol and other drug services relative to rate of average annual avoidable deaths from suicide by SA3 (2013 to 2017, ASR per 100,000)



Source: Public Health Information Unit, Torrens University Australia (2020); KPMG (2020)

Having undertaken this national mapping, KPMG then undertook the same classification process applied for the suicide-specific support services. This drew upon a similar, but tailored, set of classification criteria as set out in Figure 9.

Figure 9: Assessment criteria for level of provision of mental health, alcohol and other drug services



Source: KPMG (2020)

The results of this assessment have been consolidated in Table 6 overleaf. This demonstrates that psychosocial support and counselling services are by far the most available services, having medium to high levels of provision in major cities and medium availability in regional areas. It also highlights very stark service gaps across all service types for remote communities.

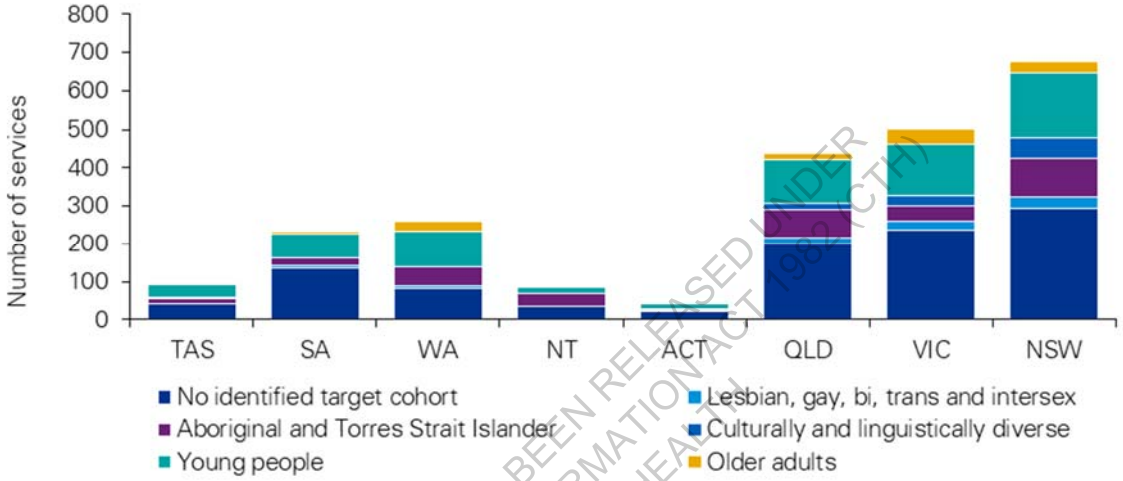
Table 6: Assessment of the provision of mental health, alcohol and other drug services

	Major cities	Inner and outer regional	Remote and very remote
Residential services and supports for people experiencing mental health and/or alcohol and other drug concerns	152 services identified	94 services identified	8 services identified
Psychosocial support and counselling services for people experiencing mental health concerns and/or alcohol and drug concerns	781 services identified	703 services identified	162 services identified
Social and emotional wellbeing services and supports	20 services identified	63 services identified	43 services identified

Source: KPMG (2020)

Similar to the analysis above for suicide-specific services, Figure 10 shows that the majority of mental health and alcohol and other drug services across Australia were identified as generalist supports. There is also reasonable provision of supports targeting young people, with over 27 per cent of all services identifying this cohort as a focus. A further 14 per cent of services specifically target Indigenous Australians but LGBTQI+, culturally and linguistically diverse and older Australians are less well catered for with 5 per cent or less of services each.

Figure 10: Identified target cohorts for mental health, alcohol and other drug services



Source: KPMG (2020)

Taken together, this analysis indicates that mental health and alcohol and other drug supports are generally more available than suicide-specific support services. This is likely to support linkages from one type of service to the other where guests of the National Safe Spaces Network need and request this (see further discussion of service linkage in *Section 4.6: Service model*). However, large service gaps remain both in terms of the availability of these services in regional and remote communities. This is particularly the case for some at-risk communities such as LGBTQI+ people, culturally and linguistically diverse communities and older people, with specialist services being largely concentrated in metropolitan areas within Australia's more populace states.

Service mapping – conclusions

This analysis confirms the advice provided in the National Safe Spaces Network proposal that there is a shortage of dedicated suicide prevention services with the characteristics of the proposed model across Australia. While there are a small and growing number of services offering supports comparable to those intended to be offered within the network, these are available only in a small number of locations and at a single community scale. Importantly too, current activity by these services is not coordinated or integrated in the manner proposed by the National Safe Spaces Network, potentially leading to gaps and variation in how supports are delivered. There appears to be significant scope to expand the supply of non-clinical, peer-led suicide prevention services across all tiers of the proposed model. If this were coordinated in partnership with state governments and other existing frontline delivery agencies, there is strong potential for the National Safe Spaces Network to fill service gaps without duplicating existing services.

More generally, this service mapping confirms feedback from people with lived experience and stakeholders that the current service landscape for suicide-specific supports, mental health and alcohol and other drug services is complex and fragmented. To the extent that a National Safe Spaces Network

could assist in making services more accessible by supporting better system navigation, this would clearly be a benefit for guests, adding value beyond the direct supports intended to be provided through each local Safe Space.

4.3. Evidence base

The National Safe Spaces Network proposal outlines a service and model of care that is relatively new in the context of existing supports for people at risk of suicide. As highlighted by the discussion in *Section 4.2*, there are only a handful of comparable services currently operating in Australia, with most of these having been in place for only a short time. This means the local evidence base on the outcomes and effectiveness of these services is limited, although preliminary evidence does point to positive benefits. Internationally, there are a number of comparable services which have been subject to evaluation and provide further insights on the effectiveness of the Safe Spaces approach. There is also a growing body of research into aspects of suicide prevention practice which underpin this model, including brief contact interventions and the role of peer supports. The following section reviews this available evidence to establish what is currently known about effective suicide prevention practice and how the National Safe Spaces Network proposal aligns with this.

Summary of findings

- Emerging evidence from comparable services operating internationally and in Australia points to the effectiveness of a non-clinical, peer led approach in meeting the expressed needs of people in crisis and supporting them to manage and reduce distress.
- Findings in relation to the impact of comparable services on their broader service systems are more mixed – there is an ongoing debate about the appropriateness of targeting metrics such as reduced Emergency Department demand. Data and attribution challenges currently confound clear conclusions on how Safe Spaces-type services impact Emergency Department presentations and demand for other clinical services.
- There is early and emerging evidence supporting underlying aspects of the Safe Spaces model in the context of suicide prevention, specifically brief contact interventions and peer-led supports. In line with the relatively new application of these services to suicide prevention, the evidence base is limited and further research will be required to conclusively establish the effectiveness of these approaches.
- The scoping study did not identify any evidence indicating the proposed Safe Spaces model would increase risks to guests compared with other existing interventions or depart from currently established effective suicide prevention practices.

Effective suicide prevention practice

The causes of suicide are very complex and can vary significantly from individual to individual depending on factors including their age, gender and sexual identity, socioeconomic status, cultural background and past experience of trauma. This diversity makes it challenging to identify specific practices or interventions which are successful in preventing or reducing suicides across the board. Within Australia, research bodies including the Black Dog Institute, the NHMRC's Centre of Research Excellence in Suicide Prevention (CRESP) and the National Mental Health Commission have dedicated significant time and resources to examining and building the evidence base on suicide prevention practices (see *Appendix J: Bibliography* for key literature review documents)[53] Their work indicates that preventing deaths by suicide requires an integrated mix of strategies and activities which address both individual and population or community-level factors. This is known as a *multilevel systems approach*, and can be achieved through different interventions being implemented in tandem within specific communities or regions[54] The important feature of this approach is that interventions are delivered in a coordinated way

to create an environment of safety which can protect people who may be at risk of suicide for different reasons and with different underlying drivers.

Based on extensive review of available evidence and data, the Black Dog Institute and NHMRC CRESP have identified key components of this approach to include:[55]

- **Aftercare and crisis care** – improving the care received by people after a suicide attempt and connecting them with crisis supports (individual level)
- **Psychosocial and pharmacotherapy treatments** – providing accessible and appropriate mental health care (individual level)
- **General Practitioner (GP) capacity building and support** – strengthening education and support for GPs to identify and appropriately respond to people experiencing distress and crisis (individual level)
- **Frontline staff training** – strengthening capacity of frontline staff including psychiatrists, psychologists, nurses, social workers and first responders to identify and respond to the needs of people at risk of suicide (individual level)
- **Gatekeeper training** – increasing the literacy and capacity of potential gatekeepers who may include police, religious community leaders, pharmacists, teachers, counsellors, family and friends, school and work peers and crisis line staff (population based)
- **School programs** – expanding opportunities for help-seeking and mental health literacy within schools (population based)
- **Community campaigns** – working at the whole-of-community level to improve recognition of suicide risk, reduce stigma and strengthen understanding of the causes and risk factors for suicide (population based)
- **Media guidelines** – promoting responsible reporting of suicide and educating media professionals about how to undertake safe, sensitive and non-sensationalist reporting (population based)
- **Means restriction** – restricting access to common or highly lethal means of suicide (population based).

In Australia, these components have been developed into the LifeSpan Framework which seeks to operationalise their combined implementation. This framework builds on earlier model developed internationally such as the European Alliance Against Depression and Zero Suicide approaches[56] The LifeSpan Framework has been fully implemented in five locations around Australia, with the implementation period for the first four sites concluding in March 2020. The evaluation of these trials is expected to provide further valuable evidence on effective suicide prevention practice in general, and the multilevel systems approach in particular.

The National Safe Spaces Network would appear to support the implementation of a number of the strategies in the above framework, including improving opportunities for aftercare and crisis care; strengthening gatekeeper training – particularly at the community level through the lower tiers; and promoting recognition of suicide risk while reducing stigma across communities. In the event that the Commonwealth opted to pursue investment in this approach, there may be benefit in coordinating implementation of Safe Spaces within a broader roll-out of a systems-based approach to suicide prevention.

In 2016 the Australian Government also commissioned a comprehensive review of evidence-based suicide prevention practices specifically of relevance to Indigenous communities through the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (AITSISPEP). In addition to the strategies identified through the LifeSpan Framework above, the project highlighted a range of further

actions which have been found to be effective or shown promise in protecting Aboriginal and Torres Strait Islander Australians from suicide:[57]

- Addressing community challenges including poverty and the social determinants of health
- Building social and emotional wellbeing by strengthening cultural identity, including through the teaching of culture in schools and to other high-risk cohorts
- Peer-to-peer mentoring and engagement with Elders
- Providing programs to engage and divert people at risk of suicide, for example, through sport
- Delivering culturally appropriate treatments supported by culturally competent staff
- Addressing alcohol and drug use
- Partnerships between community organisations and Aboriginal Controlled Community Health Services.

These findings are important because they highlight that even within a comprehensive, system-wide approach, high risk cohorts have specialised needs that require focus and intervention. The National Safe Spaces Network proposal does not specifically address the needs of Indigenous Australians and other high-risk cohorts. However, it does note that an aim of the model would be to allow specific communities to create their own Safe Spaces, including Indigenous Australians, people from cultural and linguistically diverse backgrounds and LGBTQI+ Australians[58] This may allow the evidence-based practices identified by ATSISPEP to be incorporated into the model of care.

Evidence from exemplar services

As explored in *Section 4.2* and *Appendix E: Summary of existing exemplar services,* there are a range of existing services which reflect the Safe Spaces ethos and model of care either in part or in full. While there is no service which currently replicates the full five-tiered model proposed for the National Safe Spaces Network, exploring the evidence from comparable services at each of the tiers where available provides an opportunity to understand the potential impact and effectiveness of individual parts of the model.

A significant challenge in relation to evaluations of existing services is that primarily only formative and process evaluations are available. This is due to the newness of services in the Australian context, with most comparable services having only been in place for two years or less at the time of this scoping study. In examining international services which have been operating for longer, there also appear to be challenges in maintaining the ongoing contact with service users necessary to undertake outcome evaluations – particularly longitudinal studies. If the Commonwealth opted to pursue investment in a National Safe Spaces Network, there may be benefit in the frameworks for outcomes and impact evaluation being built into the delivery from the start, to strengthen the evidence base on this area of suicide prevention practice.

Despite these limitations, prior evaluations of Safe Spaces-type services in Australia and internationally can provide useful insights on this model. KPMG has reviewed evaluation findings from a selection of the services discussed in *Section 4.2*, along with those for the Aldershot Safe Haven Café and Maytree House services operating in the UK and the Living Room in the USA. Consultation with stakeholders indicates the two UK-based models are often cited as a source of inspiration and 'proof of concept' for the Safe Spaces approach.

The Aldershot Safe Haven Café is operated by the Surrey and Borders Partnership NHS Foundation Trust in the UK – a body with some parallels to an Australian PHN. In operation since 2014, it provides a place for people experiencing mental ill-health or crisis to seek support from NHS workers and community-sector partners. The Café was established to provide an alternative to the Emergency

Department for people seeking help with their mental health. Operating at night and on weekends when other services are closed, it offers guests the opportunity to simply talk and be listened to, while also providing links to more formal supports if these are needed. Guests can drop in to the service and do not need a prior referral or to have been engaged with mental health services to access the Café[59] The Aldershot Safe Haven Café is comparable to a Tier 4 service within the National Safe Spaces Network.

The Living Room is a crisis respite service funded by the State of Illinois in the USA. It provides an out-of-hours drop-in centre for people experiencing acute crisis that would otherwise see them present to an Emergency Department. This includes people experiencing suicidal distress but also encompasses people with severe mental health challenges such as psychotic symptoms, panic attacks and severe depression. The service is staffed by a mix of mental health clinicians, counsellors and peer support workers, with a strong emphasis on non-clinical supports. The peer counsellors take the primary role in supporting guests to reduce their sense of crisis, develop safety plans and explore coping skills. The service deliberately seeks to offer a comforting environment that replicates the feeling of a familiar living room at home[60] The Living Room appears to provide services which would be equivalent to those intended to be offered through both Tier 3 and 4 services within the National Safe Spaces Network model.

The Maytree House is a residential service run by a not-for-profit organisation in London, UK. The service offers a free four-day, five-night stay for people who are experiencing severe suicidal crisis and seeking non-clinical support to explore their thoughts and feelings. The service is staffed entirely by non-clinical personnel, with guests being supported by a mix of full-time paid staff and volunteers. During a stay at the Maytree House, guests are encouraged to talk about their suicidal thoughts and underlying drivers of their distress, and are supported to develop strategies to help manage these after they leave the service. Guests are generally referred to the Maytree House through GPs or other mental health practitioners, although they can also apply directly to the service for a residential stay[61] The Maytree House is equivalent to a Tier 5 service within the National Safe Spaces Network proposal.

Evaluations from the overseas and other Australian-based services generally focus on their impacts in three areas: their capacity to help guests reduce and manage distress; the quality and appropriateness of services as assessed by guests; and their impact on Emergency Department presentations as well as other services such as police and ambulance call-outs. Collectively, the evaluations point to strongly favourable findings in relation to these first two metrics but more qualified findings for the third.

KPMG could not identify any evaluations or analysis of services which are directly comparable with the Tier 1 and 2 services proposed within the National Safe Spaces Network. For this reason, the following discussion only summarises the evidence base relating to services equivalent to Tiers 3 to 5 of the proposed model. Further information on the findings discussed here is included in *Appendix F: Summary of evaluation findings from comparable services.*

Impact on levels of guest distress and perceived wellbeing

A majority of the evaluations reviewed as part of this scoping study indicate that Safe Spaces-type services can help reduce the distress of guests in the short term, with some evaluations indicating this effect may persist for some time after a visit. For example, 90 per cent of guests surveyed for an evaluation of the Aldershot Safe Haven Café indicated they felt better able to manage their distress after having visited, and 89 per cent agreed that service had helped them get through a difficult time[62] Similarly, an evaluation of the Maytree House found that for a sample of guests who undertook the CORE assessment, there was a statistically significant improvement in perceived wellbeing and functioning and reduced perception of risk and problems between a pre-test undertaken at time of admission and a post-test delivered at time of leaving the house. Among a subset of the evaluation cohort who participated in follow-up screening between three and six weeks later, further reductions

in distress were also observed but the authors note these were not at a level indicating statistical significance[63] Similarly, guests who were surveyed as part of an assessment of The Living Room reported an average decrease of 2.13 points on the Subjective Units of Distress Scale between arriving at the service and leaving it[64] Participating guests in an evaluation of the St Vincent's Hospital Safe Haven Café also indicated they were able to use the Café as part of their coping plan until their confidence in self-management improved.

It should be noted that none of these evaluation findings were based on randomised controlled trials. In most cases they also depended on participants 'opting in' to participate in the research. This may bias the selected samples towards guests who have had a very good experience using these services. However, the strongly positive response suggests that at the very least, services equivalent to Tier 3, 4 and 5 services within the proposed model can help some sub-set of their guests manage and reduce their levels of distress, resulting in an improved sense of wellbeing.

Perceived service quality and appropriateness of supports

The alignment of services with the needs of people experiencing distress and crisis is an important indicator of their effectiveness. The evaluations of Tier 3 and 4 equivalent services reviewed for this analysis indicate very positive responses from guests about the quality and appropriateness of the supports provided through these. In the case of the Brisbane North Safe Spaces pilot, 96 per cent of surveyed guests reported finding their visits to the Safe Spaces useful and 87 per cent indicated they would attend a Safe Space again in future as part of self-managing their distress[65] Among surveyed users of the Aldershot Safe Haven Café, 94 per cent agreed the service offered them a safe place to go and 83 per cent said the supports available had equipped them to make more informed choices about their support needs[66]

While the same limitations apply here in relation to the selective nature of the participating guests, these findings suggest the model of care and supports offered through these services is well received by people experiencing crisis and distress. Importantly, most of these evaluations of Tier 3 and 4 equivalent services also identified that the services had significant repeat visitation by guests. This provides a practical demonstration of their perceived value if a large number of guests are willing to repeatedly come back.

The evaluation of the Maytree House did not include formal metrics in relation to client satisfaction, but a separate, small qualitative research project found that around 40 percent of guests had had a transformational experience accessing the service. These guests described Maytree as having "saved" or "changed" their lives, with one guest reporting feeling "reborn" after their stay[67]

Impact on Emergency Department presentations and demand for other services

With the exception of the Maytree House, each of the services reviewed for this analysis had an explicit objective to provide guests with an alternative to Emergency Departments and/or reduce the number of people presenting to hospitals for care. The evaluation findings suggest this outcome is more complex to measure than may have been anticipated when services were established, and data limitations can confound clear findings.

For example, in the case of the St Vincent's Hospital Safe Haven Café, data issues emerged in the identification and coding of mental health presentations within the Emergency Department. The inconsistent reporting of these presentations made it difficult to determine the impact of the Safe Haven Café on Emergency Department presentations. However, guests self-reported attending the Café on nights when it was open while still attending the Emergency Department on nights that it was not, suggesting the Café has supported a reduction in presentations at least during its opening hours[68] Similarly, of a sample of Aldershot Safe Haven Café guests who had previously attended an Emergency

Department for their distress before visiting the service, 53 per cent showed a decrease in hospital attendance in the months after using the Café. A further 19 per cent of guests showed no change in their use of Emergency Departments while 28 per cent actually increased their attendance[69]

As will be discussed in *Section 4.4*: *Outcomes,* increased hospital attendance could be considered a positive outcome if this group is made up of people who have never previously sought any kind of help to manage their distress and crisis. Some stakeholders have also questioned whether it is appropriate to seek to actively divert potential users from Emergency Departments if that is the service channel which best suits their needs at a particular moment of crisis. This highlights the complexity of assessing the potential impact of Safe Spaces on other services in a context as complex as suicide prevention. In the short term, data collected by The Living Room indicates that in 93 per cent of cases guests visiting the service had come there as an alternative to presenting to an Emergency Department[70] Similarly, around 90 per cent of guests to the St Vincent's Hospital Safe Haven Café were referred there by a peer worker based in that hospital's Emergency Department[71] This suggests these services do attract guests who may otherwise have attended hospital on some specific occasions.

Interestingly, the Aldershot Safe Haven Café does appear to have had a positive impact on police callouts since its implementation in 2014. The evaluation of that service found calls to police identified as mental health-related had decreased by 42 per cent within the service's catchment area. Across the wider region, the number of such callouts remained static. Police detentions under the UK's Mental Health Act also fell within the catchment area after the Safe Haven Café opened, and were consistently lower both than other parts of the region and national averages from 2014-15 to 2016-17[72] The evaluation report's authors note that there may have been several parallel drivers for this change, and the lack of a control group makes it difficult to attribute causality to the presence of the Safe Haven Café. But by providing first responders with somewhere safe and appropriate to take people experiencing distress and crisis other than a police watch house, the service may have helped reduce the number police felt compelled to take into custody.

It is not clear from the evidence reviewed for this analysis that Safe Spaces-type services are effective at diverting people experiencing distress or crisis from Emergency Departments, or whether this is an appropriate metric to apply in assessing these services. There are a number of factors which make it challenging to form clear conclusions here, including data collection limitations, the complexity of people's needs at different times in their experience of suicidality, and the fact that none of these services are open fully comparable hours to local Emergency Departments. It should also be noted that each of the services discussed here was relatively new at the time of evaluation. This may have meant levels of awareness about their availability were not sufficiently high as to drive a clear change in behaviour. The impact of Safe Spaces-type services on demand for Emergency Departments and other emergency response services is an area that will require further examination as these services mature.

Overall, the available evidence from existing services equivalent to Tier 3, 4 and 5 Safe Spaces indicates they can help guests to reduce distress and improve perceived wellbeing. Guests also generally report strong satisfaction with these services and close alignment between the supports provided and their needs. These evaluations do not offer clear support for the suggestion that these services help divert people experiencing crisis and distress from Emergency Departments overall or reduce service demand. However, they clearly have capacity to do so for some guests on some specific occasions.

These findings should be qualified by acknowledging that all are based on small, non-random samples of relatively new services, but point to promising outcomes in some important areas.

It is also important to note that implementation of the full five-tiered approach outlined in the National Safe Spaces Network proposal may lead to outcomes or benefits which are not captured when considering services operating at each individual tier. For example, the development of a national network may help to improve understanding and awareness of suicide risk, reduce stigma and improve service integration for people experience distress and crisis. These are positive outcomes which potentially arise from the *national network* aspects of the proposed model, with each individual service building towards a greater whole. The feasibility of achieving these potential benefits cannot currently be assessed because there is no equivalent network of services in operation within Australia or internationally[5]

In addition to exploring available evidence from exemplar services, KPMG has also reviewed the evidence base on relevant aspects of the model of care underpinning the Safe Spaces approach. The following section briefly summarises available evidence on the effectiveness of brief contact interventions and peer supports in supporting people at risk of suicide.

Brief contact interventions

In recent years there has been a focus on brief contact interventions as a potential avenue for reducing suicide risk without the service infrastructure and investments required for more traditional clinical or therapy-based interventions. The approach is based on short contacts with people at risk of suicide through a one-off face-to-face meeting, followed by regular and repeated short contacts by text message, phone call, email or post. Brief contact interventions have particularly been tested in the context of supporting people after a suicide attempt, given the high risk that people in this cohort will make a further attempt. Brief contact interventions do not assume any deep pre-existing relationship or the provision of clinical care. Rather, they simply aim to provide support to an at-risk person during a vulnerable time, and connect them with help if they need it[73] This underlying approach is relevant to Safe Spaces as users of the services may have had no prior contact with the network, nor be engaged in any other form of ongoing care. An individual visit to a Safe Space within the network may therefore be analogous to a brief contact intervention, particularly if this is then followed up by phone calls, text messages or other contacts.

Brief contact interventions have been tested through randomised controlled trials in a variety of contexts both internationally and in Australia. Literature reviews and meta-analyses of these studies tend to report mixed and inconclusive findings,[74] although some individual studies have shown strongly positive results. For example, the World Health Organisation sponsored a randomised controlled trial in five countries in which a selection of people who had attempted suicide received one face-to-face de-briefing, followed by repeated short contacts by phone, text message and postcard over the following 18 months. The study found people in this treatment group were significantly less likely to have died by suicide during this time than people who did not receive these brief contact interventions.[75] Qualitative studies have also identified positive effects on the wellbeing of individuals receiving brief contact interventions, and a greater sense of connection with others which helps counteract the loneliness associated with suicide attempting[76]

Brief contact interventions have only rarely been tested with people experiencing distress and crisis who have not previously made a suicide attempt or engaged with services. One study which did so found that people receiving a single face-to-face therapeutic intervention reported reduced levels of

[5] One useful point of comparison may be the national headspace network. The network's objectives include breaking down the stigma associated with mental illness and increasing help-seeking among young Australians. The effectiveness of headspace in achieving these objectives is currently being assessed through the 2020 Independent Evaluation of the National headspace Program. The findings of this evaluation may be a useful point of reference in further considering network effects in mental health service delivery and the benefits arising from these.

suicidal ideation, depression and anxiety, although their outcomes were not significantly different from the control group[77] The inconclusive findings to date on the effectiveness of brief contact interventions has made this an area of ongoing research focus. Having assessed the available evidence, the Royal Australian and New Zealand College of Psychiatrists does recommend service providers consider including these interventions within the package of supports provided to people at high risk of suicide, particularly following a suicide attempt[78]

None of the services tested through these studies directly replicate the service model proposed for the National Safe Spaces Network. However, they do provide some support for the underlying notion that brief contacts with people at risk of suicide outside of a clinical or ongoing service delivery context can play a role in helping manage distress and crisis.

Peer workforce

The intention for Safe Spaces to be delivered as peer-led, non-clinical services is a critical component of the proposed model. Peer support in suicide prevention represents a departure from traditional models of care, which assume that people experiencing distress and crisis need expert clinical intervention[79] The peer support approach instead prioritises warm, compassionate listening and support provided by people who have a shared lived experience. It has been described as a "system of giving and receiving help, founded on key principles of respect, shared responsibility and mutual agreement of what is helpful"[80]

There is a large literature on peer support in mental health and drug and alcohol addiction services, with peers being considered to have an important role to play in recovery and ongoing maintenance of wellbeing for people experiencing major mental illness or addiction[81] The role of peer supports in suicide prevention has been less well examined, although this appears to be an area of growing focus[82] For example, a recent randomised controlled trial in the USA paired peer support workers with adult psychiatric inpatients who were at high risk of suicide. The study found those receiving peer support were significantly more positive about the range of supports available to them than those in the non-treatment group. The participants also reflected positively on the peer workers' abilities in relating, listening and providing support specifically during discussions about suicide[83] Several studies have examined the role of peer supports in suicide intervention and prevention among young people, with the common findings that peer support can change perceptions about suicide, strengthen self-esteem and improve community awareness of suicide risks[84] A study of peer supports specifically provided to US military veterans has also identified positive benefits in relation to earlier identification and referral to services for people at risk who may not otherwise have been connected with support[85]

There is limited literature on the role of peer supports in preventing suicide or reducing suicide attempting. Advocates such as Calleja (2019) have argued that focusing on these specific metrics represents a 'risk averse' approach[86] The alternative is a 'life promoting' approach which focuses on the role peer supports can play in helping people manage their experience of distress and crisis, developing an improved sense of connection to others and linking in with services that can address their unmet needs.

Viewed through this lens, the available evidence for peer supports in general – and the emerging evidence regarding their use in supporting people at risk of suicide – points positively to their effectiveness.

While this remains an area that needs further investigation and research, the evidence in support of peer workers is sufficiently positive that the Australian Government has issued specific guidance for PHNs on their incorporation into mainstream service delivery. The guidelines recommend the development and implementation of services incorporating peer workers to support the provision of person-centred, recovery-oriented and trauma-informed stepped care[87]

Evidence base – conclusions

The research findings presented in this section should be considered in parallel with the strong indications of expressed need by people with lived experience and the supportive stakeholder feedback presented in *Sections 4.1* and *4.2*. While the evidence for Safe Spaces-type services and their underlying service model elements are not clear cut, this is not unusual for a relatively new and innovative service approach. The discussion in this section indicates the proposed approach is aligned with effective suicide prevention practice as it is currently understood, particularly in relation to the delivery of multiple and layered supports at the community level. The strongest benefits identified to date have been in relation to offering a more positive support experience for people experiencing in crisis and improving connectedness – both with others and with appropriate services. Benefits which will require further examination as the model of care is implemented in more places and existing services mature include the impact on demand for Emergency Departments and other crisis services, and any changes in the prevalence of suicide and attempted self-harm.

4.4. Outcomes

Having explored the service need and evidence base for a National Safe Spaces Network, it is also important to consider the intended and potential outcomes for this service. Outcomes can be defined broadly – as the social benefits that are generated by an activity or service, or narrowly – as the specific chain of results from an activity or service being delivered in a particular way by a particular agency. Many health and human services have specific outcomes they target and monitor progress against using key performance indicators, with these outcomes being selected because they support broader social benefits. KPMG has considered both these broad and narrow definitions in exploring the outcomes a National Safe Spaces Network may support.

Summary of findings

- The National Safe Spaces Network would seek to achieve outcomes at both a whole-of-network level and an individual service level. Potential target outcomes have been defined through examination of the proposal and stakeholder consultation, but would require further consultation and co-design with people with lived experience.
- Comparable services typically target both individual and service system outcomes. Individual outcomes are primarily measured using qualitative measures of guest experience and wellbeing. Services generally attempt to measure system outcomes using quantitative data on Emergency Department presentations and other system demand, but have experienced significant challenges in doing so.
- Comparable services have experienced challenges with the collection of qualitative data because vulnerable guests often do not wish to participate in data and feedback activities. Some services have been able to overcome these by personalising the collection approach.
- Inconsistency in data collection relating to Emergency Department presentations and other system use has also made tracking system outcomes difficult for comparable services. Some stakeholders questioned the appropriateness of these and other system-wide outcomes as indicators of performance for a National Safe Spaces Network given these data challenges and complexities relating to help-seeking by people at risk of suicide.

The core proposal identifies a range of aims and objectives for the network. After consideration and discussion of the model's objectives with the Expert Advisory Group, KPMG has grouped these into three broad categories as outlined in Table 7 below.

Table 7: Stated aims and objectives of the National Safe Spaces Network

Aims and objectives identified in core network proposal	Suggested grouping
• Making it easy for people to know where to go and how to access the appropriate level of support they need when experiencing suicidal crisis or distress • Offering a national level intervention in suicide prevention that would be cost effective, linked to existing services, and complements existing clinical services, providing multiple pathways to care • Allowing specific communities to create their own Safe Spaces, including LGBTQI+, Indigenous Australians and culturally and linguistically diverse communities • Complementing existing clinical services, providing multiple pathways to care	Giving individuals access to appropriate, accessible support that meets their unique needs and preferences
• Fostering a multi-pronged approach through partnering at the state level, engaging state and Commonwealth governments to work together, including central agencies such as Attorney General's offices and Coroners • Engaging Local Hospital Networks and PHNs in mapping, disseminating information, educating about and scaling the Safe Spaces network • Recognising the many rural communities already employing parts of this model unofficially and bringing greater visibility to Safe Spaces • Being easily implemented as an adjunct to other programs	Improving coordination and knowledge sharing across the community, service providers and families and loved ones to deliver more comprehensive and individually tailored support for people at risk of suicide
• Mobilising lived experience of suicide peer involvement within community networks • Creating opportunities for community capacity building as groups provide Tier 1 Safe Spaces and receive training to meet accreditation requirements	Building community capacity to engage with, and support, people at risk of suicide

If these three categories were adopted as the broad social outcomes or benefits that a National Safe Spaces Network aimed to achieve, they would be well aligned with the service need and evidence-based suicide prevention practices discussed in the previous two sections.

These would, however, need to be tested and developed further with people with lived experience of suicide and the service sector as part of the ongoing development of the proposed model.

These broad social benefits could apply across the network as a whole. More specific and measurable outcomes would then need to be defined for individual services operating within this. Reflecting the multi-tiered nature of the proposed model, it may be appropriate for services aligned with each tier to have a common set of target outcomes and shared metrics for tracking these. This would support effective comparison of Safe Spaces within tiers and allow for the identification of best-practice approaches which can support ongoing quality improvement at each tier. However, it should be noted that individual Safe Spaces are intended to provide a highly local service offering which is closely tailored to the needs of individual communities. In this context it may not be especially meaningful to compare services with each other, even within tiers. The feasibility of this would depend on the target outcomes chosen and how broad or specific these are.

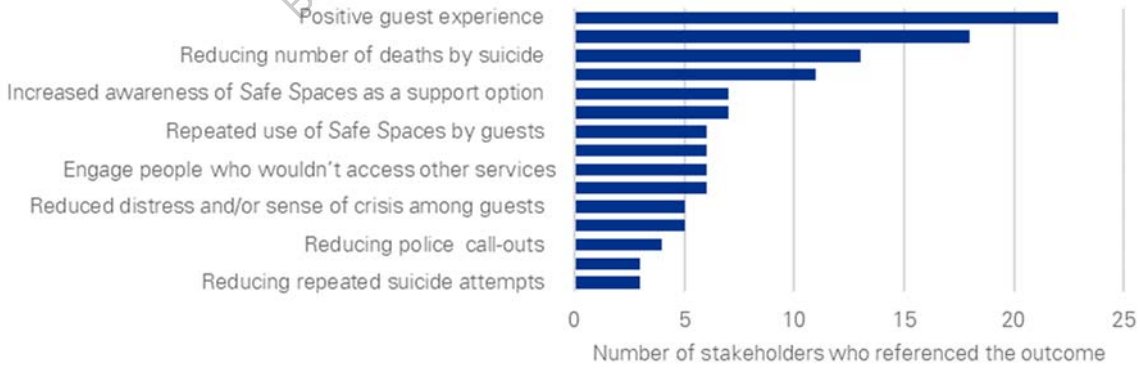
The National Safe Spaces Network proposal does not reflect on outcomes at the individual tier or service level. KPMG has therefore examined potential service-level outcomes for Safe Spaces through two channels. First, we reviewed the target outcomes set by exemplar services currently operating in Australia and internationally to understand how they approach the definition and measurement of these. KPMG also sought views and input from stakeholders on what appropriate outcomes for services operating within a National Safe Spaces Network may be, and feasible ways to measure them.

The outcomes and measurement tools employed by key exemplar services are detailed in *Appendix E: Summary of existing exemplar services*. This analysis indicates services aligned with the proposed Safe Spaces model typically target outcomes at two levels: the individual and the service system. At the individual level, focus outcomes relate to the quality of experience provided by the service itself and alignment with guest needs, as well as the capacity of services to help guests reduce and manage their distress. These are primarily measured through qualitative indicators which prioritise the perspectives of guests as the main indicator of interest.

At the system level, it is common for services to explicitly target the diversion of people experiencing distress and crisis from Emergency Departments and reduced demand for acute clinical services. Quantitative data on mental health presentations, hospital admissions and other first responder call-outs is generally used to track these system outcomes.

This mix of individual and system-level outcomes was also reflected in feedback from stakeholders about the appropriate target outcomes for Safe Spaces, as shown in Figure 11.

Figure 11: Potential target outcomes identified by stakeholders



Source: KPMG (2020)

While some stakeholders acknowledged that there would be differences in the outcomes targeted and achieved across the individual tiers of a National Safe Spaces Network, there was limited discussion of

what this may mean in practice. Considering the commonly raised options in Figure 11 suggests stakeholders were particularly focused on outcomes that may be relevant to the higher tiers proposed for the network, as a number relate to situations of severe distress and crisis. To consider potential differences between tiers further, KPMG has categorised these outcomes according to their relevance by tier along with potential data sources or indicators. This matrix is detailed in Table 8 below.

Table 8: Stakeholder-identified target outcomes by service tier

Relevant tiers	Proposed outcomes	Potential data sources
All	Positive guest experience	Qualitative – self-reported experience of guests
	Reduced distress or sense of crisis among guests	
	Increased sense of self-worth and connectedness among guests	
	Increased connectivity of guests with appropriate services	
	Engagement with people who wouldn't access other services	
	Empowering people to create safety and problem-solve for themselves	
	Repeated use of Safe Spaces by guests	Quantitative – service attendance data; market awareness surveys; service system data
	Increased awareness of Safe Spaces as a support option	
Tiers 4 and 5	Reduced ED presentations and use of medical supports	
	Reduced police call outs	
	Reduced deaths by suicide	
	Reduced repeated suicide attempts	
	Reduced suicidal ideation	

Relevant tiers	Proposed outcomes	Potential data sources
Tiers 1 to 3	Increased community confidence in supporting people at risk of suicide	Qualitative – self-reported views of community members and delivery partners

Identifying appropriate outcomes that are specific to the lower tiers may have been more challenging for stakeholders the nature of their service offerings is less clearly defined than Tier 4 and 5 services. However, it may also be the case that the general outcomes identified above as applying across all tiers would be sufficient to address the intent of these lower tier services. In this case, it may be appropriate to have a core set of general target outcomes that services at all tiers monitor performance against, with the higher service tiers then having additional target outcomes reflecting their more intensive service role. This is similar to the approach proposed for governance and accreditation discussed in *Section 4.5*, where levels of external accountability would increase with service acuity. In the event this approach was adopted, it would be important to balance the number of general outcomes that are potentially of interest with the feasibility of monitoring and reporting against these for small and community-led services operating at the lower tiers.

While all of the potential target outcomes identified by stakeholders are likely to have significant social value, the discussion of available evidence in Section 4.3 suggests they are not likely to be equally measurable or achievable. The exemplar services have tended to demonstrate strong results in relation to the individual-level outcomes, but more mixed or inconclusive results in terms of system outcomes.

This highlights a number of challenges in the observation and collection of data inputs for measuring outcomes which would be important to consider in planning for delivery of a National Safe Spaces Network.

Data collection and measurement challenges

Reviewing project implementation and evaluation reports from exemplar services identifies several common issues in collecting appropriate data to track progress against target outcomes. The experience of these services also raises some challenging questions about how to measure outcomes in a service context as complex as suicide prevention.

In relation to data collection, the St Vincent's Hospital Safe Haven Café, Brisbane North Safe Spaces Network and Way Back Support Service appear to have experienced similar challenges in that guests accessing these services frequently do not want to complete feedback surveys or engage in other data collection activities. This is understandable given people generally access these services at times of distress or vulnerability. The St Vincent's Hospital Safe Haven Café initially provided iPads for guests to record their responses to a guest feedback questionnaire, but found that they were reluctant to do so without assistance from staff. This meant that data was often not collected during peak periods when staff were busy supporting guests. Guests were also found to be reluctant to participate in focus groups. Ultimately, the service identified that having staff sit with guests and complete a paper-based form was the most successful way of engaging them to share feedback and background information for the purpose of data collection[88] During an initial pilot of the Way Back Support Service in the Northern Territory, it was also observed that Support Coordinators often did not request or record key

data because of a concern this would interfere with their relationship with the client[89] Self-selection was identified to be a further challenge to robust data collection across each of the evaluation and project reports reviewed, with only a small subset of service users generally participating in any data collection exercise. This has made it challenging for services to understand how representative any qualitative findings are.

These insights are important because in consultations, stakeholders consistently emphasised that the experiences and perspectives of guests should be the primary outcomes of interest for both the national network and individual Safe Spaces. Qualitative tools including surveys, focus groups and direct feedback channels were generally considered to be the most effective and relevant mechanisms for collecting this information and using it to inform the ongoing development and delivery of Safe Spaces. The experience of existing services indicates that the ability to easily collect this data in a meaningful and robust form should not be taken for granted. However, services like the St Vincent's Hospital Safe Haven Café have also demonstrated that these challenges can be overcome by trying different collection approaches to find one that suits guests, and allocating appropriate staff resourcing to this task.

A majority of the exemplar services have also experienced challenges in relation to the availability and quality of data tracking their impact on system outcomes. In particular, identifying whether services have diverted people from Emergency Departments has been found to be very difficult both because of data and underlying cohort challenges. The evaluations of the Way Back Support Service, the St Vincent's Hospital Safe Haven Café and Aldershot Safe Haven Café all highlight issues with inconsistent coding and reporting of presentations to Emergency Departments, which makes it difficult to establish baseline presentation numbers to compare against and ongoing outcomes. Some services have turned to alternative metrics such as asking guests where they would have gone if the service was not available to measure diversions instead[90] Tracking system outcomes is also difficult because a large number of people experiencing suicidal distress and crisis may never have previously accessed any kind of services. Stakeholders highlighted this can mean people in this cohort who engage with these services are not counted as having 'reduced' the demand for other services because they were not previously using these.

This point raises a broader, challenging question about what success looks like in the context of support for people at risk of suicide. In consultations, a number of stakeholders highlighted that suicide prevention interventions can sometimes drive up presentations to Emergency Departments and other acute services, because people are seeking help who may not otherwise have done so. Evaluations of some of the exemplar services have similarly identified increased uptake of other services among some of their guests[91] In the context of the target outcomes set for the exemplar services, this would represent a failure of their models. However, it could equally be viewed as a success because more people are reaching out for help to stay alive. For this reason, many stakeholders reflected that diversion from Emergency Departments is unlikely to be an appropriate target outcome for the National Safe Spaces Network, while noting there is potential for this to be a beneficial side effect of the network's delivery. One representative of a first responder organisation suggested that this entire conversation would benefit from being re-framed away from 'diverting people from the Emergency Department' in favour of a focus on 'helping people find the appropriate care pathway for their needs'. In this framing Safe Spaces would not be presented as *alternatives* to EDs, but as *one among of a range of services* that may be appropriate to meet a person's needs in their time of distress.

A significant number of stakeholders also identified reducing the number of deaths by suicide and self-harm attempts in Australia as potential target outcomes for the National Safe Spaces Network. These were often raised in a context of being overall objectives for any suicide prevention service, with stakeholders acknowledging that the complexity of suicide would make it difficult to link observed changes to any single service. Other stakeholders argued that while it may not be reasonable to use overall suicide rates as an outcome of interest for Safe Spaces, reducing rates of repeated self-harm

among guests of the network is a more tangible indicator which could be tracked with some rigour. The Way Back Support service has explicitly examined this in the context of its Northern Territory and Hunter region trials, with inconclusive findings[92] The extent to which these high level outcomes can meaningfully be linked to individual services is an area that would warrant further in-depth examination with expert suicide prevention researchers.

Selection and measurement of outcomes – conclusions

The effective measurement and tracking of suitable outcomes is often challenging for health and human services. The difficulties faced by previous exemplar services and explored here reflect those which are often seen in other areas of service delivery for vulnerable people, such as domestic and family violence and services for Aboriginal and Torres Strait Islander people. Some of these challenges can be overcome through the development of sensitive and appropriate data collection methodologies, and there would likely be valuable learnings from both of the above sectors for a National Safe Spaces Network. However, they also call for careful consideration of the underlying target outcomes selected, to avoid an innovative new service being 'set up to fail'.

In discussions with the Expert Advisory Group, it was particularly highlighted that the appropriate target outcomes for a future network are likely to change over time as the model matures and develops. Attaching overly prospective or aspirational outcomes to the new service at its inception has the potential to undermine balanced observation of the model's potential. The experience of the exemplar services discussed here suggests that focusing on the experience of guests who engage with the network and their perceptions of its effectiveness is likely to be a more appropriate approach in the early stages of service development. This focus would also align with the strong feedback from stakeholders that user perspectives should be the primary outcome of interest. Additional target outcomes may then be able to be identified and applied as governments, guests and the broader sector develop a deeper familiarity with the network and individual services within it.

4.5. Governance and accreditation

As a service model that is intended to support very vulnerable people, governance and accreditation are critical considerations for the proposed National Safe Spaces Network. In the health and human services context, governance describes a set of relationships and processes which aim to ensure high-quality, safe and appropriate service delivery. Governance can address corporate and clinical aspects, with these two components both playing an important role in the oversight and effective day-to-day delivery of services. This section of the report considers the governance requirements of a National Safe Spaces Network and examines the models adopted by other suicide prevention, mental health and community services to seek insight on potential models.

Accreditation is also an important foundation for quality service delivery. Accreditation frameworks set out the standards that organisations must meet, and provide criteria for monitoring their performance against these. There are a range of existing national accreditation frameworks used in the health, mental health and community services sectors which may be relevant to the National Safe Spaces Network. This scoping study has examined the strengths and weaknesses of these frameworks in the specific context of the proposed service, while also considering the feasibility of adopting a more bespoke accreditation approach.

Summary of findings

- Stakeholders identified a potential role for the Commonwealth in developing the national policy, governance and accreditation architecture for a National Safe Spaces Network. There was a strong view that this work would best be undertaken in close coordination with other levels of government and community partners.
- There is likely to be a need for both national, whole-of-network governance structures and service-level structures to support safe and high-quality service provision within the proposed network. Services such as headspace, Lifeline and the Royal Flying Doctor Service provide different potential models to address these multi-level governance requirements.
- Stakeholders have a strong and unified view that people with lived experience should play a central role in the governance of the proposed national network at all levels – from whole-of-network oversight and coordination to leadership of local services.
- The optimum governance model for a National Safe Spaces Network would need to be guided by decisions about the role of different levels of government and other delivery partners.
- Existing national accreditation standards used within the health and human services sector are not likely to suit the requirements of the proposed network. However, the recently released Suicide Prevention Australia Standards for Quality Improvement provide a promising sector-specific accreditation approach.

Key considerations for a National Safe Spaces Network

When determining the governance and accreditation settings for a National Safe Spaces Network, there are a range of considerations that would need to shape the chosen approach. Based on discussions with the Expert Advisory Group, stakeholders and KPMG's review of the proposed service model, these include:

- **Wellbeing of guests** – Safe Spaces guests will be people experiencing distress and crisis – in some cases at very acute levels. Protecting the wellbeing of guests and ensuring they receive appropriate support – including supported connections to other services if necessary – is a priority objective that governance and accreditation frameworks must support.
- **Diversity of delivery partners** – Individual Safe Spaces may be delivered by a wide range of partners with varying levels of professionalism – from local volunteer community groups with no paid staff in Tier 1 to full-time, dedicated service providers in Tier 5. The network's governance and accreditation frameworks will need to be navigable by a diversity of delivery partners.
- **Spectrum of service delivery** – The services proposed to be delivered through the lower tier Safe Spaces are quite different from those intended to be delivered at the highest tiers. The severity of need by guests and the risks associated with this are also expected to vary significantly by tier. The governance and accreditation approaches adopted would need to be flexible enough to address these differences so that the specific requirements and risks associated with each tier are appropriately addressed.
- **National consistency** – The intention of this model is that guests can access a Safe Space at a tier appropriate to their needs wherever they are across Australia, with this service providing a consistent and reliable standard of care and support. Achieving national consistency across a distributed delivery model potentially involving a diversity of local partners is a key challenge that will need to be addressed through the governance approach and accreditation frameworks.
- **Layers of accountability** – Individual Safe Spaces services may have multiple accountabilities depending on their funding structure. For example, Safe Spaces funded by governments will be directly accountable to those funding partners, while services commissioned by other local partners such as PHNs or non-government organisations will be accountable to those commissioning agencies. There may also be Safe Spaces which are run on a voluntary or community basis and have no direct accountability to any other body. The integration of these services into a national network may then also require additional accountabilities to a national coordinating body to achieve the objectives of quality and consistency in service delivery Australia-wide. These intersecting accountabilities have the potential to add significant complexity to how governance and accreditation frameworks are applied to individual Safe Spaces.

These considerations have informed KPMG's examination of the governance and accreditation models discussed throughout this section. During the consultations, we also sought views on the potential roles the Commonwealth and other partners may play in the governance of the proposed network.

There was broad agreement from stakeholders that there would be value in the Commonwealth coordinating closely with state and local governments and community-led organisations to support the governance of a future National Safe Spaces Network. Concern was frequently expressed that if the Commonwealth did not work collaboratively with these other partners, this would add to the current complexity and fragmentation of the service landscape. At the same time, stakeholders acknowledged the important role the Commonwealth could play in developing the national architecture for a National Safe Spaces Network. It was often noted that this is a role *only* the Commonwealth can play because individual states and territories do not have a national perspective or line of sight to activity in other jurisdictions.

Stakeholders identified that an effective national network would need to be guided by an overarching philosophy of care, service principles, governance approach and quality standards to ensure a degree of consistency in what is delivered across individual sites. The Commonwealth could take a leading role in developing, disseminating and maintaining these components, in close consultation with other partners including people with a lived experience of suicide. Alternatively, some stakeholders and Expert Advisory Group members suggested this work could be auspiced by the Commonwealth but carried out by a national lived experience body or leadership group.

Importantly, there was a consensus that any national governance approach would need to be flexible enough to be adapted to community needs and should not be overly proscriptive. State government representatives also emphasised the importance of considering the guiding principles that are already used to deliver similar services in states and territories across Australia as part of this process. In particular, there was a concern about any national approach ending up representing a 'lowest common denominator' in order to secure broad agreements by all jurisdictions.

It should also be mentioned that some stakeholders expressed reservations about the development of a national architecture at a time when Safe Spaces-type services are still being developed and piloted around the country. These stakeholders indicated this may be work that is better left until there is more local evidence and information available about what works in the context of community- and peer-led suicide prevention services. This would allow the future national frameworks to be informed by a stronger evidence base. These are considerations the Commonwealth would need to weigh closely if it opted to pursue the proposed model further.

Governance models

The National Safe Spaces Network proposal does not discuss governance in detail, beyond noting that this would need to be addressed as part of service development. As a starting point for considering this aspect of the model, KPMG has examined the governance structures of a range of health, mental health and community services organisations to identify core common features. These typically include:

- **A board** – providing strategic direction and oversight. In health and mental health services it is common for board members to have a mix of service delivery, clinical, corporate and sector-specific expertise. Increasingly too, organisations are working to ensure the perspectives of people with lived experience or service users are reflected on their boards through dedicated positions for these representatives.
- **Advisory bodies** – As an alternative or addition to lived experience and consumer representation on boards, many organisations have advisory bodies made up of these representatives which provide input to both boards and executive teams. The focus of these advisory bodies is generally on ensuring continuous alignment of services with the needs of their intended users and ongoing quality improvement.
- **An executive** – having responsibility for implementation of the strategic direction set by the board, day-to-day delivery of services, achievement and maintenance of required accreditation and reporting of progress against agreed organisational outcomes and metrics.

To achieve the national consistency and quality of support that is intended, there is likely to be a need for governance structures spanning both a national, whole-of-network level and an individual region or service level. The national governance components would need to address standard setting, service delivery requirements and other considerations such as policy across the network as a whole. Local governance components would then need to focus on ensuring services are delivered in line with these national requirements while meeting local community needs.

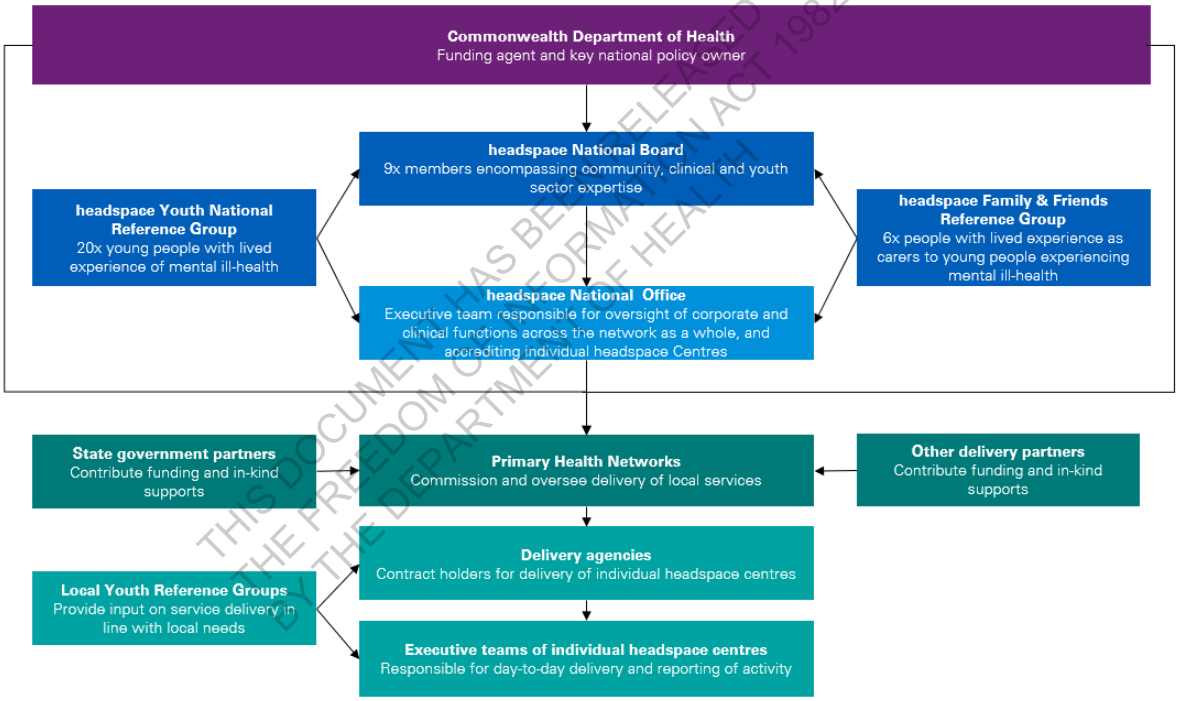
Together, these three elements support effective governance by providing for the development, delivery and oversight of services according to an organisation's agreed strategic priorities and offerings, in line with community needs and in adherence to required legislation, regulation or accreditation frameworks. These key governance structures have been adopted both by large national

organisations and individual local services. However, this straightforward model of governance does not appear to be sufficient for the proposed National Safe Spaces Network.

There are several national organisations whose governance models provide some potential learnings for a National Safe Spaces Network. Each of these works to deliver services which are tailored and responsive to local community needs, under a national governance umbrella that promotes consistency and quality of care.

The first of these is headspace, the Australian Government's flagship mental health program for young Australians. The headspace program is funded by the Commonwealth and overseen by a national board, executive and advisory groups which set and monitor service standards. It is then delivered through individual commissioning relationships between PHNs and service providers within communities, each of which establish their own local executives and reference groups to support effective governance. A high-level representation of this governance model is provided below.

Figure 12: headspace governance model

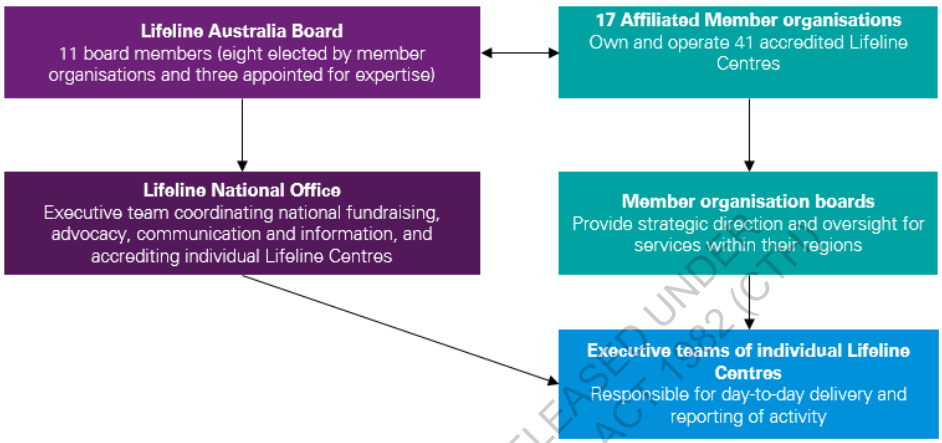


Source: headspace National/Commonwealth Department of Health

The value of this approach lies in the combination of national oversight and local accountability. Individual services are accountable to their commissioning bodies, with these bodies then engaging with the national coordinating body and the Commonwealth as their strategic partners. However, feedback from within the program suggests this model also has some weaknesses in that lines of accountability are not always clear, with local services often engaging directly with the national office or Department of Health rather than their commissioning bodies. This model also ensures young people with a lived experience of mental ill-health are involved in governance at all levels of the service through the National Reference Group and the individual Youth Reference Groups established as part of the leadership structure for each centre.

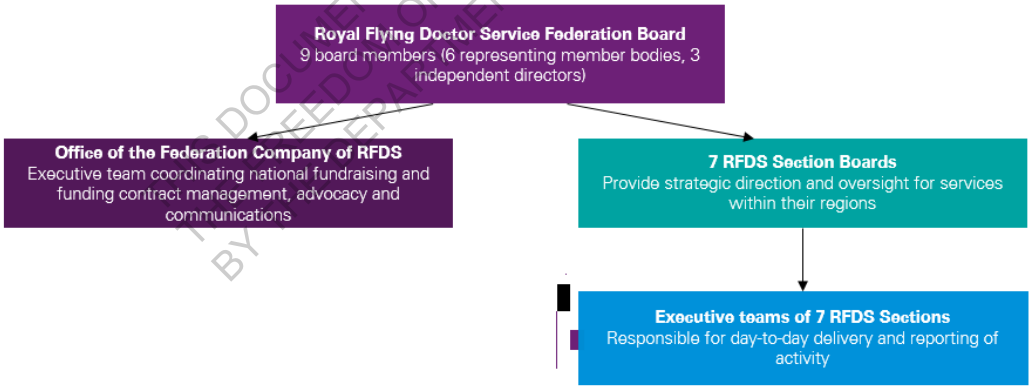
Outside of a Commonwealth service delivery context, the governance models adopted by Lifeline and the Royal Flying Doctor Service also provide potential insights for the National Safe Spaces Network.

Figure 13: Lifeline governance model



Source: Lifeline Australia

Figure 14: Royal Flying Doctor Service governance model



Source: Royal Flying Doctor Service

Both of these models rely on state or regionally based agencies to lead the design and delivery of services, with the national boards and offices then supporting coordination and shared visibility of this activity. In the case of Lifeline, the national office also has an accreditation function for individual services delivered by affiliated member organisations. These models provide for less centralised control than the headspace approach outlined above, but this is appropriate in a context where funding is not delivered primarily from a single source.

One factor which is not addressed in depth by any of these models is the role of state and territory governments. In consultations, many stakeholders highlighted the importance of involving this level of

government in the design and/or delivery of a National Safe Spaces Network. This was because of their significant existing roles in the provision of services for people at risk of suicide, and concern about making the service landscape more fragmented if Safe Spaces are not delivered in coordination with other services. Several stakeholders highlighted benefits in a co-delivery model which would see the Commonwealth and states and territories take joint responsibility for funding and implementing the national network. This approach would also require a joint governance model, with both levels of government taking an equal role in the strategic coordination and oversight of the network. The federated approach adopted by the Royal Flying Doctor Service may be applicable in this context. Instead of section boards leading delivery in each region, state and territory governments could take responsibility for doing so.

All of these models also incorporate both clinical and corporate governance components. Clinical governance is implemented differently across each organisation, but core elements include risk identification and management, ongoing measurement and monitoring of the quality of care provided, continuing professional development to ensure frontline staff maintain up-to-date skills, and feedback mechanisms for consumers and carers to monitor the quality of their service experiences. While recognising the intention for Safe Spaces to be non-clinical, the nature of the services provided and the vulnerable nature of its guests means there would also likely be strong benefits to incorporating these aspects of clinical governance into the network's broader governance architecture. Some of these aspects are discussed further later in the report in the context of the service model (*Section 4.6*) and implementation considerations (*Section 4.8*).

The suitability of these different models for a National Safe Spaces Network would ultimately depend on decisions of government about the Commonwealth's role in it. However, the analysis undertaken for this scoping study indicates the following aspects would align with contemporary governance practice and support the objectives of achieving high quality local service delivery within a coordinated national network:

- A national body with responsibility for providing standard setting, coordination, accreditation and oversight across the network as a whole – incorporating lived experience, clinical and service delivery expertise
- State or regional bodies with responsibility for aligning the national standards with community needs and preferences for service delivery, with accountability to the national body for delivery of services across their state or region – potentially led by people with lived experience and incorporating clinical and service delivery inputs
- Service-level executive teams with responsibility for day-to-day delivery of services in line with the parameters determined by the state or regional bodies, with accountability to them for this – including people with lived experience in key service leadership positions.

It should be noted that this governance model is likely to be a better fit with the higher tiers of the proposed network than the lower ones. This is because the Tier 4 and 5 elements will likely be standalone services delivered by agencies with a specific focus on suicide prevention. By contrast, the lower tiers are intended to be delivered as an adjunct to other activities and services in cafés, libraries and other community settings, by a wide range of organisations and businesses with potentially limited prior engagement with human services delivery and governance. It is not clear whether these intended delivery partners would be equipped to participate in formal governance or be willing to dedicate the resources required to do so. In the event that individual delivery partners at the Tier 1 and 2 level *were* able to establish the necessary local governance structures, keeping track of this activity in a way that supported effective oversight would be a significant logistical challenge for state or regional bodies. All of these points indicate that designing a governance approach which is appropriate for the lower tiers of the proposed model is likely to be more challenging than for the higher ones.

As highlighted by this discussion, accreditation can be closely interlinked with governance in a health and human services delivery context. Ensuring services meet and maintain the standards required for accreditation against relevant frameworks is a key responsibility for governance bodies. Having explored potential governance models for a National Safe Spaces Network, it is therefore important to also consider options for the accreditation of services within it.

Accreditation frameworks

There are several key existing accreditation frameworks developed by government and other standards bodies which guide the delivery of health and mental health services in Australia. It is important to consider how these frameworks may intersect with the proposed network given they apply to other services within the system that currently serves people at risk of suicide. However, recognising the intention for Safe Spaces to provide a new service offering which departs from current practice within this system, KPMG has also looked further afield to accreditation models used in other community contexts.

In undertaking this analysis, it was not anticipated that any single existing accreditation framework would be fully suitable to meet the bespoke needs of the proposed National Safe Spaces Network. By examining existing frameworks, the intent was to identify components that may be relevant for inclusion in a tailored accreditation approach – which would then need to be developed as part of further design of the network. In considering existing frameworks, it should also be noted that their applicability to the proposed National Safe Spaces Network is likely to vary across tiers. For example, the residential nature of Tier 5 services means these are likely to engage with a range of the issues addressed by the National Safety and Quality Health Service Standards, which set standards for the delivery of care in hospital and inpatient settings. This is less likely to be relevant for the lower tiers of the proposed model, where support is delivered on a drop-in basis in community settings.

Table 9 overleaf summarises KPMG's mapping and analysis of the key existing national frameworks and their applicability in the context of Safe Spaces.

Table 9: Existing relevant national accreditation frameworks

Framework	Sector	Application	Accrediting Agency	Example accredited organisations	Compulsory?	Potential applicability to Safe Spaces tiers	Benefits for National Safe Spaces Network	Weaknesses for National Safe Spaces Network
National Standards for Mental Health Services[93]	Mental health	Widespread application nationally	Australian Council on Healthcare Standards Quality Innovation Performance Limited (QIP)	Community and bed-based mental health services in the clinical, non-government and private sectors	Not mandatory for all mental health service providers but jurisdictions often require accreditation as a condition for funding	Tiers 4 and 5	High level principles underpinning all standards in good alignment with principles of the proposed network Well established nationally with many services currently accredited; existing monitoring arrangements	Strong mental health system lens – standards primarily designed for clinical and community service delivery Multi-step accreditation process may be challenging for Safe Space providers depending on levels of professionalism and concurrent delivery of other services
National Quality and Safety Health Service Standards[94]	Hospitals	National	Seven accrediting agencies approved by the Australian Commission on Safety and	All public and private hospitals in Australia	Mandatory for all public and private hospitals, does not apply to community	Tier 4 (if co-located with hospital facilities) Tier 5	Elements of the standards *recognising and responding to acute deterioration* and *communicating for safety* may be	Lack of direct integration with National Standards for Mental Health Services Three of the eight standards have

Framework	Sector	Application	Accrediting Agency	Example accredited organisations	Compulsory?	Potential applicability to Safe Spaces tiers	Benefits for National Safe Spaces Network	Weaknesses for National Safe Spaces Network
			Quality in Health Care		mental health services		particularly relevant and useful for Safe Spaces	limited relevance to non-clinical care delivered outside of a hospital setting Complex and technical accreditation process
Quality Improvement Council Health and Community Services Standards[95]	Community health and human services	National	Quality Innovation Performance Limited (QIP)	Alcohol and other drug services Disability services providers	No, but may be a condition of funding for some services	All (May not be sufficient for Tiers 4 and 5)	Practical lens which may be useful for volunteer-led or community-based organisations	Strong emphasis on data collection, service planning and process documentation, which may limit flexibility Standards are owned and maintained by a private provider (QIP) rather than being developed by government/s with community input

The analysis confirms that none of the key existing national accreditation frameworks used in the health and human services sectors are a neat fit with the requirements of a National Safe Spaces Network. In particular, achieving accreditation under each of these frameworks would likely be challenging for the proposed lower tier services because of the time and resourcing required to undertake this.

As an alternative to applying an existing framework, KPMG also examined the feasibility of developing a bespoke accreditation approach for the proposed network. There are several practical precedents for this, with two relevant examples being the **headspace Model Integrity Framework** and the **Rainbow Tick** accreditation framework.

The headspace Model Integrity Framework is used by headspace National to accredit services within the headspace network[96] The framework has 16 components which outline the criteria individual services need to meet to be accredited as a headspace centre and use the highly recognised national brand. These criteria span requirements for the involvement of young people, their families and communities in the planning and delivery of services, clinical and non-clinical service requirements, service-level governance arrangements, workforce and monitoring and evaluation components. While the criteria within the framework have been developed by headspace in collaboration with the Australian Government and delivery partners, they are also explicitly mapped to the National Standards for Mental Health Services as part of the framework documentation. By achieving accreditation under the headspace Model Integrity Framework, services therefore also demonstrate their alignment with these national standards. In addition to setting out principles-based criteria that services must meet, the framework also indicates the minimum standards that will be used to demonstrate compliance and the data sources required to do so. An illustrative excerpt from this framework is included at Figure 15.

Figure 15: Excerpt from headspace Model Integrity Framework

Sub-component	Evidence	
	Documents	Data
1.1 **Youth participation at a governance level** The centre ensures young people can participate in strategic planning and oversight at a governance level through a range of activities.	**Documented evidence of youth input at consortium meetings. This must include:** – minutes from at least **two (2)** consortium meetings within the last **twelve (12)** months showing youth input – terms of reference or standing agenda showing mechanisms for youth input **Demonstrated commitment to youth participation including evidence of:** – assignment of responsibility for youth participation – resource allocation including at least **one (1)** of the following: ▫ budget allocation ▫ staffing ▫ other (please specify)	Local Youth Reference Group (LYRG) has provided feedback via the **headspace** *hMIF Youth Participation Survey* (developed by **headspace** National).

Source: headspace National

The headspace Model Integrity Framework provides a useful case study of a tailored approach to accrediting services delivered by different partners around Australia within a single coordinated network. There are likely to be a range of useful learnings from this model which could be drawn upon to inform the development of a similar bespoke framework for the National Safe Spaces Network.

It should be noted however that headspace National receives significant annual funding from the Commonwealth to undertake its accreditation function. Individual headspace centres are also supported to meet their accreditation requirements as part of the broader annual funding received through PHNs. Given the scale of effort at both a national office and individual service level associated with accreditation, it is unlikely such a comprehensive approach would be viable in the context of Safe Spaces without similar resourcing being made available. As with the existing national frameworks, services at the lower tiers may also face challenges in achieving accreditation against a framework that contains as many standards and requirements as the headspace Model Integrity Framework.

The Rainbow Tick accreditation framework provides an alternative example of a lighter touch approach which may be more achievable for community-level services than the comprehensive headspace approach. Rainbow Tick is a voluntary accreditation framework for health and human services providers seeking to demonstrate their commitment to delivering services that are safe and inclusive for LGBTQI+ Australians[97] The standards were developed by Rainbow Health Victoria in response to calls from the LGBTQI+ community for more inclusive services addressing their specific needs. There are six standards, addressing areas including organisational capability, consumer participation and the provision of culturally safe and acceptable services. Providers can be assessed against the standards and confirmed as a Rainbow Tick Provider following accreditation undertaken by the standards agency QIP. When service providers have achieved Rainbow Tick accreditation, they are able to display the accreditation mark and be listed on a national register of accredited organisations. This supports LGBTQI+ people to easily find services which are safe and inclusive. It also provides a mechanism for service providers to demonstrate that their practices and programs have been externally assessed as supporting the needs of LGBTQI+ service users. To date, more than 40 providers in Victoria, Western Australia and Tasmania have received accreditation under the framework. These services span primary health, mental health and aged care services delivered by a range of public and not-for-profit providers.

This approach has several potential strengths in the context of a National Safe Spaces Network. First, achieving accreditation under the standards does not appear to require the same degree of administrative and compliance effort as other national standards or the headspace model. Because the Rainbow Tick is designed to be used by a wide range of providers in the health and human services fields, it is also not as proscriptive or specific as other standards such as those developed specifically for use in a mental health or hospital context. A further benefit is that the Rainbow Tick functions both to assure quality *and* provide a recognisable brand mark to help LGBTQI+ people identify safe and inclusive services. This is an important consideration in the context of the proposed network, as finding ways to identify community or public facilities as 'Safe Spaces' will be necessary to drive uptake. During this scoping study, the Rainbow Tick model was often mentioned by stakeholders and the Expert Advisory Group as having the strongest potential for adaption to deliver a bespoke but relatively light touch accreditation approach suited to the needs of the National Safe Spaces Network.

KPMG's review of accreditation frameworks generally supported the value of the Rainbow Tick approach as one which could effectively balance quality and flexibility while supporting active network promotion to drive service uptake. However, in June 2020 while this scoping study was underway, Suicide Prevention Australia released the first national Standards for Quality Improvement designed specifically for services whose primary purpose is suicide prevention.

The standards are comprised of six elements which have been co-designed with sector stakeholders and people with lived experience to recognise the particular requirements of suicide prevention services. These address needs assessment, service alignment, the role of people with lived experience of suicide, stakeholder engagement, program planning and workforce development. A summary of the framework and its key elements is included at *Appendix G: Suicide Prevention Australia Standards for Quality Improvement*.

The development of these standards reflects the growing status of suicide prevention as a distinct service stream from other mental health and community services. The standards recognise that the features of quality care in a suicide prevention context may look different from those in clinical and other community-based environments – particularly in relation to aspects like the role of peer supports. In this sense, there seems to be a strong alignment with the underlying philosophy of this framework and that of the National Safe Spaces Network proposal.

Importantly too, the Suicide Prevention Australia Standards for Quality Improvement provide for multiple levels of assurance depending on the nature of the organisation delivering services. Within the framework, services may choose to become certified or accredited. Certification is undertaken on the basis of self-assessment and a desktop review of available service documentation by an independent auditor. Accreditation requires the further step of an onsite inspection by audit teams who will undertake observations of practice and one-on-one interviews with staff. This means that organisations which are providing lower risk or intensity services – such as those proposed for Tiers 1 and 2 of the Safe Spaces model – can still opt-in for quality oversight but with a reduced compliance burden.

At the time of writing, these standards had only recently been launched and Suicide Prevention Australia was in the process of encouraging uptake by existing suicide prevention services. This means it is not yet possible to examine how services are implementing these or whether there are gaps and issues requiring further work to address. However, on the basis that the standards have been designed by Australia's suicide prevention peak body with the specific needs and service delivery requirements of suicide prevention in mind, they would appear to be strongly applicable for accrediting services within a National Safe Spaces Network.

There is only one consideration for the network this framework does not specifically address: the branding and communication element associated with the Rainbow Tick model. In consultations, stakeholders consistently emphasised the value of there being a highly visible brand or identifying mark associated with Safe Spaces so that potential guests can find them. This was considered to be particularly important for services at the lower tiers. Stakeholders suggested a recognisable brand would encourage people to 'walk in off the street' and spontaneously seek help in times of distress. The Suicide Prevention Australia standards may not achieve this as effectively as the Rainbow Tick approach because any suicide prevention service can be accredited, not just Safe Spaces. This raises the potential for inconsistencies in models of care and a lack of clarity for guests about whether a service is a Safe Space, an accredited suicide prevention service – or both. This could potentially be addressed through a requirement for all accredited services to provide Safe Spaces, along with the introduction of a dedicated brand mark. However, this is an area that would require further discussion and negotiation with Suicide Prevention Australia as the standard owners to explore the feasibility of integrating these two components.

As with the key aspects of governance discussed in the previous section, the optimum approach to accreditation for a National Safe Spaces Network would be defined by broader decisions about the role of different levels of government and service partners in delivering Safe Spaces. For example, if the Commonwealth opted to lead delivery and funding of the proposed network, a bespoke accreditation approach informed by the headspace Model Integrity Framework would likely be beneficial in ensuring service quality and consistency across its funded sites. By contrast, the Suicide Prevention Australia Standards for Quality Improvement and/or the Rainbow Tick approach appear suited to a more distributed model of delivery where no single body or level of government has ownership of the network.

Governance and accreditation requirements – conclusions

Effective governance and accreditation are key enablers of high-quality service delivery. They are especially critical for services supporting vulnerable communities, as the National Safe Spaces Network aims to do. There is no single governance or accreditation approach which is best suited to the proposed network, with the optimum approach being determined by the roles adopted by government and other delivery partners. However, there are a range of governance models and accreditation frameworks already in use through Commonwealth programs and national human service delivery bodies which provide possible templates for the new network to follow. In selecting the preferred approach to governance and accreditation for this service, there is one key consideration which should take precedence above all others: protecting the wellbeing and safety of vulnerable guests who will use Safe Spaces.

4.6. Service model

The National Safe Spaces Network proposal outlines a recommended structure for the network across its five tiers, and identifies key aspects of its underlying service ethos. This includes the focus on providing non-clinical supports, the leading role for people with a lived experience of suicide in delivering services within Safe Spaces, and the importance of the network being embedded within communities while being closely connected with other service providers. Given the proposal was developed as an initial approach to Government, it does not however outline the detailed service model for each individual tier or address issues such as access, staffing and the specific supports to be provided.

To explore these issues, KPMG has primarily relied on examination of the service models adopted in each of the relevant exemplar services within Australia and overseas, along with inputs from stakeholders through the consultation process and discussions with the Expert Advisory Group both collectively and individually. Stakeholders provided a large amount of practical input and insights on the potential service model of a National Safe Spaces Network, particularly people with lived experience, service providers and suicide prevention experts. In discussing these findings, it must be noted that stakeholders also consistently called for the detailed model of care for a future network to be developed through co-design involving people with lived experience.

Summary of findings

- It is unlikely to be possible to define a single service model for the National Safe Spaces Network. Rather, there would need to be individual service models developed at each proposed tier reflecting different needs in key aspects like staffing and the range of supports to be provided.
- There is broad support for Safe Spaces to be delivered as primarily non-clinical services, but stakeholders also identified potential roles for clinicians in assessing and providing referrals for guests who want clinical help, and supporting lived experience peer workers through mentoring and professional development. Reflecting the ethos of community decision-making that is at the heart of the Safe Spaces model, decisions about the extent of involvement by clinicians in the delivery of individual Safe Spaces may be best left to local communities.
- Training and support for lived experience peer workers will be critical to the safe and successful delivery of the proposed peer-led model. The NSW Government's recent development of minimum training and support requirements for suicide prevention peer workers offers a well-considered and stakeholder-endorsed model to follow.
- Stakeholders voiced concerns about the complexity of the proposed five-tiered approach and people's ability to effectively navigate to the right supports within this. The proposed settings for Tier 1 and 2 services are also considered to present a range of challenges in relation to their safety, accessibility and appropriateness for supporting people at risk of suicide. There would be value in undertaking further co-design with people with lived experience to explore whether and how consolidating the network into three tiers of physical locations augmented by online, phone and group-based peer supports may better achieve the intent of the model.

The National Safe Spaces Network proposal and discussion with the Expert Advisory Group indicates Safe Spaces would be intended to deliver the following supports across the network's individual tiers:

- **Tier 5:** A residential safe house supporting multi-day stays for people experiencing very acute and/or chronic suicidality

- **Tier 4:** A safe alternative to emergency departments providing a dedicated environment for people in acute distress to reduce their sense of crisis
- **Tier 3:** A safe space to access psychosocial support and safety planning for people who may be on a trajectory towards acute suicidal crisis
- **Tier 2:** A safe, community-based space to talk to someone who has gatekeeper training about suicide, and be connected to other services or supports
- **Tier 1:** A place to sit and feel safe in the company of others for people experiencing anxiety, distress or feeling unsafe on their own.

Within this overarching framework, KPMG's scoping work indicates there are service model elements which would be common across these tiers along with a number that are specific to individual levels. These differences are discussed throughout the following sections. *Appendix E*: *Summary of existing exemplar services* also maps out important aspects of the service models employed by existing Safe Spaces-type services, to inform consideration of key service model elements.

Access

All tiers of the National Safe Spaces Network are intended to be accessible to guests without a referral from a clinician or other service provider. This mirrors the approach taken by each of the comparable existing services, which generally welcome any guest aged over 18 who is not a danger to themselves or others (see *Appendix E* for details). Across Tiers 1 to 4, guests would be able to drop in to services whenever these are open and access support without a prior appointment or extended waiting time. Stakeholders indicated this is a critically important aspect of the model which closely aligns with the needs of people at risk of suicide, as distress and crisis can often arise unexpectedly at times when other services are closed or unavailable.

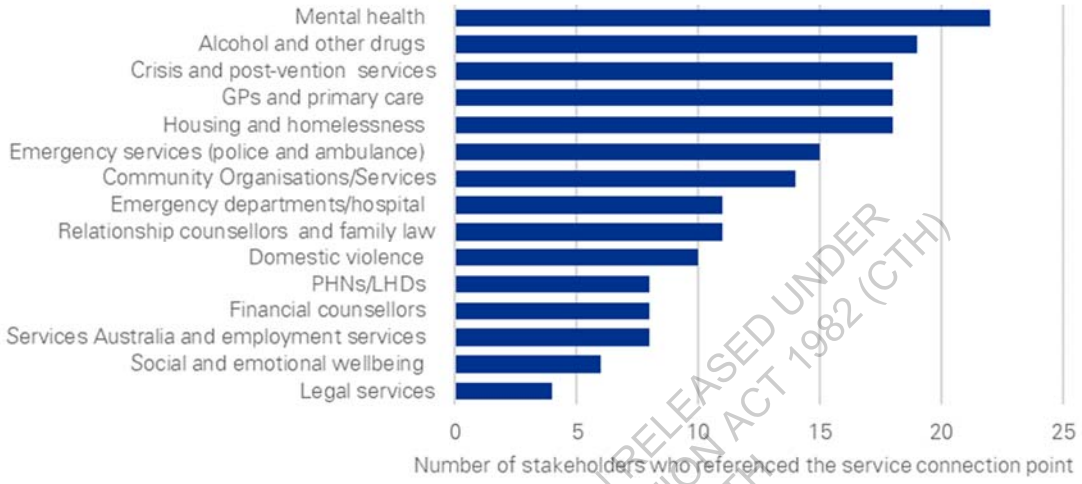
Given the more limited capacity of Tier 5 services and the importance of providers having a deep understanding of guest needs, people would not be able to drop into these services. However, the Maytree House allows potential guests to apply directly to the service for a residential stay without prior referral; this approach is also intended to be adopted for Sydney's SPARC when it is operational. At Maytree, guests are then assessed for their suitability through a 'befriending' process which includes discussion of their goals and objectives for their stay at the house[98]

Comparable services generally do not have specific eligibility criteria for access. All guests are welcome unless they are underage, seriously affected by drugs and alcohol, or requiring urgent medical care. Again, stakeholders emphasised this inclusive approach would be beneficial for a National Safe Spaces Network because it would help avoid people falling through the cracks. This was seen to be an ongoing challenge with mental health and suicide prevention services which apply tighter eligibility or service criteria. It should be noted however that wider eligibility criteria may lead to very large service demand. This could be challenging for individual services to meet depending on the scale of investment provided to support service delivery; stakeholders highlighted that budget constraints are often a driver of the use of exclusionary criteria in mental health services. For example, data from the Australian Institute for Health and Welfare indicates that in 2018-19 around 79,455 people presented to Emergency Departments because of suicidal distress or attempting. These people were a subset of a much larger group of 303,340 people who presented to Emergency Departments as a result of mental and behavioural disorders[99] While not all of these presentations would have involved a person experiencing suicidal distress, it is likely that a large number did. A fully demand driven approach that sought to support these people through Safe Spaces instead would require a very large roll-out of sites across the proposed national network.

In addition to accessing services directly, the consultations identified a wide range of connection points the network would need to be linked with to support effective guest linkages both *into* and *out of* Safe

Spaces. Stakeholders acknowledged that many referrals to Safe Spaces would likely come from clinicians in relation to people under their care – particularly GPs and mental health specialists. But they also pointed to a wider range of connection points that would be valuable for engaging with people whose suicidality is driven by life stressors, as indicated by Figure 16 below.

Figure 16: Possible service connection points for Safe Spaces



Source: KPMG (2020)

Within this range of services, there are likely to be significant differences in the depth of expertise about identifying and making appropriate connections for people at risk of suicide. Even for clinical services which are accustomed to making referrals to other specialists, stakeholders highlighted that information gaps and lack of awareness about the needs of people experiencing distress and crisis can be an obstacle to effective service linking. This suggests there would be a need for extensive engagement with service providers and agencies spanning all of the above areas as part of the delivery of the proposed network. This engagement would need to focus on building awareness of the network and its service offerings at each individual tier, and establishing partnerships for information-sharing or co-case management where guests agree to this. While all tiers of the network would benefit from having relationships with each of these providers, services across the tiers may also prioritise building particular relationships over others. For example, Tier 4 and 5 services may have more need for strong relationships with emergency services providers and Emergency Departments than lower tier services, given differences in the levels of acuity of their expected guests.

Stakeholders consistently emphasised that close engagement with clinical services would be particularly critical to supporting guests whose experience of distress and crisis is linked to mental ill-health. Where guests agree to them doing so, Safe Spaces at all tiers would need to have the capacity to provide warm connections to appropriate clinical services, as well as share information with mental health care providers who are providing ongoing care to a guest. It was also flagged that there would be benefit in this relationship running both ways – with information about a guest's mental health and prior engagement with services also being accessible to staff within Safe Spaces. A range of suggestions were provided on how this could be achieved efficiently, including the use of a shared information database and an app which allows information to be entered about a person's engagement with services and then shared with a list of clinicians and support services previously authorised by them. The digital storage and use of health data is a vexed topic in Australia, and implementing these kinds of solutions would not be straightforward.

Significant further examination would be needed to identify feasible approaches to information sharing that could be implemented at a whole-of-network level – particularly for Tier 1 and 2 services which are not delivered through dedicated suicide support services with specialist infrastructure. At the individual service level, local relationships and partnerships within the service delivery community would also be important to support this. The implementation of Safe Spaces-type services in New South Wales, Queensland and Western Australia provides an opportunity to observe how these linkage and information-sharing relationships are managed at a state level, and draw lessons from this which could be applied within a potential future national network.

When examining how Safe Spaces may support people whose experience of distress and crisis is driven by mental ill-health, there are a range of important considerations which go beyond referral pathways and information sharing. These are discussed further in the following sections in relation to the kinds of supports available at different tiers within the network and the potential staffing mix for Safe Spaces.

Available supports

Across all tiers of the proposed National Safe Spaces Network, there is a focus on guests being able to access a calm, welcoming and safe environment where they can talk openly about their distress and suicidality with people who share a lived experience of suicide. The core service offering of all Safe Spaces is warm, non-judgemental support provided through empathetic listening and conversation – giving people the time and space to unburden themselves without fearing this will lead to hospitalisation, medication or a loss of autonomy.

There are a range of ways in which this broad ethos of support could be operationalised within a service model, particularly across the different tiers. To explore this further, KPMG sought stakeholder input on what quality care would look like within a National Safe Spaces Network. This conversation was framed in terms of seeking stakeholder views on the kinds of services or supports Safe Spaces would need to provide in order to meet the needs of people experiencing distress and crisis. Figure 17 below identifies the elements which were most frequently identified across all stakeholder groups.

Figure 17: Stakeholder-identified features of quality care

Source: KPMG (2020)

This emphasises the critical role of people with lived experience in the Safe Spaces service model, with stakeholders identifying this as a central feature across all proposed tiers. Stakeholders pointed to a number of common benefits from Safe Spaces having a peer-led service model, including their ability to:

- **Provide an empathetic response** – There was clear consensus that peers are able to understand potential client needs on a deeper level than people without a lived experience and provide more appropriate support and care accordingly.
- **Provide a non-judgemental approach** – Stakeholders indicated that a peer-led workforce supports a non-judgemental approach to care which promotes trust and psychological safety. Service users are more willing to accept supports and engage in recovery pathway co-planning when this is offered in a non-judgemental way.
- **Remove power imbalances** – People with a lived experience reported that the power and relationship dynamic between peer workers and potential guests feels more equal than that present in other environments such as within clinical care. This helps service users feel like they can remain in control of their own situation while accessing the support they need.
- **Reduce stigma** – Stakeholders highlighted that there remains a very strong stigma around suicide, which can be a barrier to help-seeking for many people. Having staff with a lived experience supports the reduction of this stigma by showing service users that there are 'people just like them' who have experienced and recovered from suicidality.
- **Build hope and resilience** – It was frequently noted that people experiencing suicidal distress often can't see a way out and have lost hope. Being able to talk to someone who has been in a similar situation and recovered builds hope that they too can move past their current crisis with the right supports.
- **Ensure cultural safety** – Engaging peer workers from diverse cultural backgrounds can open up opportunities to ensure the support and care delivered is culturally safe and appropriate on both a cultural and lived experience level.

As is evident in the chart above, there was also a strong focus on these lived experience staff members having the appropriate training to effectively support people experiencing distress and crisis. It was acknowledged that a combination of lived experience *and* specialist training would be required to underpin safe and effective service delivery within Safe Spaces; this point will be explored further below under the discussion of staffing models.

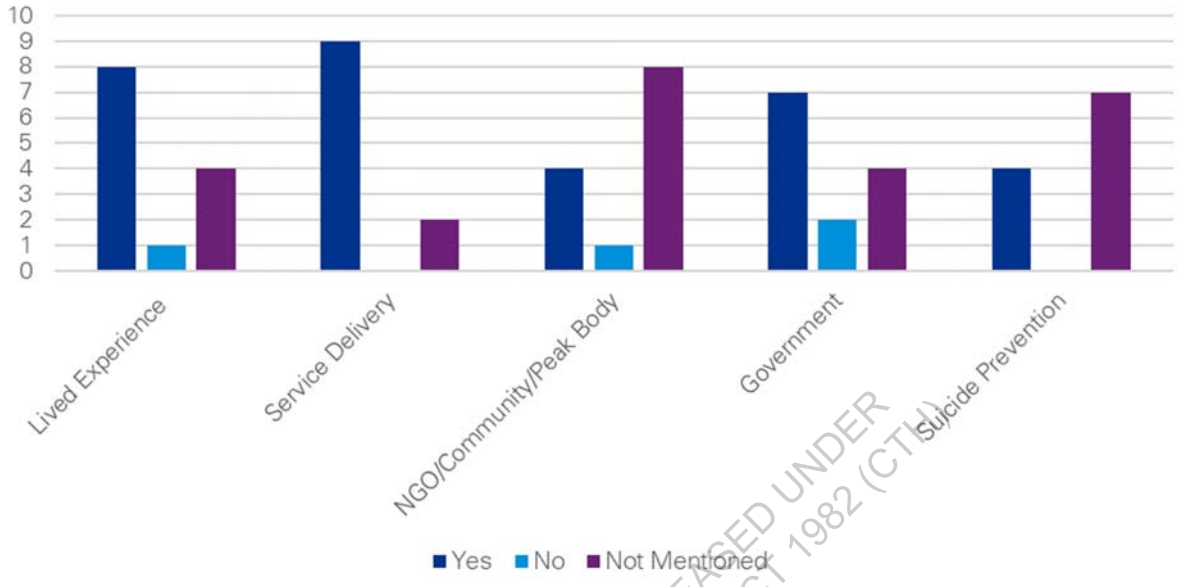
The three further aspects most frequently raised by stakeholders were access to clinical supports and/or oversight; connecting people with other services and supports; and involving family, friends and community to build a network of safety. System navigation and engaging communities to help keep people safe are discussed at a high level in the National Safe Spaces Network proposal as intended aspects of the model. The service model summary provided at *Appendix E* confirms they are also part of the offering for comparable services delivered in Australia and internationally.

As has previously been discussed, people experiencing suicidal distress are not always able to effectively navigate the service system to address their own support needs. Stakeholders considered that helping users undertake this navigation – while remaining fully in control of their own situation and circumstances – would be a valuable part of the service offering. This may include helping users make smooth and supported transitions from one tier to another within the Safe Spaces network, providing information on who to contact for follow-up support after visiting a Safe Space, or linking guests to other services that can address their underlying drivers of distress – as discussed above. The network proposal identifies this service navigation function as a particular focus for Tier 1 and 2 services, although discussions with stakeholders suggest there is likely to be a role for this across all tiers up to Tier 4.

Helping to build sustainable support networks around guests was also considered to be an important aspect of the Safe Spaces service model. Stakeholders identified this could be achieved in multiple ways, including through direct follow-up by Safe Spaces staff following a person's visit and the involvement of family, friends and communities both during visits to Safe Spaces and afterwards. This latter aspect was highlighted as particularly important for supporting Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities and men. Current service models are generally based on individualised care provided by a clinician to one person alone, with confidentiality and privacy requirements preventing the open sharing of information with others about that person's needs or emotional state. This can mean that families, friends and broader support people within the community are either not aware of these needs, or do not know how they can help. It can also reduce people's willingness to seek help in the first place because it is confronting to interact with the service system alone. Stakeholders argued that shifting to a more collective model of care which actively involves family and friends throughout a guest's time with the service would be beneficial for establishing a 'scaffold of support' around them which can endure after they leave the Safe Space. This aspect of service delivery was considered to be important across all tiers. At the lower ones, the emphasis would be on leveraging support networks to help prevent people from escalating into acute crisis. At the higher tiers, the focus would be directed towards supporting people after a suicide attempt or acute episode to help them recover and manage their distress.

KPMG approached the stakeholder consultations with respect for the intent of the National Safe Spaces Network proposal to deliver a peer-led, non-clinical service option. In this context, stakeholders were not asked for their views on the role of clinical supports or the appropriateness of a fully peer-led service. However, approximately half of all stakeholders raised this issue independently in responding to questions about the potential features of quality care, the alignment of the model with the needs of people at risk of suicide and integration with existing services.

Figure 18: Support for integration of clinical services or supports by stakeholder group



Source: KPMG (2020)

There was general consensus across all stakeholder groups – including people with lived experience – that there would be a need for some level of integration between non-clinical and clinical supports in the delivery of Safe Spaces. The level of integration proposed tended to vary according to the stakeholder perspectives represented. For example, lived experience stakeholders generally favoured a model of clinical reach-back or support only when requested by frontline peer workers. Other stakeholders highlighted benefits in a mixed service delivery model involving both peer workers and mental health clinicians working collaboratively onsite to meet people's individual needs as they present. It was noted that addressing the holistic needs of people experiencing suicidality will often – but not always – need to involve some level of clinical services, so the inclusion of staff who are trained to make appropriate assessments and service connections would support more coordinated care.

The relevance of clinical supports was also considered to vary by tier. Stakeholders generally agreed that it would not be necessary or feasible to incorporate clinical care into the lower tiers of the service. This reflects both the lower levels of acuity of expected guests and the wide range of community-based settings these Safe Spaces would be intended to be delivered within. By contrast, clinical supports were considered to be a necessary and important part of the service mix for Tier 5 residential Safe Spaces, and a potentially relevant offering for many guests of Tier 4 services. This would reflect the mix of supports currently provided through existing Tier 4 equivalent services outlined in *Appendix E*, although the Tier 5-equivalent Maytree House does deliver a fully peer-led model.

It is possible that stakeholders' preference for the inclusion of clinical supports at the higher tiers reflects the greater perceived risk of these services. That is, because Tier 4 and 5 services are intended to support people experiencing acute distress who are at high and potentially imminent risk of suicide, stakeholders may believe the engagement of clinical supports is necessary as a risk management tool. This is an important consideration, but it is also a different matter from what guests accessing these services may want and need. Consultation with the state governments which are currently in the process of implementing Safe Spaces-type services suggests this has been a central tension in their service model development. Some lived experience advocates have a strong view that the inclusion of clinical supports within Safe Spaces-type services will prevent many people at risk of suicide from engaging with them. However, the Local Hospital Networks and health agencies tasked with implementing these new services have different levels of risk appetite and therefore a preference for

some level of clinical supervision or shared delivery. Jurisdictions appear to have arrived at different conclusions about this, as the Queensland and Western Australian models are planned to include clinical supports while the New South Wales model is explicitly non-clinical. This seems to be linked to broader policy decisions about the focus of services and their intended service cohorts, with both Western Australia and Queensland opting to locate their services on hospital grounds. By contrast, the New South Wales services will be located at sites selected through local co-design, with the intention these be based in close proximity to hospitals but not co-located. In its guidance material for Local Health Districts implementing the services, the NSW Ministry of Health has also stated that the non-clinical nature of the services is one of five essential elements of the service model. It should be noted that all of these services are equivalent to Tier 4 Safe Spaces, so the insights from their service model development processes are likely to be most relevant to that tier.

The role of clinical supports in peer-based service delivery is a debate that extends beyond the context of the National Safe Spaces Network. As new service models emerge, both consumer expectations and the risk appetite of service delivery partners are evolving over time. This is bringing an increased focus on peer-led services – an issue the Commonwealth is currently exploring through the development of the next National Mental Health Workforce Strategy and Peer Workforce Development Guidelines[100]

The service model proposed for the National Safe Spaces Network aligns with the approach adopted by the NSW Government for its new services, which provides a strong opportunity to observe how this model works in practice in an Australian context as services commence within the next 12 months. The network's focus on localised service delivery meeting community needs also means this is not necessarily a debate that needs to be resolved at a national level. Rather, the overarching intent and ethos of the service model could emphasise the non-clinical nature of Safe Spaces, with local communities then able to determine through co-design how much involvement they want – if any – from clinicians.

Feedback from the Expert Advisory Group indicates it would be considered important to 'set the standard' for Safe Spaces as non-clinical services through any national architecture established by the Commonwealth. At the same time, members recognised that individual communities will approach this question differently and decisions about the extent of clinical involvement should ultimately be made at that level with genuine co-design.

Staffing

The staffing mix for Safe Spaces at each tier is closely linked to the discussion above about the role of clinical supports. As has previously been discussed, the stakeholder consultations identified support from peers with a lived experience as a critical feature and benefit of the service model.

Examining how comparable services are staffed indicates peer workers with a lived experience commonly provide the frontline, client-facing services. However, most of the services identified in *Appendix E* do combine this with some level of clinical supports. For example, the St Vincent's Hospital Safe Haven Café (Tier 4 equivalent) is staffed by two lived experience peer workers along with a mental health nurse and casual and volunteer workers who may also have a lived experience. Similarly, The Living Room in Illinois (Tier 3 and 4 equivalent) uses a mixed staffing model including three peer counsellors, a psychiatric nurse and a general counsellor. The Maytree House and Living EDge both report having a fully peer-led staff. However, during consultations some stakeholders suggested that

many of the volunteers at Maytree are actually also students working towards psychology and other mental health clinical qualifications[6]

Where services do use a mixed staffing model, it is common for guests to interact primarily with lived experience peer workers and for these staff to be the 'public face' of services. Mental health clinicians are then available to support assessment and connection to clinical services where this is sought by a guest[101] Clinicians also play a role in mentoring and supporting peer workers to build their capabilities and protect their wellbeing – a point which is discussed further below.

In line with the discussion in the previous section, the specific staffing mix employed in each Safe Space service would likely need to be determined through co-design with local communities. This would also need to take into account the specific tier of service to be offered, because examining existing services indicates there are likely to be significant differences in the size of team needed across tiers. The Tier 3 and 4 equivalent services generally use three to six workers per shift comprising a mix of paid staff and volunteers. In New South Wales, each of the 20 new Emergency Department alternative services (Tier 4 equivalents) will be funded for two full time equivalent peer workers and one full time equivalent service manager. By contrast, the Tier 5 equivalent Maytree House has a permanent staff of seven and more than 100 rotating volunteers. As will be discussed in *Section 4.7*, these differences in staffing requirements are expected to be a major driver of cost differences across the tiers.

Tier 1 and 2 services would not be expected to have dedicated staff, in line with their delivery through existing community and private facilities. This raises a range of complex questions about how staffing needs would be met, including:

- Would businesses and facilities which become Safe Spaces be compensated for staff time spent with guests?
- How would staff in these Safe Spaces be screened for safety and suitability to work with guests?
- Who would pay for any required staff training and ensure this was undertaken?
- Who would take responsibility for ensuring there are appropriately trained staff rostered on and available during designed Safe Spaces operating hours?

In discussions with stakeholders, these factors were among those raised in querying the feasibility of these lower tier services – as will be discussed further below. Answering these questions requires a detailed level of service design which is beyond the scope of this study, but resolving them would be critical to the successful delivery of these tiers of the proposed network.

While endorsing the value of a peer-led workforce, stakeholders emphasised that having peer workers with the right experience, training and information would also be crucial to the provision of high-quality support through the National Safe Spaces Network. It was frequently noted that supporting people in crisis requires a skill set which does not automatically emerge as a result of having a lived experience of suicide. Peer workers also need to be specifically trained in empathetic listening and safe dialogue about suicide, trauma-informed practice, de-escalation techniques and other evidence-based suicide prevention practices.

Some service delivery stakeholders also highlighted the importance of training peer workers to operate within a service delivery context. This includes gaining familiarity with systems and processes, risk management frameworks and other elements that underpin high quality service delivery in any context.

[6] KPMG sought clarification on this point from the Maytree House but had not received a response at time of writing.

While many peer workers will already have gained these skills through their prior work in health or mental health service delivery, some stakeholders identified this as an area that would need focus to ensure Safe Spaces operate with the same underlying rigour as other kinds of services.

Australia's mental health peer workforce has been becoming increasingly formalised in recent years. In that context, there are now a number of formal qualifications peer workers can undertake. In particular, the Certificate IV in Mental Health Peer Work has become a commonly required qualification for people undertaking paid roles as a lived experience peer worker. During consultations some stakeholders suggested this would be an important foundation qualification for Safe Spaces workers. However others emphasised the importance of developing a suicide prevention-specific workforce. This links back to the discussion about the range of drivers for suicidal distress and crisis, of which mental ill-health is only one.

The NSW Government is creating 70 new peer worker positions as part of staffing its new Emergency Department alternatives. In that context, the NSW Ministry of Health has undertaken significant work on peer workforce training and professional development. The Ministry has specified essential training requirements for both suicide prevention peer workers and managers supervising them, as well as essential components of professional support that must be provided. These requirements are detailed in the boxes overleaf. The full draft guidance on peer workforce can be provided by the NSW Ministry of Health. Discussions with the Expert Advisory Group indicate strong endorsement for its approach to suicide prevention peer workforce development and support.

NSW Suicide Prevention Peer Workers

Essential training

- Completion of the Certificate IV Mental Health Peer Work (CHC43515) or successful completion of course within 12-18 months of commencing employment, including the elective CHCCCS003 *Increase the safety of individuals at risk of suicide*. If the person already has this qualification but did not undertake CHCCCS003, they should complete this module separately.
  - Intentional Peer Support (IPS) Core Training – 5 days
  - Voices of Insight – Roses in the Ocean – 2 days
  - SafeSide
  - All mandatory training for frontline mental health staff (see below).

Recommended training

- Intentional Peer Support (IPS) Advanced Training – 3 days
- Safe story telling – Mental Health Coordinating Council – 1 day
- Purposeful storytelling South Eastern Sydney Recovery and Wellbeing College – 1 day.

Essential support and professional development

- Monthly individual peer supervision with an experienced peer worker (internal or external to the organisation dependent on local availability and workload of Senior Peer Workers in district/network).
- Participation in state wide Community of Practice for the Towards Zero Suicides initiatives
- Inclusion in existing mental health peer work governance and support structures, such as team meetings, forums, networks, group peer supervision etc.
- Inclusion in lived experience of suicide activities such as forums and other professional development.

Managers supervising NSW Suicide Prevention Peer Workers

Essential training

- SafeSide Recovery-Oriented Suicide Prevention – in person and online
    - Developed by Dr Tony Pisani, SafeSide is a framework for suicide prevention that goes beyond merely keeping people safe' toward a vision of evidence-based care that is connected with a person's needs, experiences, and growth potential.
- All mandatory training for frontline mental health staff, including:
    - COPSETI for mental health clinicians learning pathway.

Recommended minimum training (essential if the manager is new to supervising peer workers)

- Mental Health in the Workplace – Mental Health Coordinating Council – 1 day
    - This is for workplace leaders who want to support mental health in their workforce. It explores management practices that promote good mental health and the legal requirements relating to mental health in the workplace.
- Management of Workers with Lived Experience – Mental Health Coordinating Council 1 day
    - This training is for managers who support a peer workforce, building on the Mental Health in the Workplace 1 Day course.

While these training requirements are likely to be well suited to the higher tiers of the proposed National Safe Spaces Network, they may be too intensive for the lower tiers – particularly where staff are not full-time, dedicated suicide prevention workers. Stakeholders suggested a number of training options which may be more suitable for staff at the lower tiers. These included:

- **Question, Persuade, Refer Suicide Prevention Training (developed by the QPR Institute)** – a 60 to 90-minute online course which provides knowledge and skills to identify warning signs that someone may be suicidal; confidence to talk to that person about suicidal thoughts and awareness and ability to refer to available supports
- **safeTALK (developed by LivingWorks)** – a half-day workshop focused on suicide alertness, giving people the skills to recognise words and actions that point to suicide risk and take action by connecting people with life-saving intervention resources
- **Applied Suicide Intervention Support Training (ASIST) (developed by LivingWorks)** – a two-day workshop which teaches participants how to intervene and help prevent the immediate risk of suicide.

Each of these courses are readily available in Australia and do not require an unreasonably large commitment of time or money. They would also appear to be somewhat aligned with the needs of staff at different tiers, such that it may be appropriate to require staff at each tier to complete some combination of these. For example, at Tier 1, the QPR training may be sufficient to allow support workers to identify people at risk and make appropriate service linkages. At Tier 2, a combination of QPR and safeTALK could equip staff to support the needs of intended guests, while for Tier 3 there may be value in requiring staff to have completed all three courses. However, as discussed above staff

working in the lower tier services may need to be supported to undertake this training because there could be limited capacity or willingness from businesses to meet the cost otherwise. It is also worth noting that this training is likely to need to be refreshed at regular intervals – both to ensure workers remain current with up-to-date best-practice and provide opportunities to reflect on their experiences with the service in a structured and constructive way.

In addition to an emphasis on training for peer workers, stakeholders expressed a high degree of concern for their wellbeing given the risk of re-traumatisation and vicarious trauma when working with people experiencing distress and crisis. This was often raised in the context of the importance of appropriate support, supervision and debriefing of peer workers. Stakeholders emphasised that these would be risks for any lived experience peer worker within the proposed network, but this may be particularly challenging for people working in regional and remote communities. This is because in smaller communities, it can be harder for people to 'leave their work at work' by separating their peer support role within a Safe Space from their more general role in the community.

The existing Safe Spaces-type services appear highly attuned to this risk and have formal supports in place to protect the wellbeing of peer support workers. The St Vincent's Hospital Safe Haven Café builds supervision, debrief and planning time into every staff shift, as well as providing opportunities for support and one-on-one debriefing outside of Café opening hours[102]. Other services have implemented buddy systems and mentoring relationships which share responsibility across teams to support colleagues and identify the warning signs of distress[103]. In addition to these elements, the New South Wales support model focuses on the inclusion of lived experience peer workers in professional communities of practice and governance processes. This is intended to continually reinforce their status and voice as key partners in the ongoing development of these services, supporting a sense of empowerment. More broadly, there are a range of peer-led support models employed by frontline and first responder agencies to support workers who are exposed to trauma as part of their daily roles. For example, the Queensland Ambulance Service's Priority One peer support model has been developed over many years and is considered to be an exemplar in the Australian service context[104]. It is based around frontline worker peers who receive dedicated training in how to identify colleagues who may be struggling with their mental health, and intervene to connect them with workplace supports. There are likely to be many practical lessons to be learned from existing peer worker support services such as Priority One in designing an appropriate approach to support workers within the National Safe Spaces Network.

Developing structures and processes to support the wellbeing of lived experience peer workers would be a clear priority for the development of the National Safe Spaces Network. In particular, it may be beneficial for expectations about how peer workers will be supported to be clearly articulated in the national architecture for the network, with this being linked to assurance levers such as accreditation.

Service tiers

So far throughout this report, KPMG has examined the National Safe Spaces Network proposal in line with its five proposed tiers. In consultation with stakeholders however, around one in three people raised concerns about the complexity of the model and flagged this as a potential risk to effective navigation by people experiencing distress and crisis. KPMG did not specifically seek input on this aspect of the proposed model, but the number of stakeholders raising these concerns unprompted pointed to a need for further examination. Stakeholders also expressed a number of reservations about the proposed service offering at Tiers 1 and 2.

Concerns about the complexity of the model were generally raised in the context of querying whether five tiers are too many, and would risk adding further complexity to a service landscape which people already struggle to navigate. Some stakeholders suggested that consolidating the model to three tiers may be more suitable, combining the services intended to be offered across Tiers 1 to 3 into a single service offering all the supports proposed across these individual tiers. This tier would have a particular focus on early intervention, service connection and support to avoid escalation into crisis. The currently proposed Tier 4 and 5 services would maintain their focus on supporting people experiencing acute crisis or following a suicide attempt, with an improved ability to maintain support as people's wellbeing improves through the lower tier service. In this context, some stakeholders also highlighted the value of support groups, warm lines and online services in providing some of the functions originally intended to be delivered at Tiers 1 and 2. These services are not currently included in the model but could add significant value as part of a broader networked offering – particularly for people living in rural and regional areas. There are a range of existing supports which could be integrated with the network initially to strengthen its offerings, including peer warm lines like the newly launched BEING Supported service in New South Wales and online peer support groups led by organisations like the Illawarra Shoalhaven Suicide Prevention Collaborative. Other online, phone and peer-based supports may then evolve over time as the network expands.

In addition to flagging the general complexity of the proposed model, stakeholders identified a range of risks associated with its lower tiers and concerns about a lack of clarity in the model of care. Questions were particularly raised about the appropriateness of places such as libraries, hairdressers and coffee shops for this type of service. These risks included:

- **Training** – concerns were raised around the ability to adequately train staff, and ensure consistent knowledge throughout the team including ongoing training of new staff members. Challenges were also highlighted in relation to ensuring that at least one trained staff member is present onsite at any time when services are open, taking into account shift work and the variable nature of staffing in these environments.
- **Availability of staff** – given staff in libraries, cafes and hairdressers are typically busy with the core functions of these services, there was concern about the ability to guarantee that a staff member will be available at any given time to spend adequate time talking with someone experiencing distress. It was noted that if a client were to present at a service and not be attended to adequately, this could have a significant adverse impact on their willingness to seek help again.
- **Appropriateness of location** – some stakeholders questioned the appropriateness of general public services as a place for people to go in distress, for example, the ability for guests to feel comfortable to speak freely or express emotions openly when other members of the public are transacting business around them. Some lived experience stakeholders particularly highlighted challenges in achieving the sense of psychological safety needed to talk about distress and suicide in these environments.
- **Ability to manage complex needs** – stakeholders commonly highlighted the risk of guests presenting at a tier level inappropriate for their level of need, for example, guests presenting to a lower tier with more severe and acute complex illness such as psychosis or paranoia and staff not being adequately equipped to manage this.
- **Risk of demand for ongoing, intensive support** – if a staff member in a lower tier service is identified and recognised as a supportive and trustworthy person, guests may continue coming back to them for intensive support even if referred on or encouraged to attend a higher tier service. This was raised as a risk due to the potential burden this may place on a lower tier staff member for whom crisis support is not their core responsibility and which they may not have adequate training or support to manage for an extended period. This was noted to be a particular risk for small communities due to close-knit social structures.

- **Replicating existing services** – some stakeholders felt that lower tier services did not offer anything significantly new or different to services that are currently available for people in distress to talk to someone about how they are feeling, for example, via a crisis line. It was raised that there is a risk in introducing more services into an already crowded marketplace that is difficult for people to navigate, adding to this complexity.

While acknowledging these stakeholder concerns, members of the Expert Advisory Group expressed the view that there are many venues across Australia which may already be delivering the kinds of supports intended to be delivered in Tier 1 and 2 services, albeit in an informal way. For example, in some regional communities the local coffee shop or corner store functions as a hub for community activity, with people seeking out staff who are well-known community leaders when they need support or a sympathetic ear. Similarly, in some remote Indigenous communities the homes of local elders or public facilities such as parks can function as shared spaces for community members to offer or receive support. The Expert Advisory Group members suggested that a particular priority for the National Safe Spaces Network would be to harness this activity as the foundation for Tier 1 and 2 activities, making these existing supports more visible and connected.

There is anecdotal evidence that such support activity occurs in communities around Australia, but KPMG's work through this scoping study does not indicate stakeholders necessarily see this as analogous with the supports proposed through Safe Spaces. There are also questions about the feasibility of identifying, drawing together and accrediting activity that may be happening at such a local level in potentially thousands of individual communities. These are issues that would need to be explored further through the implementation phase of work if the Commonwealth opted to pursue the National Safe Spaces Network proposal.

Taken together, this suggests they may be value in further considering the tiered approach as part of ongoing model design. Concerns about both the complexity of the network and the service model proposed for the lower tiers could be addressed by consolidating the network into three tiers of physical locations augmented by online, phone and group-based peer supports.

It is important to note that the original five-tiered proposal was developed in close consultation with people with lived experience. A proposed change of this kind to the underlying model would also need to be subject to further consultation and co-design. But it is important any new service offering genuinely improves service navigation and accessibility for its intended users. Stakeholder feedback indicates this aspect of the proposed model will require further consideration to ensure a future National Safe Spaces Network genuinely achieves this.

Service model – conclusions

The service model for each proposed tier of the National Safe Spaces Network is an area that would require significant further development in the event that the Commonwealth chose to pursue this proposal. In relation to access and eligibility there is a clear intent and approach to delivery which could be consistently implemented across all proposed tiers. But in a range of other key areas – including the type of supports on offer, the staffing mix and the environments in which services are offered – this scoping study indicates there are likely to be major differences between tiers. Significant further work would be needed to refine the relevant service models for each. Co-design with local communities may also lead to significant variation *within* tiers in how services are implemented, including in relation to

the involvement of clinical supports. Complexity and diversity are not, in themselves, bad things if they lead to people at risk of suicide having more and better service options. But they can also impede access to support if they create barriers to effective system navigation or major inconsistency in the help available. Consolidating some of the proposed tiers while wrapping in virtual and peer group supports which are not currently reflected in the proposal may be an effective way to balance these considerations.

4.7. Investment and operating costs

Understanding the initial investment and ongoing operating costs of the proposed network is an important aspect in assessing its overall feasibility. The National Safe Spaces Network proposal provides indicative costings for piloting each of the different tiers of service, partially informed by costs for the small number of comparable services operating to date. This provides a valuable starting point for examining potential costs associated with delivering a national network. However, there are a wide range of factors that may influence the actual costs of delivery – particularly chosen locations for sites, staffing mix and the capacity to re-purpose existing infrastructure. The overall number of sites delivered is also a key cost driver.

To explore the potential investment required to implement this network, KPMG has focused on identifying its key cost components and examining how much variation there is likely to be based on these key components. This will support further consideration by government of the preferred service model and feasibility of delivery in different locations. It is not currently possible to provide an estimated costing for the total network, as this would depend on decisions by government about how this was intended to be rolled out. Instead, KPMG has developed estimates of the costs of delivery per service and per guest at each tier, to support understanding of the relativities between these and feasible potential levels of delivery.

It should be noted that the indicative costs presented here could be met by any delivery partner and it is not assumed that the Commonwealth would necessarily bear all or some of these. In undertaking this analysis, KPMG has simply focused on identifying the potential scale and range of costs associated with the network. Further discussion about how these may be funded would be a matter for government.

Summary of findings

- KPMG's analysis confirms there is likely to be significant variation in cost of delivery for Safe Spaces at each of the proposed tiers within the network. Baseline analysis indicates this may range from $20,000 per year for Tier 1 and 2 Safe Spaces up to $2.6 million in year one for Tier 5 spaces.
- There is also the potential for significant variation in cost of delivery within individual tiers, depending on decisions made about the service model and level of infrastructure, as well as service demand. The widest potential variation is identified at the Tier 3 level because of significant differences in the cost of accommodation depending on location and extent of co-location with other services.
- There is significant uncertainty about the actual costs of delivery for the lower tier Safe Spaces. This is because of a lack of available data to accurately estimate service uptake and questions flagged by stakeholders about the availability of existing infrastructure and staffing to deliver services at these tiers.
- In addition to considering the cost of individual Safe Spaces tiers and/or services, it is also important to factor in costs associated with national coordination and governance, marketing and other 'whole of network' costs. The Commonwealth's own internal costings for undertaking these functions in relation to national services like headspace are likely to offer the best insights into these cost components.
- It is not possible to estimate the cost effectiveness of the proposed network until key aspects of its service model have been determined – particularly its specific target outcomes.

Cost components of Safe Spaces

Based on a review of the network proposal and comparable services, the core cost components of individual Safe Spaces are expected to include:

- **Infrastructure** – space to provide the service – existing community and public facilities are intended to be used to deliver Tiers 1 and 2, with commercial tenancy agreements or dedicated, newly-built spaces expected to be required for Tiers 3 to 5
- **Staffing** – personnel to provide the service – including peers with lived experience (paid) and volunteers (unpaid) across all tiers, with the potential for engagement of mental health clinicians and centre managers at some tiers depending on the service model chosen
- **Governance accreditation and administration** – regulatory requirements and compliance costs – including costs of undertaking regular accreditation against any national standards and supporting ongoing governance functions
- **Insurance and liability** – coverage protecting the spaces and workers from claims such as professional malpractice or public injury – with different levels of insurance expected to be required across the different tiers reflecting their varying levels of service intensity and risk
- **Consumables** – items used in the day-to-day operating of the service such as food and supplies – with costs expected to be minimal at Tiers 1 and 2 but significant in relation to the proposed Tier 5 residential services.

To estimate these core costs across each tier of the proposed model, KPMG has reviewed costing information from current, past or forthcoming Safe Spaces to produce a year one cost (including infrastructure investment costs), recurrent annual costs (excluding the initial one off costs), and an annual cost per client cost (excluding the initial one off costs). s 47, 47G

In developing these indicative costings, KPMG has been able to draw on actual delivery and service data from comparable services to inform the Tier 4 and 5 figures. However, estimating costs for the lower tiers is more challenging because of a lack of comparator services. In particular, it is difficult to estimate the expected uptake of these services as they are intended to address a service need that is currently largely unmet. As Tier 1 and 2 Safe Spaces are intended to be delivered within existing community services and businesses, we have estimated that each space receives two guests per day. Guest rates above this level may become difficult for staff to manage alongside their core functions if these spaces were to be provided in venues such as libraries and coffee shops. Tier 3 Safe Spaces are intended to offer more intensive support including psychosocial support and safety planning, with the network proposal suggesting these may encompass PHN-commissioned services. These Safe Spaces would potentially be more likely to be located within dedicated health, community or mental health services and therefore receive a larger number of guests each day. These assumptions have informed KPMG's analysis but actual guest numbers could vary significantly if the model were to be rolled out.

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Table 11: Estimated costs by tier – National Safe Spaces Network Proposal

Tier	Establishment/ infrastructure costs	Ongoing costs
Tier 1	$200,000 per site	$100,000 p.a.
Tier 2	$200,000 per site	$100,000 p.a.
Tier 3	$200,000 per site	$100,000 p.a.
Tier 4	$50,000 per site	$500,000 p.a.
Tier 5	$1,000,000 per site	$1,250,000 p.a.

Source: National Safe Spaces Network proposal

These differences highlight the fact that as a new service offering, it is difficult to develop high level estimates of costs without undertaking detailed site and service-level scoping. KPMG's estimates have been informed by the description of services provided in the network proposal and further discussions with the Expert Advisory Group. However, differences in the underlying assumptions used to arrive at the costings in Table 10 would be expected to lead to different modelled outcomes.

This breakdown also indicates that the distribution between upfront investments and ongoing delivery costs is likely to vary across the tiers. Tiers 1 and 2 have no upfront capital costs because they are intended to leverage existing infrastructure. However, there are questions about the extent to which such infrastructure may be available. Initial capital investments for Tier 3 would be expected to be relatively minor and limited to any fit-out costs necessary to furnish rental spaces. Even this may not be required if Safe Spaces are based within existing health or community centres. This means that across these three tiers, the majority of costs are ongoing delivery costs, such as staff and consumables. By contrast, Tier 4 and 5 services are expected to require much larger upfront investments because these are intended to be delivered in dedicated or purpose-built bases. In the case of Tier 4 services, the experience of the St Vincent's Hospital Safe Haven Café suggests infrastructure costs may represent around one-third of total costs. For Tier 5 services this is expected to rise to around half of all costs, based on the capital investment made for SPARC. In relation to funding for a national network of Safe Spaces, this highlights that funding for services at the higher tiers would likely need to include both capital and recurrent components.

As the above table demonstrates, staffing is another significant component of the overall delivery cost of Safe Spaces at the higher tiers, and accounts for the largest share of recurrent delivery costs for Tiers 3 and 4. The costings above demonstrate potential costs of delivery with a fully peer-led service model. For comparison, Table 12 also presents the staffing costs if a mix of clinical and non-clinical supports were used to deliver the services.

Table 12: Staffing cost comparison – peer led and mixed staffing models

Components	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Staff – fully non-clinical	No paid staff; funded training for volunteer staff to complete QPR training	No paid staff; funded training for volunteer staff to complete QPR and ASIST training	1 FTE Senior Health Education Officer 0.75 FTE Non-graduate Health Education Officer (at median salaries – see Table 13 below)	1 FTE Senior Health Education Officer 1 FTE Non-graduate Health Education Officer (at median salaries – Table 13 below) 0.5 FTE unpaid volunteers	1 FTE Senior Health Education Officer 1 FTE Administration Officer 3 FTE Non-graduate Health Education Officer (all at median salaries – see Table 13 below) 1 FTE unpaid volunteers
Staff – mixed	As above	As above	*1 FTE Senior/Clinical Psychologist* 0.75 FTE Non-graduate Health Education Officer (at median salaries – see Table 13 below)	*1 FTE Senior/Clinical Psychologist* 1 FTE Non-graduate Health Education Officer (at median salaries – Table 13 below) 0.5 FTE unpaid volunteers	*1 FTE Senior/Clinical Psychologist* 1 FTE Administration Officer 3 FTE Non-graduate Health Education Officer (all at median salaries – see Table 13 below) 1 FTE unpaid volunteers
Estimated annual cost – fully peer-led staffing model	-	-	$165,249	$182,230	$389,661
Estimated annual cost – mixed staffing model	-	-	$192,050	$209,031	$416,462
Difference	-	-	**$26,801**	**$26,801**	**$26,801**

Source: KPMG (2020)

This suggests that the model would be more expensive to operate with a mixed staffing model, but not significantly so.

Potential drivers of cost variation

Importantly, some of the cost components discussed above will vary depending on where or how Safe Space are delivered. There are several reasons for this, including the ability to leverage existing infrastructure or secure the support of funding partners. In some cases, this could reduce costs to near zero. Reviewing the costs and models of care of similar programs in the health and human services sector suggest material differences will most likely stem from variations in:

- Models of care, as expressed through staffing costs
- Infrastructure and capital costs
- Service demand.

The following sections explore these variations in more detail to help inform the development of more detailed, location-specific costings in the event the Commonwealth opted to pursue delivery of the network.

Variation in models of care

Communities around Australia face different constraints in relation to the availability of appropriately skilled workers to deliver Safe Spaces. As a result, the specific staffing mix adopted may vary by location. Similarly, the cost of employing a worker with particular skills can vary across Australia. KPMG has considered labour inputs for different occupational categories at different wage levels to explore how this may drive variation in the cost of delivering Safe Spaces. The relevant NSW Health industrial awards have been used for this purpose. On costs such as superannuation, payroll tax and other vary by state and employment type, however typically sum to around 20-21 per cent of wage and salary costs. These have been accounted for using an inflator relevant to NSW of 21.27 per cent as reported by Flinders University (see Table 13). Comparing the lower and upper bound costs in Table 13 below highlights that salaries and wages can vary by up to 63 per cent depending on experience and personnel.

Table 13: Salary and wage costs for staffing Safe Spaces (2019 Australian dollars)

Cost inputs*	Senior/Clinical Psychologist	Senior Health Education Officer	Health Education Officer	Administration Officer	Health Education Officer (Non-Graduate)
Median hourly rate	**$84.34**	**$51.48**	**$51.48**	**$36.23**	**$51.48**
Low	$77.13	$47.66	$47.66	$29.26	$47.66
High	$91.56	$55.30	$55.30	$43.19	$55.30
Median salary	**$141,106**	**$114,305**	**$97,173**	**$71,582**	**$67,925**
Low	$125,909	$98,204	$73,904	$57,818	$64,120
High	$156,304	$130,406	$120,442	$85,347	$94,484

**note these salaries and wages are inflated by 21.27% to include the typical on-costs for those employed in NSW according to Flinders University 2020.*

Source: NSW Health Education Officer Award; Health and Community Employees Psychologists (State) Award; Public Hospitals (Professional and Associated Staff) Conditions of Employment (State) Award; Flinders University.

Table 14 illustrates the effect of this when considering different staffing combinations for Tiers 3 to 5. Here, 'low' and 'high' scenarios resemble changes from the base case staffing mix in Table 10 above with broadly equivalent, but more or less expensive alternatives:

- **Tier 3** – instead of 1 FTE Senior Health Education Officer and 0.75 FTE Non-graduate Health Education Officer (at median salaries), Safe Spaces might equivalently use 1 FTE Senior Health Education Officer (low hourly rates) and 0.75 FTE volunteers as supports **(low);** or rather 2 FTE salaried Non-graduate Health Education Officers **(high).**
- **Tier 4** – instead of 1 FTE Senior Health Education Officer, 1 FTE Non-graduate Health Education Officer (at median salaries) and 0.5 FTE volunteers, Safe Spaces might equivalently use 1 FTE Senior Health Education Officer (low salaries) and 1 FTE volunteers **(low);** or opt for a mix of supports with 1 FTE Senior Health Education Officer, 1 FTE Non-graduate Health Education Officer, 1 FTE Senior/Clinical Psychologist (at high salaries) **(high).**

- **Tier 5** – instead of 1 FTE Senior Health Education Officer, 1 FTE Administration Officer, 3 FTE Non-graduate Health Education Officer (all at median salaries) and 1 FTE volunteers, these Safe Spaces might equivalently opt for a 1 FTE Graduate Health Education Officer rather than an Administration Officer (at low salary) (low); or rather 1 FTE Administration Officer, 3 FTE Non-graduate Health Education Officers, 1 FTE Senior/Clinical Psychologist (all at high salaries) and 1 FTE volunteers as supports (high).

Table 14: Salary and wage costs for Safe Spaces under different staffing mixes (2019 Australian dollars)

Labour cost ($) per annum	Tier 3			Tier 4			Tier 5		
Scenario	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Medium**	**High**
Senior/Clinical Psychologist(s)	-	-	-	-	-	$156,304	-	-	$156,304
Senior Health Education Officer(s)	$92,935	$114,305	-	$98,204	$114,305	$130,406	$98,204	$114,305	$130,406
Administration Officer(s)	-	-	-	-	-	-	-	$71,582	$85,347
Graduate Health Education Officer(s)	-	$50,943	-	-	$67,925	-	$73,904	-	-
Non-graduate Health Education Officer(s)	-	-	$188,968	-	-	$94,484	$192,361	$203,774	$283,452
Unpaid volunteers(s)	$0	-	-	$0	$0	$0	$0	$0	$0
Annual labour cost	**$92,935**	**$165,249**	**$188,968**	**$98,204**	**$182,230**	**$381,194**	**$364,470**	**$389,661**	**$655,508**

Source: NSW Health Education Officer Award; Health and Community Employees Psychologists (State) Award; Public Hospitals (Professional and Associated Staff) Conditions of Employment (State) Award

*can be a graduate or non-graduate health education officer; **can be fu filled by different people.

This analysis suggests overall labour costs at the individual service level can vary by a factor of between 1.8 and 3.9 under different staffing mixes and models of care. This would be an important consideration both for the service model chosen and broader decisions about the feasible number of delivery sites.

Variation in infrastructure costs

Recognising the intent for Tier 1 and 2 Safe Spaces to be delivered through existing community infrastructure and local businesses on a voluntary basis, KPMG has assumed that services delivered at these tiers would not have any infrastructure costs. As dedicated suicide prevention services, Tier 3 and above would be expected to require their own infrastructure – whether this is rented accommodation or purpose-built facilities.

Rental arrangements are most likely for Tier 3 services, reflecting the fact that they do not necessarily require any specialised infrastructure beyond spaces for people to meet. KPMG's analysis indicates the cost of this space varies significantly by factors of location and size. For example, annual rents per square metre in Sydney's CBD ($1,025) can be nearly triple those in areas of Queensland such as the

Gold Coast ($380). Depending on the required space, these price differentials will have a material impact on total accommodation costs for individual Safe Spaces, as outlined in Table 15.

Table 15: Potential cost of rental tenancies in Australia

Input	Small space Low cost	Medium space Medium cost	Large space High cost
Square metres	15	32.5	50
Cost per square meter (monthly)	$28	$46	$65
Annual cost (excl GST)	$5,016	$18,109	$39,000
Annual cost (incl GST)	**$5,518**	**$19,920**	**$42,900**

Sources: Healthcare Practice Sales; Commercial Real Estate

If Tier 4 and 5 services were delivered in newly-built or purpose-refurbished spaces, variation may arise due to differences in underlying costs including scope of works and project management costs. This variation would be determined on an individual basis but for simplicity, KPMG assumed this variation would lie within +/– 25 per cent of the base case infrastructure costs.

Appendix H: Costing scenarios and sensitivity analysis provides a range of possible cost scenarios based on this variation in infrastructure costs across each proposed tier. These suggest that infrastructure costs could range from between $5,518 and $42,900 for rent on Tier 3 spaces to between $937,000 and $1.56 million for delivery of purpose-built Tier 5 spaces. This analysis indicates that decisions about the location and extent of infrastructure used to deliver Safe Spaces at each tier would have a significant impact on the cost of individual sites. In turn, this would likely affect the overall number of sites which could be funded by the Commonwealth or any other partner.

It should also be noted that there may be cases where existing infrastructure is made available at low or no cost – for example through existing health and community facilities. This is an important consideration given infrastructure costs represents one-eighth, one-third, and half of the implementation costs for Tiers 3 to 5 respectively[8] By reducing these costs, co-location with other services is likely to increase the affordability of the network overall. However, the selection of sites for co-location would need to be carefully considered in the context of the stakeholder feedback already discussed about the accessibility of different settings for intended service users.

One further factor which may affect the infrastructure requirements of Safe Spaces at each tier is the potential shift to virtual service delivery prompted by COVID-19. Many mental health and community services have moved away from face-to-face servicing during 2020. At the time of writing there was a live discussion about the extent to which digital service delivery would become the norm going forward for a wide range of sectors. If Safe Spaces were established with a 'digital first' model or a significant digital service offering at some tiers, this may change the infrastructure requirements in ways that would then reduce this aspect of service delivery costs.

[8] Note that this analysis has ignored the potential for 'zero infrastructure costs' in the sensitivity analysis of each tier because this is likely an edge case. This ensures that the reported cost ranges are narrow enough to be informative rather than being unhelpfully wide.

Variation in service demand

Variation in the uptake of Safe Spaces is also an important consideration for the overall cost of operation within individual sites. Sites with high service demand may benefit from increased economies of scale, but they also generally have greater resourcing needs and ongoing costs due to being located in metropolitan or larger regional areas. Sites with low demand may not need to operate as intensively or provide the same scale of staff resourcing – for example in rural and remote areas – but will also be unable to spread their fixed costs over as many guest visits.

KPMG has considered the potential impact of a +/– 50 per cent change in service demand compared with the base scenario presented on page 86. This extent of increase or decrease in demand would be expected to impact services in a number of ways:

- **Staffing and operating hours** – With higher demand, Tier 4 spaces may deliver a 24-hour, 7 day a week service rather than operating part-time. Spaces with less demand may operate fewer hours each week, allowing them to use fewer staff and pay casual hourly rates rather than fixed salaries.
- **Infrastructure** – The physical infrastructure required for services will vary greatly depending on how many people are expected to access them. Areas with low population are therefore likely to have lower infrastructure costs as they can service expected demand in a smaller and more affordable space, as highlighted by the discussion above. However, it should also be noted that the nature of the Safe Spaces service is such that sites likely cannot grow to be too large without losing important features of the service model. In areas with very high demand, service providers would likely need to consider the delivery of multiple sites rather than seeking to meet all demand through a large service at any single site. This is particularly relevant to Tier 5 services, which would be expected to have a fixed total number of guests who could access the service at any one time, and operate at near full capacity in most circumstances because of the nature of the service offering.
- **Consumables** – The total cost of consumables such as food and other supplies would likely be significantly higher for high-visitation sites than low ones. This is expected to be particularly relevant at Tiers 4 and 5 where guests are offered more amenities than at other service tiers.

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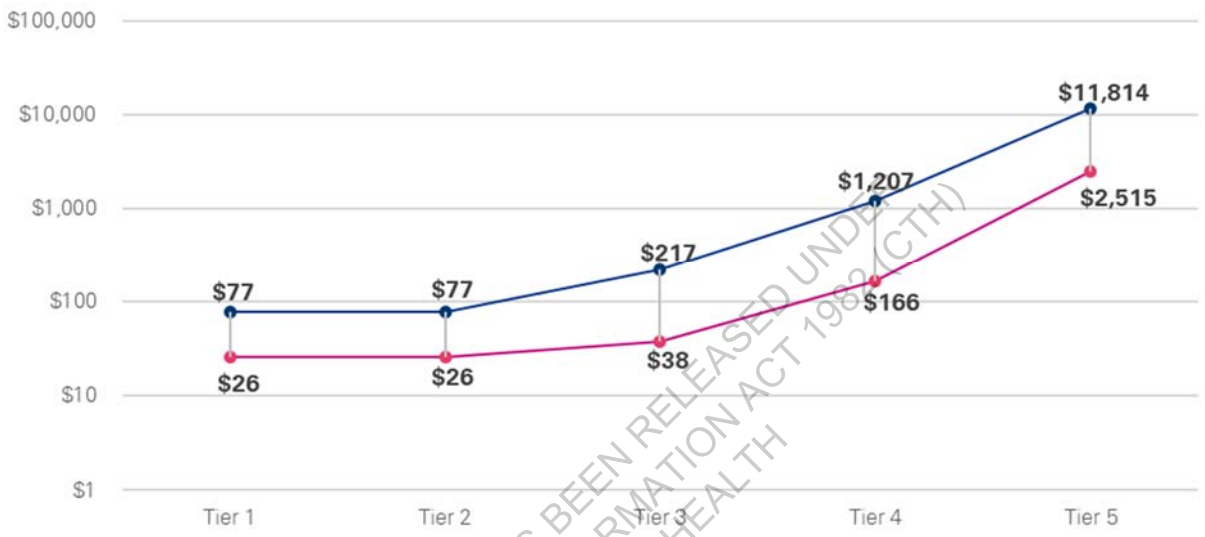
Informed by these drivers of variation, KPMG has estimated the range of per-client costs by tier of service within the Safe Spaces model. This is achieved by taking the high (low) implementation cost scenario for each tier and dividing it by the lowest (highest) expected service demand for each tier. Figure 19 illustrates the range of potential costs of delivery for each tier inclusive of changes in service demand, models of care and infrastructure costs.

Figure 19: Per-client cost ranges by Safe Space tier



Source: KPMG (2020)

This confirms that the proposed Tier 5 services are relatively more expensive than other tiers in all scenarios, with an estimated cost of delivery between $2,515 and $11,814 per client. The widest variations in potential cost is at the Tier 4 level, primarily reflecting large potential differences in staffing costs for longer operating hours.

Whole-of-network costs

In addition to the service-level costs discussed above, there are also a range of expected costs which would be associated with delivery of the national network components of the proposed model. These are anticipated to include:

- **Coordination and governance** – establishing and maintaining the structures for effective governance and coordination of activity across the network as a whole – this may include funding for a board and executive leadership, policy/framework development functions and network operations staff. The Commonwealth may choose to undertake these directly or contract them to a qualified national organisation.
- **Accreditation** – supporting the setting and maintenance of quality standards – depending on the approach adopted, this could include funding a dedicated body or team to undertake accreditation and oversee compliance with standards by individual Safe Spaces; alternatively this could involve supporting small community-level organisations to undertake the steps necessary to achieve accreditation.
- **Marketing and awareness-raising** – undertaking national and community-level activities to promote awareness and uptake of the network – potentially including traditional, online and social media advertising, community campaigns and outreach activities targeting priority audiences.

- **Enabling systems and infrastructure** – providing data and information systems to facilitate the effective sharing of information among services operating within the network and commissioning partners – potentially including delivery of digital platforms (e.g. a website and mobile app) and common service delivery database.

More detailed scoping and design of the network would be required to support the costing of these components, as there is potential for very wide variation depending on decisions taken by government. However, the Department of Health should be able to cost these by drawing on actual costs associated with undertaking these functions within other Commonwealth programs – particularly headspace given the parallels to its networked model. Consultation with other teams within the Department would likely be the most reliable source of recent and applicable costing information on which to base estimates for these whole-of-network components.

Steps to considering the cost effectiveness of Safe Spaces

Establishing estimates of the potential per-person cost of service delivery at each tier of the proposed network is an important step in considering the overall cost effectiveness of the service. Cost effectiveness analysis compares the cost of achieving a particular health or wellbeing outcome through one intervention compared with another.

It is not possible to undertaking a full cost effectiveness analysis at this stage in consideration of the National Safe Spaces Network proposal, because this methodology requires establishing the outcome that is being sought through a given intervention. As discussed in *Section 4.4*, these have not yet been defined or agreed for the proposed network. This is important because the outcomes selected would also drive the relevant comparison point for other interventions. For example, if the target outcome was reducing deaths by suicide, relevant points of comparison for cost effectiveness may include services like The Way Back Support Service or inpatient mental health facilities. However, if the target outcome was improved guest wellbeing, there are a much broader range of community interventions which may be relevant for comparison. The target outcomes for Safe Spaces at each tier would need to be more clearly defined to facilitate cost effectiveness analysis against other services addressing these same outcomes. To support further consideration by Government, the Department may wish to select a number of indicative target outcomes and consider the potential cost effectiveness of Safe Spaces in supporting these compared with other Commonwealth-funded services.

One comparison which can be considered is between the cost of service for a person in distress in a Safe Space within the network relative to an Emergency Department. Data from the National Hospital Cost Data Collection indicates that in 2017-18 the average cost of a non-admitted Emergency Department presentation across Australia was $561.[105] The data indicates significant variation in this cost across jurisdictions, with Western Australia having the highest at $667 and Tasmania the lowest at $393. These costs sit in the range between KPMG's highest and lowest estimates of the cost per person for Tier 4 Safe Spaces, which are intended to provide the most direct alternatives to Emergency Departments.

If people experiencing distress and crisis visited a Tier 3 Safe Space, in most cases the cost of that visit would be lower than the average cost of presenting to an Emergency Department. These are only initial observations about one possible metric for assessing the cost effectiveness of a future National Safe Spaces Network. But they do suggest that if Safe Spaces were used as an alternative to Emergency Departments by some guests, there would be potential for cost savings at a whole-of-system level.

This was the conclusion reached by a 2018 benefits assessment of the St Vincent's Hospital Safe Haven Café[106] It should be noted however that this is only likely to be relevant to the Tier 3 and 4 Safe Spaces within the proposed network, as the higher and lower tiers are intended to serve guests at different levels of acuity.

Funding models

Having considered the potential costs of individual services within a National Safe Spaces Network, it is also worth briefly considering possible funding models for these. There are a range of options for the delivery of Safe Spaces, depending on the role adopted by the Commonwealth and other partners.

In the course of this scoping study, KPMG has identified a range of funding models currently used to deliver mental health and suicide prevention services. The more prominent examples include:

- **Commonwealth funding via PHN commissioning** – Suicide Prevention Trials; headspace
- **Commonwealth seed funding to community sector delivery agents** – SPARC initiative
- **Co-funding with state and territory governments** – Inpatient mental health services
- **State and territory funding and delivery** – New South Wales Alternatives to Emergency Departments; Queensland Safe Haven Cafes
- **Individual health service funding and delivery** – Living EDge; Brisbane North Safe Spaces pilot
- **Philanthropic funding supporting non-government organisation delivery** – Maytree House.

Each of these funding models will bring different benefits and risks. Some may also be better suited to different tiers of the proposed network than others. For example, a number of stakeholders suggested that direct Commonwealth funding of Tier 5 services may be appropriate and valuable because state governments have less capacity to make investments of the necessary scale to deliver these services in multiple locations. Similarly, stakeholders noted there may be particular synergies in states and territories funding Tier 4 services given these governments will benefit most from a reduction in Emergency Department presentations.

Based on KPMG's costing analysis and consultation with stakeholders, there is no single funding model that is obviously better suited to the requirements of a National Safe Spaces Network than others. Decisions about the model adopted would need to reflect broader considerations about the appropriate roles for different levels of government and delivery partners, as discussed elsewhere in this report.

It should also be noted that there may, in fact, be multiple funding models for the network depending on the diversity of partners delivering services within it. This would not be unusual in the Australian service delivery context, but does have the potential to add complexity to the model. In this case, other implementation considerations such as governance and accreditation would become particularly important to ensure services funded by different partners adhered to the overall principles and service model of the national network.

Investment and operating costs – conclusions

This analysis has identified that there are likely to be substantial differences in the cost of delivery for Safe Spaces across the proposed tiers of the network. Tiers 1 to 3 could be delivered at relatively

minimal cost – although this would depend greatly on businesses and community facilities being willing to make their space and staff resources available. As will shortly be discussed under *Section 4.8*, this aspect of the proposal remains to be tested. By contrast, Tier 4 and 5 services are expected to require substantial investments – both capital and recurrent – to establish and run dedicated spaces.

Within individual tiers, there is also the potential for large variation in costs between sites depending on decisions about the chosen service model, the infrastructure used for delivery and the level of service demand. To further refine the costing of services at each tier, the Commonwealth could consider identifying a preferred service model and indicative metropolitan, regional and rural/remote site locations.

Developing a detailed costing of the proposed National Safe Spaces Network as a whole would then require consideration of factors including:

- The total number of sites to be delivered at each tier across Australia and over what timeframe
- The ratio of lower and higher tier services across the network as a whole
- Distribution of sites at each tier within specific locations.

This could be done using a scenario-based approach testing whole-of-network costs using different investment assumptions about each of these key factors.

Determining the cost effectiveness and preferred funding model for the network would depend on a range of broader decisions about the outcomes Safe Spaces are intended to achieve and the range of participating partners who would work towards these through the network. These aspects of the proposal would need to be further developed and articulated through a detailed service model to support considered analysis of cost effectiveness and funding options.

4.8. Implementation considerations

The final aspect examined as part of this scoping study is the implementation of a potential National Safe Spaces Network. In this domain, KPMG sought to identify key considerations for how the model would need to be rolled out and factors that may determine the feasibility of this. The findings discussed in this section generally relate to implementation of the model by any agency which chose to take the lead on delivering it. Specific steps the Commonwealth would need to consider if it decided to pursue this model further are discussed separately under *Section 7: Implementation Considerations.*

The findings primarily reflect feedback and insights provided by stakeholders, along with lessons learned through the implementation of comparable services. As with any program, the details of an implementation approach will be driven by a range of policy and program design decisions made upstream of delivery. For this reason, the discussion in the following section does not make recommendations on the highlighted implementation considerations. Instead, feedback from stakeholders and other inputs are provided on options to address these to help inform further consideration of model feasibility.

Summary of findings

- While the National Safe Spaces Network model proposes five tiers of service, it would not be a requirement for all tiers to be delivered by a single agency or within a single community. Input from local communities is expected to drive prioritisation of specific tiers for delivery depending on local need. Delivery by a mix of partners may then be appropriate depending on the chosen tiers.
- Identification of appropriate locations across Australia and individual sites for Safe Spaces at each proposed tier of service would require close consultation with state and territory governments, existing service providers and other potential delivery partners. Co-design with local communities to determine siting and access preferences would also be essential. Because of this, there is unlikely to be a single, national approach to implementation for each tier of service.
- Integration of existing Safe Spaces-type services within the network would have strong potential benefits for users and services alike. However, some stakeholders have expressed resistance to this approach which would require further consultation to understand in detail and address.
- Effective marketing and communication of the National Safe Spaces Network would be critical to its ability to engage and support people experiencing distress and crisis. This is likely to require a sustained education campaign which raises general community awareness through media channels, and more direct engagement and assertive outreach aimed at priority audiences.
- In designing the marketing and communications approach for the future network, co-design with priority cohorts including Indigenous Australians, culturally and linguistically diverse communities, men and young people would be crucial to ensure it is presented in ways that engage with these audiences. This is likely to require a range of tailored campaigns and initiatives, within an overarching communications approach. In the context of engaging with some of these audiences, this should include considering the capacity for services to develop their own branding within the broader network architecture.

Site selection and infrastructure

The identification of appropriate sites for delivering Safe Spaces is a key implementation consideration for the model. There are two elements to this: the distribution of services at each tier across a community, region or Australia as a whole, and the siting of individual services once locations have been chosen.

Looking first at the distribution of services, stakeholders consistently emphasised the importance of a future network filling service gaps rather than duplicating what is already available. The service mapping presented in *Section 4.2* indicates this would make regional and remote communities – and to a lesser extent, metropolitan areas outside of Australia's east coast – priorities for the potential location of Safe Spaces. In these communities, all tiers of the network are likely to be needed because there are limited existing services specifically addressing the needs of people experiencing distress and crisis. Within the original network proposal, there is an emphasis on individual communities organically developing their own Safe Spaces based on identification of local need. However, local organisations may not have capacity to do this without funding from government or other partners, particularly at the higher tiers. This means there is also likely to be a role for those funding partners in deciding where Safe Spaces are located and which tiers of service are delivered there. Ideally, investment would be coordinated to ensure distribution of sites in line with greatest community need across Australia, but this depends on broader decisions about the network's underlying funding sources.

In each of the states and territories which are currently implementing Safe Spaces-type services, state governments have identified the delivery locations, with funding provided to Local Health Districts (or their equivalent) to implement services. If the Commonwealth opted to lead or support investment in a National Safe Spaces Network, it may be appropriate for sites to be selected in partnership with states and territories following analysis of need – as determined by factors including localised suicide rates and current availability of other services. This would ensure chosen locations help address high priority service gaps and do not duplicate state-based services. As noted in *Section 4.1*, the scale of potential demand for suicide prevention services is such that it is unlikely a future National Safe Spaces Network could accommodate all of this without a very large annual investment by governments. In this context, governments would need to make strategic choices about where to deliver services and how much of the current service demand in any given location would be intended to be met through Safe Spaces.

Discussions with the Expert Advisory Group members responsible for the network proposal indicate it is not intended that services at all tiers would be available in every location, or that the Commonwealth would be expected to fund all activity within the network. Rather, communities would be empowered to determine which tiers are most relevant to their needs and pursue delivery of these. Further, it is envisaged that services at each tier may be delivered by different partners within a single location. For example, stakeholders frequently mentioned that as state and territory governments are already delivering Tier 4 equivalent services, there would be limited value in the Commonwealth also investing in these. By contrast, it was proposed that the near-total lack of Tier 5 services and their high expense may make these particularly suitable for Commonwealth investment. With lower tier services potentially able to be delivered through some combination of philanthropy and local volunteer activity, this could see multiple tiers delivered in a single location through a mixed partnership model. This emphasises the importance of the governance and accreditation issues discussed in *Section 4.5*, as there would need to be strong mechanisms for assuring service quality and safety in such a mixed delivery model. A national governing and accreditation body of the kind discussed in *Section 4.5* could also then play a role in advising on and/or coordinating the selection of locations across the network as a whole.

KPMG's exploration of these issues suggests selecting appropriate delivery locations for Safe Spaces across the network should not be significantly more difficult than doing so in any other service delivery context. Some complexity arises, however, in the likely interaction between a range of partners to deliver services at specific tiers within a single location. Close coordination would be required between levels of government and other partners, along with detailed local service mapping to identify priority gaps that need filling.

Once locations have been selected, a further set of implementation considerations arise in relation to the siting of Safe Spaces and the infrastructure needed to deliver these. Stakeholders emphasised that genuine co-design would be critical at this stage to ensure chosen sites meet the needs and preferences of local communities. This is the approach currently being adopted by the NSW Government for their emergency department alternative services. Following the identification of 20 locations by the Ministry of Health, Local Hospital Districts and communities are co-designing a range of delivery elements, including the selection of appropriate sites.

In consultation, stakeholders raised a number of considerations in relation to site selection which would need to inform implementation of the future network. A large number of stakeholders noted that Safe Spaces should not look or feel like a government service or a clinical mental health service. Rather, they should seek to provide a warm, relaxing and 'home like' environment which supports people to reduce and manage their distress. This has been a priority for the delivery of several of the comparable services. For example, the St Vincent's Hospital Safe Haven Café is located in space that is also used as an art gallery, and The Living Room's spaces are set up to resemble the living room of a comfortable suburban home [107]

Stakeholders also emphasised that Safe Spaces would need to be easily accessible, for example, being located close to public transport and near shopping centres or other common places people regularly frequent. It was suggested that sites would need to be highly visible, although not so obvious that other members of the public can clearly identify everyone entering and leaving. In these discussions, an important distinction was drawn between services being 'available' and being 'accessible'. A service may be available in the sense that it is open, has staff available to help and is located in a place people can easily get to. But if this service is not presented in a way that engages with the needs of potential users, or does not offer an environment that feels psychologically safe, it may still not be accessible. This was flagged particularly in the context of the intended location of Tier 1 and 2 Safe Spaces in existing community spaces such as libraries and coffee shops. Some stakeholders questioned whether the environment of these service would be accessible to someone who is in distress, even if Safe Spaces are available there.

There were mixed views among stakeholders on whether Safe Spaces should be co-located with hospitals or other clinical services, as the Queensland and Western Australian Tier 4 equivalent services will be. Some stakeholders felt that co-location would facilitate smooth escalation from a Safe Space to an Emergency Department if required, or alternatively, a transition pathway from the Emergency Department across to a Safe Space. On the other hand, some stakeholders felt that co-locating with clinical services would make people feel uncomfortable and deter attendance. The range of perspectives put forward by stakeholders suggests there is unlikely to be a clear consensus on this, or other matters relating to the siting of individual services. These site-specific issues would likely be best addressed through local co-design so that communities can choose their preferred approach.

The re-purposing of existing infrastructure to deliver Safe Spaces is an important aspect of the proposed model, particularly for the lower tiers. Stakeholders consistently raised a number of challenges here which suggest this aspect of implementation would require further consideration. First and foremost, stakeholders emphasised that rural and remote communities are often poorly serviced by all kinds of community infrastructure, including coffee shops, libraries, community centres and health care facilities. In these communities, it is questionable whether sufficient community facilities could be found to host Safe Spaces as intended. Where these facilities are available, they may require guests to travel significant distances to reach them, reducing their accessibility and availability.

Second, stakeholders queried how many small businesses or local councils would be willing to make their facilities available as Safe Spaces, given the potential risks and disruptions to their core business that may come with this. This is a significant unknown at the centre of the proposed model which would need to be tested further through direct engagement with representatives of business and local government.

Finally, first responder stakeholders particularly flagged concerns about the physical safety of the infrastructure proposed for use at the lower tiers. Where suicide prevention and mental health services are delivered through dedicated spaces, these are designed with suicide risk in mind – for example by removing potential hazards such as hanging points. It may not be logistically feasible to do this for community-based spaces which serve a range of other purposes, resulting in environments which do not provide the same level of physical safety for people in distress. It should be noted that the lower tier services are not necessarily intended to support people who are at imminent risk of suicide, and these considerations may be more relevant to Tier 4 and 5 services. But given the possibility that people experiencing acute crisis may also present to lower tier services within the network, this remains an important point.

Examination of comparable services indicates Tier 4 and 5 equivalent supports are usually delivered with dedicated infrastructure and therefore do not have the same implementation challenges. However, this raises a separate set of issues in relation to the cost of rolling out services at these tiers. The costing analysis presented in *Section 4.7* indicates these tiers are significantly more expensive to deliver, in part because of their higher infrastructure requirements. Further, the Commonwealth's grant of $1.25 million in seed funding for the Sydney SPARC points to the scale of initial infrastructure investment that may be needed for each dedicated Tier 5 space. Stakeholders reflected that this is likely to constrain the total number of these spaces which can feasibly be delivered within the network.

Taken together, this discussion emphasises that the selection of sites and infrastructure across a future National Safe Spaces Network would require significant coordination across multiple levels of government, delivery partners and local communities, with a strong focus on local co-design for individual services. Based on the feedback from stakeholders, the proposed implementation approach for lower tier services also presents feasibility challenges which would require further work and co-design with people with lived experience to address.

Marketing and awareness

For the National Safe Spaces Network to effectively support people experiencing distress and crisis, it will be critically important they are aware of the service as a whole and know where to seek help locally. This makes marketing and awareness-raising key implementation activities for successful delivery of the network. Stakeholders highlighted several important considerations in this area, including the use of direct and indirect channels to deliver information about the network, the content of messaging about what it offers, and the need to consider how different priority audiences can be engaged.

In relation to raising awareness about a new service, stakeholders emphasised that there are plenty of existing services potential users are simply not aware of because they have not undertaken a sustained communication and marketing effort. By contrast, services such as Lifeline are well known because they have undertaken consistent awareness-raising campaigns over many years. Stakeholders indicated that communication about a National Safe Spaces Network would likely need to include both nation-wide advertising campaigns to raise whole-of-community awareness and more targeted campaigns through social media and direct engagement to reach priority audiences. To undertake this direct engagement, existing organisations and services that priority audiences trust were seen as particularly useful potential channels. Frequent suggestions included partnering with:

- Aboriginal-controlled health organisations to reach Indigenous Australians
- Men's Sheds and sporting clubs to engage with men
- LGBTQI+ health services to connect with sexually and gender diverse people
- Migrant or refugee settlement services for raising awareness among culturally and linguistically diverse communities
- Universities and headspace centres to reach young people (depending on decisions about young people's eligibility for Safe Spaces services – see discussion below).

Direct engagement through these trusted channels would serve the valuable double purpose of also making key potential gatekeepers aware of the network so they can refer people to it. Stakeholders considered this element to be as important as individual awareness about Safe Spaces, given many people will reach out for help to others before accessing specific suicide prevention services. Gatekeepers who were considered to be a particular priority for direct outreach in addition to the above included GPs, police and ambulance workers and Emergency Department staff.

Stakeholders also highlighted the importance of both gatekeepers and individuals being able to easily find a Safe Space near them, once they are aware of the network. Several suggested that an app and website be developed which would use location services to identify the nearest sites and direct people to them. These digital services could also offer practical, plain English information about suicide prevention, services and supports, and connect people with virtual supports. However, this would potentially replicate some of the functions of existing digital resources provided by *Life in Mind*, *Lifeline* and *BeyondBlue* as well as the rapidly growing number of mental health and wellbeing apps. It would be important to ensure any new digital services for the National Safe Spaces Network connected with these existing resources and avoided duplicating their content where possible, as overlapping services increase complexity of navigation for users.

In addition to awareness-raising through campaigns and direct engagement via trusted partners and gatekeepers, there would also appear to be a role for more assertive outreach in some contexts. For example, both the St Vincent's Hospital Safe Haven Café and Living EDge have based peer workers in their respective hospital Emergency Departments to identify people who may benefit from the services and invite them in. This approach would be particularly useful for Safe Spaces co-located with hospitals, but could also be feasible in other contexts such as Family Courts and Services Australia offices. Assertive outreach may also be beneficial to engage with men at high risk in light of their relatively

lower likelihood of help-seeking. For example, given the risk of suicide among men working in the construction industry, assertive outreach could be undertaken on building sites, with a focus on men identifying friends or colleagues who would benefit from support[9] Assertive outreach is a key focus for existing suicide prevention services like The Way Back Support Service, so there are likely to be valuable precedents to follow for the National Safe Spaces Network.

The feasibility of undertaking some or all of these awareness-raising activities would largely depend on the National Safe Spaces Network's available budget. All of these have been successfully implemented previously by a wide range of health and human services agencies, and professional expertise can easily be procured to support delivery. But raising awareness of a new service on a national scale requires a large, sustained investment in advertising and communication over an extended period.

This is therefore an area that would likely require dedicated resourcing if the network were to be implemented. The Department undertakes a range of national health promotion campaigns which could be examined to estimate the required scale of investment.

Across all marketing and awareness-raising activities, stakeholders emphasised the importance of careful communication about what the National Safe Spaces Network is and does. In particular, there was a strong view that the network should not be presented as a mental health service or make prominent references to suicide prevention. Language about mental health was considered to be alienating for people whose experience of distress and crisis is not driven by an underlying mental illness. Stakeholders also noted people experiencing distress will not necessarily identify as being 'suicidal'. Language that frames the network more broadly as being available to support people 'feeling distressed' or 'having a tough time' was considered to be more appropriate and accessible for different audiences. However, this may need to be balanced with some more specific messaging about the kinds of supports available through Safe Spaces, as stakeholders also pointed out that people need to know how a service can help them before they will reach out.

These points link to further considerations about how the presentation of a National Safe Spaces Network engages different priority cohorts. While consistent branding and messaging will be important for promoting national awareness, stakeholders pointed out this can also be alienating for some audiences. For example, a communications approach which leads to Safe Spaces appearing too 'government' or institutional is unlikely to support engagement by Indigenous Australians. Some Aboriginal and Torres Strait Islander stakeholders highlighted this as factor behind levels of engagement with existing Commonwealth services like headspace. This can also be a barrier for culturally and linguistically diverse communities which have different, and less positive, perceptions of government services.

Further, where Indigenous or ethnically diverse community-based services already exist, it may be disempowering for these to be subsumed into a national brand and network when they have already worked to build local engagement and buy-in through grassroots activity. In a similar vein, it was suggested that framing the network in language that emphasises talking, opening up and being supported may not engage some men because of entrenched gender stereotypes about these being

[9] The *Tradie Tune Up* service delivered by OzHelp in the ACT is an existing example of this assertive outreach approach in an industry-specific context.

feminine behaviours. These are complexities which would need to be carefully considered as part of designing the communications approach for the National Safe Spaces Network. Co-design with people with lived experience from different priority cohorts will be important to strike the right balance in national marketing activities. But it should also be acknowledged that there is unlikely to be a single approach capable of reaching all audiences. Rather, individual campaigns and messaging would likely be needed to engage with priority audiences in line with their needs and preferences. In some cases, this may need to include the flexibility for local Safe Spaces to be accredited but not branded or marketed as such.

Getting the messaging right about Safe Spaces at the network and individual service levels will be a critical implementation priority for this service. Given the importance of this aspect and its complexities, this is an area that would appear to warrant close consideration from the commencement of network design and planning. That is, the network would need to be designed in a way that supports its effective marketing and communication to priority audiences, including considerations like the kinds of supports available, how people can access them and the environments in which they will be provided. This would help ensure that both the substance and the marketing of Safe Spaces is authentic, appropriate and aligned with genuine community needs.

Relationship with existing Safe Spaces-type services

As discussed in *Section 4.6*, there are a wide range of existing services a National Safe Spaces Network would need to integrate with. These range from primary and mental health services to alcohol and other drug supports, financial, relationship and legal services. Integration with these services will require building effective service linkage pathways and strong working partnerships at the local level, along with the potential development of national data and information sharing architecture to support this (see discussion on p.71). This is an important aspect of service implementation, but these relationships would be expected to develop over time as individual services become established within their local communities. A more immediate consideration is the relationship between the National Safe Spaces Network and existing services delivering comparable supports for people at risk of suicide. Until recently, this would not have been a significant consideration as there were only a handful of existing services in Australia. However, the roll-out of a significant number of Tier 4 equivalent services in New South Wales, Queensland and Western Australia during 2020-21 makes this a more pressing question.

In terms of developing a national network that is easy to navigate for users, available in as many locations as possible and provides a consistent standard of care, there would appear to be significant merit in integrating all existing services into a future National Safe Spaces Network. If existing services are not integrated, there is a risk that the current fragmentation and lack of coordination experienced by users of mental health and suicide prevention services would be replicated in this new area of service delivery. Effective integration could be achieved through the accreditation process discussed in *Section 4.5*, with individual services completing accreditation to become recognised as Safe Spaces according to the criteria set for the network as a whole. However, state government stakeholders expressed reservations about this approach on the basis that it may add unnecessary administrative burden to services that are already governed and overseen through state government mechanisms. These stakeholders queried how much value accreditation and integration with a future national network

would bring for local services, particularly if this was not linked to any additional funding or delivery support.

A scan of potential benefits suggests existing services may, in fact, receive a range of advantages from integration with a national network including:

- Strengthened opportunities for knowledge-sharing and the dissemination of best-practice in a rapidly evolving field
- More direct service connection pathways for guests whose needs cannot be accommodated within that specific service
- Access to any data or information-sharing infrastructure set up to support the national network
- External advice and input on quality improvement and opportunities for ongoing service innovation.

These service-level benefits come alongside the significant benefits for users in terms of service quality and ease of navigation discussed above. Integrating existing services into the National Safe Spaces Network would therefore appear to be a high priority for its implementation. This aspect would require further consultation with state governments to better understand and address their current reservations.

Tailoring services for priority cohorts

The overarching service model for Safe Spaces at all tiers is based on warm and empathetic support from peers with a shared lived experience. In consultations, stakeholders consistently emphasised the importance of the peer and lived experience aspects addressing factors such as cultural background and life experiences *as well* as prior experience of suicidality or bereavement by suicide. This was considered to be particularly relevant for priority cohorts such as Indigenous Australians, people from culturally and linguistically diverse communities, men, LGBTQI+ Australians and young people. The National Safe Spaces Network proposal also notes that there is likely to be a role within the network for dedicated Safe Spaces established by and for communities such as Indigenous Australians, culturally and linguistically diverse people and those who are sexually and gender diverse.

In considering implementation of the network, this raises the question of whether, where and how many services may be established specifically for priority cohorts versus more general audiences. For example, some stakeholders suggested it would not be safe or appropriate for young people to access the same Safe Spaces as adults. Others indicated that some potential guests would not use the services unless they could be assured of speaking to a peer worker from their own community or cultural background. In a range of areas of health and human services delivery, it is acknowledged that specialist services are sometimes necessary to meet the needs of diverse communities. Establishing dedicated Safe Spaces aimed at priority cohorts would be consistent with the approach adopted through services such as headspace, Aboriginal-controlled healthcare organisations and migrant support agencies. In light of the relative suicide risks of some communities (discussed in *Section 4.1*), there would appear to be a strong case for this as part of broader network implementation.

However, it would also be important to ensure *all* Safe Spaces are accessible to people from different priority cohorts to maximise their potential uptake of these services. Some key implementation considerations highlighted by stakeholders here include:

- Proactively engaging people from priority cohorts when undertaking co-design for both the network as a whole and individual local services, including acknowledging and taking steps to address barriers to their participation (such as language, travel and cultural considerations)
- Including people with lived experience of suicide from priority cohorts in both the national and service-level governance of Safe Spaces

- Ensuring Safe Spaces are staffed by peers representing a range of ages, backgrounds and life experiences, with a particular emphasis on matching the staffing mix to the characteristics of the local communities in which services are based
- Requiring all Safe Spaces staff to undertake training which supports cultural competence in meeting the needs of Indigenous and culturally and linguistically diverse Australians, and the creation of culturally safe environments for people from these communities
- Including cultural competence and cultural safety as criteria for assessment within the accreditation framework used to accredit individual Safe Spaces
- Providing avenues for ongoing dedicated co-design and feedback from priority cohorts about the extent to which Safe Spaces are meeting their needs.

Each of these aspects would need to be built into the implementation approach for the network and individual services within it to ensure Safe Spaces are genuinely accessible for everyone who may need them. The establishment of specialised services could be a valuable way to address the needs of priority cohorts, but ensuring all Safe Spaces are capable and equipped to do so would be an important further step in strengthening service availability and access.

Implementation staging

A final, practical implementation consideration relates to how the roll-out of a National Safe Spaces Network could be staged. The network proposal calls for an initial pilot involving the establishment of all five tiers of service at three locations across Australia over four years. This would see the Commonwealth provide direct funding to first establish Tier 4 and 5 services in each location, followed by seed funding to commission services across Tiers 1 to 3 and the integration of existing services.[108] This pilot approach aligns with that adopted for the Commonwealth's Adult Mental Health Hubs, which are currently in the process of being rolled out over 2020-21 and 2021-22. Eight hubs will be piloted – one in each jurisdiction across Australia – with these being subject to evaluation ahead of decisions by government about further delivery. A similar approach was adopted for headspace, with the Commonwealth progressively expanding the network over multiple funding rounds since 2005. The 12th funding round was announced in 2019, taking the total number of headspace services around Australia to more than 150 after 15 years of gradual expansion.

A pilot-based approach would allow for testing and validation of aspects of the proposed service model and capacity for Safe Spaces to integrate effectively with other services across the health, mental health and human services landscape before proceeding with a broader national roll-out. Given that some state governments have already commenced roll-out of Tier 4 equivalent services, there may be value in looking to these for evidence of effectiveness and delivery insights rather than trialling further Tier 4 services. Additional pilot investments could focus on providing Tier 5 and a consolidated lower tier offering in high need locations where Tier 4 services are already being put in place – such as regional New South Wales, Queensland and Western Australia. This would enable testing of both the full multi-tier model and the effectiveness of a mixed delivery approach involving multiple partners, as discussed on p.98.

In addition to establishing new services, a Safe Spaces pilot would also need to explore the feasibility of integrating and engaging with existing services. This would involve testing the proposed approach to accreditation with existing Safe Spaces-type services (operating at any tier) as well as trialling the establishment of referral relationships and local partnerships with the range of broader services the network would need to connect with. The ability for Safe Spaces to connect guests with appropriate services and supports addressing their diverse needs is a key feature of the proposed model, beyond the direct support that would be provided by peers. Testing their capacity to effectively build the networks and relationships required to achieve this would therefore be an equally important aspect of any network pilot.

A pilot-based approach to implementation is likely to provide the strongest opportunity to understand the benefits of a National Safe Spaces Network and develop appropriate mitigations for identified risks. Given the distinct service models of each proposed tier, this would also provide an opportunity to explore differences in implementation requirements. These cannot currently be assessed in detail because the full service models for each tier have not be defined.

Based on the scoping study findings in *Section 4.7* this variation would be expected to include significant differences in the amount of new versus re-purposed infrastructure required for each tier, the degree of workforce development and training needed, and the extent of integration with other services – particularly clinical services.

Implementation considerations – conclusions

Implementing a National Safe Spaces Network would be a complex undertaking. The relatively new nature of its service offerings, combined with the multi-tiered model and the range of priority cohorts whose needs would have to be considered all seem likely to make implementation of the proposed network more complex than some other service delivery undertakings. While none of the complexities discussed in this section seem insurmountable, it would be important to ensure sufficient time and resourcing is provided to address them as part of any future service pilot or roll-out. In consultation, a number of stakeholders highlighted that the implementation timeframes set by governments for new services are often unreasonably short. This places pressure on implementation planning and service design, leading to sub-optimal delivery outcomes. While acknowledging that suicide prevention is a national priority and there are urgent calls for new services, stakeholder feedback strongly emphasised the importance of taking the time to get them right. This feedback has particularly informed KPMG's discussion of implementation priorities for the Commonwealth in the event it chose to pursue investment in a National Safe Spaces Network, provided in *Section 7.*

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6. Feasibility assessment

The findings of this scoping study have informed an initial feasibility assessment of the National Safe Spaces Network proposal. This addresses the feasibility of pursuing further development of the model, potential roles the Commonwealth may choose to take and options to address challenges or risks which emerged through this analysis. The discussion in this section does not provide recommendations on *whether* the Commonwealth should proceed with this proposal. Rather, it seeks to assess the feasibility of doing so and factors which could inform a future delivery approach if the Commonwealth opted to pursue investment.

Based on the findings of this scoping study, KPMG assesses that the National Safe Spaces Network proposal outlines a service which is closely aligned with expressed and observed community need.

Its design reflects currently understood best practice in suicide prevention and there is early evidence to indicate the effectiveness of the proposed approach in improving the wellbeing of some people experiencing distress and crisis.

Some aspects of the proposed model would require further detailed co-design with people with lived experience to develop these to a level of specificity that can facilitate full service costing and potential future implementation of a national network. These elements include:

- The intended target outcomes and priorities for measurement
- The appropriate number of service tiers and complementary roles for online, telephone and peer group supports
- The specific supports best provided at each tier of service to meet the needs of intended guests.

Because these elements relate to the design of services at individual tiers, this further co-design and model development could feasibly be undertaken in the context of a trial or pilot of Safe Spaces – with appropriate public caveats about this informing consideration of any broader national roll out. This would be consistent with the approach adopted for other innovative Commonwealth Government services such as headspace and the current pilot of Adult Mental Health Hubs. There are also a number of service model elements which would need to be co-designed at a local community level once pilot locations had been identified, including the preferred extent of involvement for clinical supports and appropriate delivery sites – addressing the complexities discussed in *Section 4.6*. This would not be expected to affect the overall feasibility of delivery, but would need to be factored into realistic project timeframes for any future pilot.

Development, training and support for the lived experience peer workforce will be critical to the successful delivery of the proposed model. This is an area where the Commonwealth could play an important leadership role, including through the work underway to develop the next National Mental Health Workforce Strategy and Peer Workforce Development Guidelines. More practically, the peer workforce training pathways and support infrastructure currently under development in New South Wales are endorsed by stakeholders and appear suitable and adaptable for delivery of a future pilot or roll-out of Safe Spaces. It is important to recognise that the suicide prevention peer workforce will provide services and supports which are qualitatively different from those provided through the existing clinical service system. This would reasonably be expected to be reflected in different training and accreditation pathways. However, the safety and wellbeing of vulnerable people must be a paramount consideration when designing and delivering these pathways. This means that the training and accreditation processes for this peer workforce need to be evidence-based and subject to appropriate external oversight to the same extent that other professionals working with vulnerable communities are required to be.

Governance and accreditation frameworks will provide the backbone for any future national network. In the absence of a national agency or organisation taking a coordinating role in this area, delivery of a national network of services delivered to a consistent standard is unlikely. In a context where state governments and other partners are currently rolling out new services aligned with aspects of the Safe Spaces model at specific tiers, the window of opportunity to develop a nationally consistent approach may be relatively limited. A bespoke governance and accreditation approach reflecting aspects and learnings from the headspace model is likely to be needed in the event the Commonwealth opted to take on this national role. However, if the Commonwealth's intended role does not encompass direct funding and delivery responsibilities, Suicide Australia's new Quality Improvement Standards for suicide prevention services could provide a suitable foundational accreditation framework for Safe Spaces across all tiers. Further consideration would then be needed about the alignment of services at the higher tiers with either the National Standards for Mental Health Services or the Quality Improvement Council Health and Community Services Standards. Discussion and negotiation with stakeholders – including both jurisdictions and the broader range of potential delivery agencies – would be required to secure agreement to the use of these standards as a common approach to accreditation. Stakeholder feedback provided through this scoping study suggests this agreement may be challenging to secure in the absence of funding or other incentives.

Implementation of services at each agreed tier would need to be closely coordinated with state and territory governments and other service delivery stakeholders to ensure any future pilot or roll-out of the National Safe Spaces Network addresses priority service gaps and improves system navigation by users – rather than adding further complexity. If agreement to, and endorsement of, this model cannot be secured with jurisdictions, there is a risk that Safe Spaces would fail to meet the core expectations of stakeholders and intent of the model. This is because individual services would likely face challenges in closely integrating with the existing service landscape and supporting ease of navigation to and from the network's supports. Achieving jurisdictional buy-in would therefore be an important pre-requisite for feasible implementation of the proposed national model.

This scoping study has found the proposed National Safe Spaces Network model is endorsed by stakeholders and aligned with community need. Options and mitigations are available to address many of the challenges and risks highlighted by this scoping study, with co-design in partnership with people with lived experience providing an avenue to explore the next necessary layer of detailed service design.

In this context, there are a number of potential roles the Commonwealth may opt to play in a future National Safe Spaces Network. These are outlined below and mapped for comparison in the matrix at Table 18. This matrix also identifies the complementary roles that may be required by other partners to support each identified approach.

Leadership model

In this model, the Commonwealth would take the leading role in the development of a National Safe Spaces Network. This would include establishing service principles and standards for the network as a whole, developing the required workforce and directly funding a significant number of services. In line with the existing headspace model, service commissioning and oversight of delivery could be undertaken by the 31 Primary Health Networks following receipt of Commonwealth funding. In this model the Commonwealth would also play an active role in service and workforce accreditation, oversight and performance monitoring. This role could be undertaken directly by the Department of Health or contracted to an external body, as is the case with headspace National Office.

The leadership model would see the National Safe Spaces Network established as an Australian Government program, with responsibility for its design, development and ongoing delivery resting primarily with the Commonwealth. It should be noted that few stakeholders indicated a preference or

expectation for the Australian Government to play such an extensive role when discussing the potential implementation of the network.

Partnership model

In a partnership model, the Commonwealth would play a shared role with the Australian states and territories in developing and delivering a National Safe Spaces Network. This would involve the two levels of government working closely together to agree a set of national principles and service standards, develop the suicide prevention peer workforce and undertake whole-of-network governance and oversight. Funding could be provided by both levels of government, helping to ensure states and territories feel a reasonable degree of buy-in and responsibility for the network. Individual state and territory governments would then take responsibility for the commissioning of local services within their jurisdictions, as well as accrediting both these services and the peer workforce. In many ways, this partnership model mirrors the features of existing health agreements between the Commonwealth and states and territories.

As has been discussed throughout this report, consultation with stakeholders highlighted a strong preference for collaboration between different levels of government in the delivery of a National Safe Spaces Network. Stakeholders commonly reflected that a partnership approach would support the effective integration of Safe Spaces into the broader service landscape, which is primarily made up of state-based services.

Architecture-setting model

Under an architecture-setting approach, the Commonwealth would take the lead in setting whole-of-network principles and service standards, and play a strategic coordinating role in national workforce development. However, it would not take any role in the practical commissioning, funding, accreditation or oversight of services, with these functions being addressed by a range of other partners. In this model, a national body would likely need to be established or appointed to provide both ongoing governance and monitoring for the network as a whole, and accreditation functions for individual services. This body could also take responsibility for accrediting and supervising the peer workforce, although this may be a role that is more appropriately filled by state and territory governments as they already do so for a range of other health sector workers.

In the architecture-setting model, funding and commissioning of services would be undertaken by a diverse range of partners. This could potentially include state and territory governments, community sector organisations and business or philanthropic entities. This would reflect the current situation, in which various Safe Spaces-type services are starting to be designed and delivered by different government and non-government agencies across the country. This architecture-setting approach broadly reflects the role envisaged by the scoping study's Expert Advisory Group for the Commonwealth. However, members also emphasised the value of the Commonwealth providing funding to support whole-of-network initiatives such as promotion and communication, enabling infrastructure and network coordination.

Dispersed delivery model

Finally, in the dispersed delivery model the Commonwealth would play no role in the design, development or delivery of a National Safe Spaces Network.

In this model, responsibility for developing a national, networked approach would likely fall to the community sector, with membership and adherence to agreed service principles and standards being achieved through negotiation and voluntary agreement. State governments would continue to have responsibility for workforce development and accreditation of workers, as is currently the case for health services generally. However, this work would not be undertaken within any framework that is

specific to Safe Spaces, unless state governments either chose to establish their own services – as is currently happening in NSW, QLD and WA – or also signed up to the community-sector led network model.

Similar to the architecture-setting model, in a dispersed delivery approach commissioning and funding of services would be undertaken by a diverse mix of partners. This would have benefits in relation to local tailoring of services, but would also likely lead to less consistency and comparability in the supports provided across the network. Achieving the reliable quality of support, service consistency and national community awareness anticipated by the National Safe Spaces Network proposal would likely be challenging with this model. Without a central body or agency which has the authority and resources to play a national coordinating role, the network may struggle to achieve the broad engagement and service coverage required to build a national service footprint.

In considering these models, the optimum approach would need to be determined taking into account various factors including:

- the Commonwealth's appetite and capacity for investment
- the degree of interest from other required partners
- the relative complexity of models integrating inputs by more or less actors.

However, in relation to achieving a nationally consistent approach to the design and delivery of a network of Safe Spaces, the leadership and partnership models are considered more likely to support this objective than the architecture-setting and dispersed delivery models. This is because these models combine a valuable national principle-setting and coordinating function with a level of practical engagement – including both funding and oversight – which can support effective delivery of the network within individual communities.

The matrix of potential roles presented in Table 18 reflects key responsibilities supporting a National Safe Spaces Network which have been identified through this scoping study. These would need to be subject to further consideration by the Department as part of ongoing model design.

Table 18: Matrix of potential roles for consideration reflecting key responsibilities identified through the scoping study

Responsible body	Whole-of-network governance and oversight	Whole-of-network standard and principles setting	Workforce development and oversight	Accreditation of individual services	Accreditation of individual workers	Service-level funding	Service commissioning/ delivery
Commonwealth Government	(L) (P)	(L) (P) (A)	(L) (P) (A)	(L)	(L)	(L) (P)	
State governments	(P)	(P)	(P) (D)	(P)	(P) (A) (D)	(P) (A) (D)	(P) (A) (D)
PHNs							(L)
National NFP body	(A)			(A)	(A)		
Community sector	(D)	(D)		(D)		(A) (D)	(A) (D)
Business/philanthropy						(A) (D)	(A) (D)

Key

(L) = Leadership model (P) = Partnership model (A) = Architecture-setting model (D) = Dispersed delivery model

Source: KPMG (2020)

7. Implementation priorities

In the event the Commonwealth opted to pursue the National Safe Spaces Network proposal, there are a range of steps which would need to be undertaken to support detailed service design, planning and delivery. This scoping study provides information and analysis to support this work, but should not be considered a substitute for detailed further design – including genuine co-design with people with lived experience of suicide.

This section outlines the streams of work that would be required to support implementation of the National Safe Spaces Network. KPMG has also mapped out a high-level implementation timeline for the further development of the network over a period of 18 months. This plan is intended to illustrate the dependencies between the different streams of work discussed above and provide an indication of the timeframes required for each. Actual timeframes may differ based on decisions by government about the implementation approach.

Table 19: Implementation workstreams

Workstream 1: Co-design involving people with lived experience	**Priority:** **Immediate term** *(Commence within three months)*
Genuine co-design involving people with a lived experience of suicide would be required at different times to inform both national level service development and the delivery of individual local services. Given the diverse needs and priorities highlighted throughout this scoping study, this would need to include strong representation from at-risk groups including Aboriginal and Torres Strait Islander Australians, people from culturally and linguistically diverse communities, men, young people and LGBTQI+ Australians. The national level co-design could be used to inform whole-of-network architecture and key model design aspects, including: • Philosophy of care and service principles • Network objectives and target outcomes • Model of care for each service tier (including consideration of appropriate number of tiers and specific supports to be provided through each) • Cultural safety and additional model components required to address the diverse needs of at-risk communities. This phase of co-design could be undertaken in partnership with major national lived experience advocacy organisations, but an open call for expressions of interest may also assist in ensuring a diverse range of voices and views are represented in this process. Co-design would also be vital at a local level to ensure services delivered in communities align with the needs and preferences of intended users. This would inform decisions about a range of practical delivery elements, including: • Site selection • Service and staffing mix	

- Operating hours and model
- Priority partnerships for referrals and service linkages
- Specific local requirements or preferences supporting service uptake by at-risk groups.

At the time of writing, the NSW Government was in the process of undertaking local service-level co-design for its 20 Alternative to Emergency Department services. There are likely to be practical learnings and insights from this process which could inform local co-design for the National Safe Spaces Network Scoping Study.

It should be noted that stakeholders indicated co-design with people with lived experience would be a foundational requirement to support trust and uptake of the National Safe Spaces Network. Initial co-design which is perceived to be rushed or inauthentic may affect longer-term buy-in and stakeholder engagement with this model.

Workstream 2: Partnership scoping and consultation	**Priority:** **Short term** *(Commence within six months)*

Consultation with jurisdictions will be critical as part of further model design and planning, given the close intended connections between the National Safe Spaces Network and a range of services delivered by state and territory governments.

The National Safe Spaces Network proposal notes that the underlying model has previously been presented to a number of cross-jurisdictional bodies and secured in-principle agreement. This includes the National Suicide Prevention Summit and the 5th Mental Health and Suicide Prevention Plan Implementation Committee. This should provide a foundation for taking forward discussions collectively with states and territories through the COAG Health Council (or its replacement under the new National Cabinet arrangements).

There may also be value in initiating direct consultation with NSW, Queensland and Western Australia as a priority ahead of formal engagement through COAG. This would provide an opportunity to explore options for integrating services which are currently in the process of being rolled out by these states within a national network.

Consultation and discussion with jurisdictions would need to address a range of model design and implementation issues including:

- Network ownership and potential roles to be adopted by different levels of government
- Initial network investments and options for ongoing delivery funding
- Integration of existing services
- Agreement to elements developed through co-design including philosophy of care and service principles; network objectives and target outcomes; and models of care
- Governance and accreditation frameworks
- Priority service cohorts
- Implementation timeframes and delivery considerations – including consideration of parallel Commonwealth and state/territory government initiatives.

Given the range and complexity of issues which would need to be scoped and consulted on with states and territories, there may be value in establishing a cross-jurisdictional Working Group involving state and territory representatives, the National Suicide Prevention Adviser and the Commonwealth. This group could take the lead on developing and negotiating model design elements for further discussion and agreement by the COAG Health Council.

Depending on the Commonwealth's preferred delivery model, this workstream may also need to include partnership scoping and consultation with agencies beyond government. For example, if the Commonwealth opted to pursue the *Architecture setting* or *Dispersed* models outlined in *Section 5*, there would be a need to identify or establish an appropriate not-for-profit partner to act as the national coordinating and accreditation body for the National Safe Spaces Network. There would also be a need to engage with the community, business and philanthropic sectors to test levels of appetite for their involvement in delivery of individual Safe Spaces within the proposed national network. In the first instance, this could be undertaken through engagement with peak and representative bodies. However, given the reliance on individual providers, businesses and organisations to deliver Safe Spaces under these models, there may also value in direct engagement with a representative sample of these stakeholders to test and validate inputs and feedback from peaks.

Workstream 3: Needs identification and prioritisation	**Priority:** **Short term** *(Commence within six months)*

This scoping study has emphasised the importance of any future investment in a National Safe Spaces Network addressing current service gaps, rather than duplicating or overlapping with existing services. In that context, a detailed process of needs identification should be undertaken to identify where these gaps are and prioritise them for action through future delivery of the network.

KPMG's service mapping outlined in Section 4.2 provides a high level indication of current service gaps by region and need across Australia. This could be used as a starting point for more detailed work in partnership with states and territories on community-level service mapping and needs analysis. In particular, data limitations have meant KPMG's service mapping does not capture community-level activity of the kind intended to be delivered through the lower two tiers of the proposed model. Understanding the current availability of services comparable to those intended to be offered at all tiers would be important for planning a delivery approach which is responsive to the local context of individual communities.

There are a range of criteria which could drive the prioritisation of locations for future delivery of Safe Spaces. This could include:

- Current suicide prevalence at a regional, community and cohort level
- Representation of at-risk groups as a share of population
- Availability of other suicide-specific support services as well as mental health and alcohol and other drug supports
- Local health system capacity, particularly Emergency Department demand
- Local engagement and capacity to support a whole-of-community approach to suicide prevention.

Workstream 4: Detailed model costing	Priority: **Medium term** *(Commence within 12 months)*
Understanding the expected costs of delivery of Safe Spaces at each tier and in different locations across Australia would be necessary to inform the development of a detailed New Policy Proposal. As the analysis presented in *Section 4.7 – Investment and operating costs* highlights, there is likely to be significant variation in cost both across tiers and within these depending on the locations chosen for delivery. Having refined the service model through *Workstream 1: Co-design* and identified priority delivery locations through *Workstream 3: Needs identification and prioritisation*, it should then be possible to develop detailed costings addressing both whole-of-network and site-specific costs. These costings would need to take into account the following factors: • Preferred/agreed roles for Commonwealth and other delivery partners • The total number of sites to be piloted or rolled-out at each tier across Australia, and over what timeframe • The ratio of lower and higher tier services across the network as a whole • Distribution of sites at each tier within specific locations • Actual variation in cost of key service inputs including staff and infrastructure in identified priority delivery locations • Service-level capital and operating costs (depending on availability of existing infrastructure) • Whole-of-network costs including governance, accreditation, communication and marketing. Having developed detailed costings for the National Safe Spaces Network reflecting its planned delivery approach, the Commonwealth may also wish to undertake a preliminary cost effectiveness analysis. This would need to be informed by the target outcomes defined in consultation with people with lived experience through Workstream 1. Relevant Commonwealth or state/territory services addressing comparable outcomes could be used as the benchmark to determine whether the National Safe Spaces Network would be expected to be more or less cost effective in delivering its intended outcomes. It should be noted that this analysis would be indicative only until the service has been piloted or rolled out and both outcomes and actual costs can be measured. Designing data collection frameworks to support ongoing monitoring of cost effectiveness would need to be an important consideration in *Workstream 6: Data, systems and monitoring.*	
Workstream 5: Workforce planning and development	**Priority:** **Medium term** *(Commence within 12 months)*
Developing the suicide prevention peer workforce is an important sector priority which is already underway through Commonwealth initiatives including the development of the next National Mental Health Workforce Strategy and Peer Workforce Development Guidelines. In the context of the National Safe Spaces Network, there is the opportunity to leverage the existing work undertaken in	

NSW to address peer workforce needs in the short term, while this broader, whole-of-sector work continues.

The NSW peer workforce guidelines identify and map out pathways for peer workforce training, accreditation, development and support. The Commonwealth could support national implementation of these guidelines through the following activities:

- Securing agreement of all jurisdictions to the training and support pathways outlined by the NSW model as an interim workforce development framework – or appropriate alternatives
- Strengthening agreed training pathways by mapping the availability of required courses to identify and address any current gaps
- Working with professional bodies and peak organisations to develop innovative solutions to known sector training challenges (such as a lack of supervised work placement opportunities) and secure buy-in to the support model for suicide prevention peer workers
- Developing estimates of the contribution of the National Safe Spaces Network to future suicide prevention peer workforce demand nationally and within individual jurisdictions

These activities would feed into the broader peer workforce development agenda, advancing the Commonwealth's ongoing work while supporting the delivery of the National Safe Spaces Network.

Workstream 6: Data, systems and monitoring	**Priority:** **Longer term** *(Commence 12 months+)*

Implementation of the National Safe Spaces Network in some form is not just an opportunity to strengthen the available supports for people at risk of suicide. It also represents an important way to continue developing knowledge and evidence about effective suicide prevention practice in the Australian service delivery context to inform the development of other interventions. As this scoping study has highlighted, there is a need for more and better evidence and data on how different types of supports can contribute to the important goal of reducing our national suicide rate, and how the needs of different at-risk cohorts can best be met. Building a focus on high quality data collection and rigorous evaluation into the network from the start would maximise the benefit generated by any Commonwealth investment by allowing its delivery to contribute to this vital evidence base.

This workstream would need to incorporate a number of intersecting but distinct tasks, including:

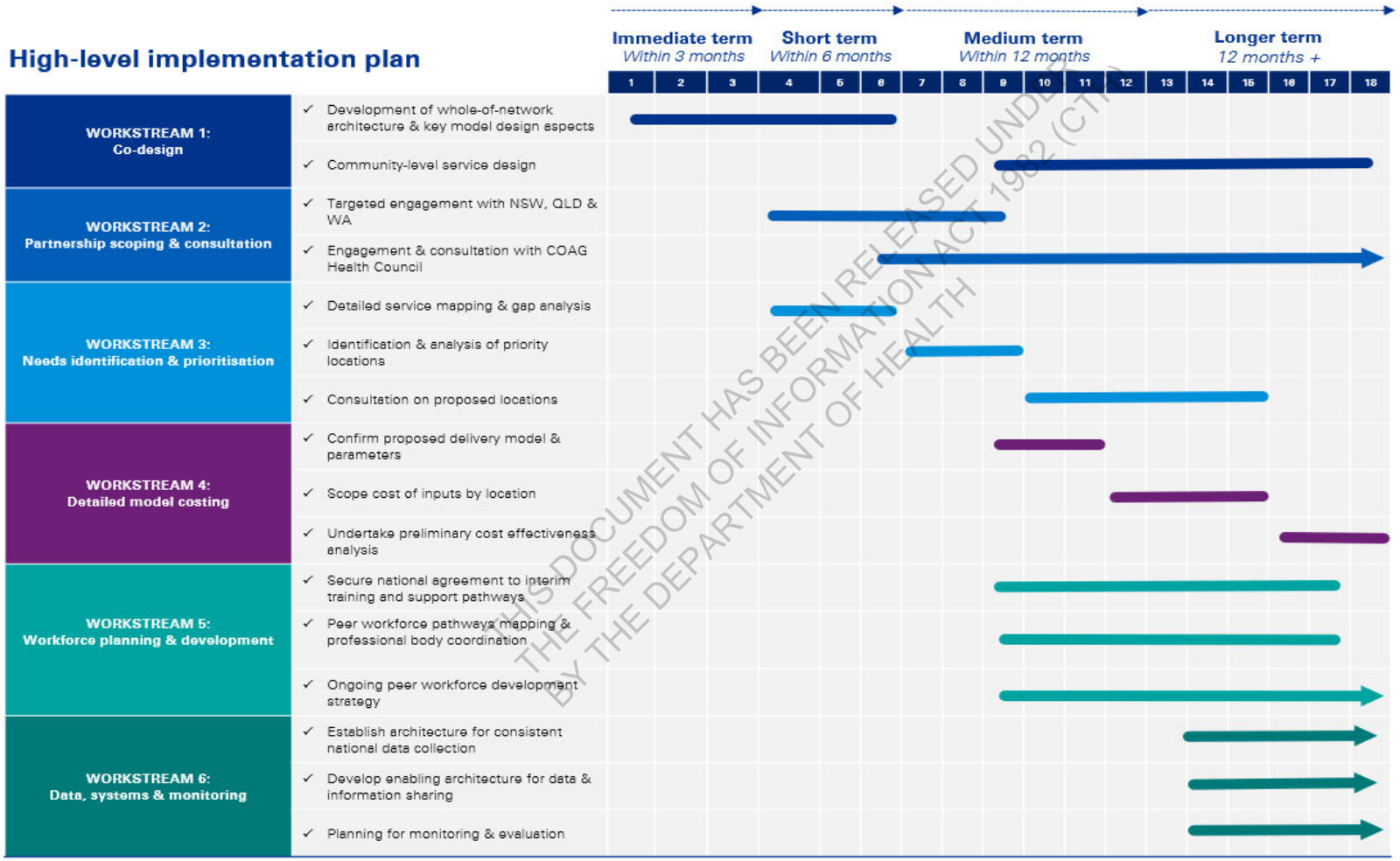
Establishing the architecture for consistent national data collection across the network – consistent and reliable data collection is a major challenge for many national services and programs, particularly those which support highly vulnerable communities. It is also critical to understanding who is being supported, how effectively Safe Spaces may be integrating within the broader service landscape and where ongoing gaps or challenges may lie. Recognising the relatively innovative service context of the National Safe Spaces Network, there may be value in engaging with providers of existing comparable services to understand in detail the specific challenges and obstacles that are likely to be encountered in terms of data collection and management across the network and within its individual services. Drawing on the advice and insights of these providers will help ensure the data architecture established for the network is practical, workable and able to support robust collection supporting ongoing performance monitoring and evaluation.

Developing enabling infrastructure to support data sharing and performance monitoring – As discussed in *Section 4.6 – Service model*, the effective sharing of guest information across Safe Spaces tiers and with other referral partners, and the ongoing monitoring of guest feedback and experiences, could be best facilitated through digital infrastructure such as an app and shared databases or service records. Developing this enabling infrastructure would require buy-in from all jurisdictions but likely need to be led by a central coordinating body. The Commonwealth's expertise in the digital health domain would be an important input for developing the range of technology, privacy, access and legal frameworks that would need to underpin the digital enabling infrastructure for Safe Spaces.

Building future evaluation into the design and delivery of Safe Spaces, including planning for evaluation of process, impact and outcomes – There is a strong opportunity to build evaluation into the design of a National Safe Spaces Network from its foundations to ensure the effectiveness of its services can be properly tracked over time. While existing comparable services have sometimes been subject to process evaluations (see *Section 4.3 – Evidence base*), outcome and impact evaluations remain rare. These evaluations can be more challenging to implement ex post facto once services are already operating because of the need to establish appropriate baselines and comparative metrics. Factoring high quality evaluation of both individual services and the network as a whole into service design and planning can therefore facilitate better evidence-building over time. This would be supported in the first instance by the development of clear frameworks underpinning evaluation of Safe Spaces, including a detailed program logic, impact framework and performance indicators. In developing these frameworks there would be benefit in consulting closely with suicide prevention experts and major national bodies such as Beyond Blue which undertake regular program evaluations. Given the complexity of the service context, their expertise could help ensure the National Safe Spaces Network's evaluation frameworks reflect lessons learned and best practice in evaluating suicide prevention interventions.

The Gantt chart overleaf provides a high-level mapping of activity within these workstreams over an 18-month period. If work were to commence before the end of 2020, this could support delivery of an initial pilot or roll-out of the National Safe Spaces Network by the third quarter of 2022.

Figure 20: High-level implementation plan



KPMG

Appendix A: National Safe Spaces Network Proposal

Trialling a National Safe Spaces Network to reduce the risk of suicide

Roses in the Ocean

Beyond Blue

Wesley Mission Queensland

Australian Red Cross

Everymind

Australian Institute for Suicide Research and Prevention

February 2019

Why the Safe Spaces Network?

The case for action:

- Evidence from people with lived experience of suicidality shows that non-clinical environments and services staffed with a combination of peer workers and community support workers, where people feel safe, supported and genuinely understood, can promote recovery. People don't just want treatment; they want "a safe place to fall, a safe place to fall apart."
- The emergency department can be an intimidating environment for people in suicidal distress who need an option other than clinical care. Common experiences reported include receiving inadequate or inappropriate treatment, no follow up care, stigmatising interactions, very lengthy waits or at worst, being turned away. This creates barriers to future help-seeking, contributes to a 'revolving door' of presentations, and ultimately, deaths by suicide.
- Suicide prevention has a significant economic impact. The cost of suicide and non-fatal suicidal behaviour in the Australian workforce was estimated in 2014 to have cost $6.73 billion. Given only one third of all suicides in Australia were of people who were employed, the cost is likely to be much higher.

The solution

Australia needs to trial a network of community-based Safe Spaces offering alternative non-clinical interventions that better meet the needs of people experiencing suicidality. The National Safe Spaces Network would consist of tiered settings tailored to different needs, comprising:

- **Tier 5** a residential safe house where people in crisis can stay for multiple days.
- **Tier 4** a safe alternative to emergency departments e.g. 24/7 Safe Haven Cafes.
- **Tier 3** a safe space to access psychosocial support and safety planning e.g. PHN commissioned services.
- **Tier 2** a safe space to talk to someone and access a referral e.g. community centres/services/chemists that are already operational, with staff who are gatekeeper trained.
- **Tier 1** a safe 'refuge' to sit e.g. library, coffee shop, hairdresser.

The investment

This submission seeks Commonwealth funding of $36.8 million over four years from

2019-20 to 2022-23 to conduct a trial of the Safe Spaces Network, phased as follows:

State-matched funding will be sought to ensure the sustainability of Safe Haven Cafes and Safe Houses (established in Phase 2) beyond the trial period.

- Phase 1: pre-establishment and co-design
- identify 3 trial sites
- establish project governance
- develop quality framework, accreditation and clinical governance
- stakeholder engagement
- communication and branding
- scope and develop digital platform
- evaluation framework

- commissioning activities
- Phase 2: establish Safe Haven Cafes and Safe Houses (Tiers 4 & 5)
- undertake commissioning activities to secure infrastructure, providers and workforce
- Phase 3: roll out and accreditation of Tiers 1-3
- work with PHN's to leverage existing services, settings and community spaces
- undertake commissioning activities.
- Phase 4: evaluation
- There is a critical need to test this approach and to obtain evidence on what works, including examination of barriers, facilitators, integration with existing pathways to care (clinical and non-clinical, and s requirements for sustainability.
- Importantly, we need to hear from those with lived experience of suicide to understand accessibility, utilisation, and the impact of Safe Spaces on their journey through suicidality to recovery.
- Evaluation and quality assurance measures will co-designed with people who have lived experience of suicide from the outset, and modified and tracked throughout implementation of the trial. This is vital as the model develops and will ensure we can determine what is needed to yield optimal client care.

Listening to the voice of people with lived experience

My life had imploded. My relationship had broken down. I reached a point where I couldn't work, even though work had been giving me a reason to breathe. My family had no idea what to do to help me. I was trying so hard to get better. I had a great counsellor who I trusted, I took the medication the GP gave me...but I was deteriorating rapidly. I felt like I was on the edge of madness, slipping fast, and I was desperate for a way out. I kept saying to my mum, 'I need a safe place, I need a safe place to fall apart'. I was privileged and lucky enough to find my safe place and I believe it's why I'm still here today. It shouldn't come down to luck or privilege though. Everyone deserves to be safe.

– Person with lived experience of suicidality

In its 2014 Contributing Lives, Thriving Communities report, the National Mental Health Commission noted the marked frustration of people with lived experience with a mental health system which is not designed to meet their needs:

> *Through the more than 1800 submissions made to the Review, the voices of people with lived experience of mental illness, their families and support people, as well as the views of professionals, advocates and peak bodies were clear. The most prominent theme to emerge from this wide range of submissions was that the way the mental health 'system' is designed and funded across Australia means that meaningful help often is not available until a person has deteriorated to crisis point.*
>
> *This is either because no mental health supports are accessible to them, they do not exist in their area, or they are inappropriate to their needs. Along the way they may have lost their job, their family or their home. Countless submissions pointed out that this makes neither economic nor humanitarian sense.*

It is beyond doubt that persons who have physical injuries as a result of suicidal behaviours need medical intervention. However, in many other cases, the response persons seek and need will not be

found in an emergency department. For many the clinical environment of the emergency department and triage process exacerbates suicidal behaviour.

What they seek is a holding or safer environment to prevent self-injury or harm until the crisis or distress abates. What is frequently desired appears to be found in a non-clinical setting, and in the presence of others including people with lived experience and other volunteers, non-clinical staff, and clinical staff facilitating the safety of the space without posing clinical interventions. This is the notion of the 'safe space' and the subject of this submission. It is the strong and recurrent request by people with lived experience of suicide.

A system in crisis

The health system fails to meet the needs of thousands of individuals in suicidal crisis and health systems reform will take significant time. We cannot continue telling people to seek help while knowing much of the support available through the health system is under stress, difficult to access, of highly variable quality, and frequently inappropriate for recovery from suicide crisis.

The main issues faced by communities around Australia are:

- difficulty in finding and navigating services;
- accessibility of appropriate services;
- lack of non-clinical environments best suited to managing suicidal thoughts and crisis; and
- experiences in time pressured, medicalised Emergency Departments.

Issues faced by Government:

- fragmented services and at times, suicide prevention sector;
- health system under significant stress;
- high rates of suicide attempts and deaths; and
- large gaps in services where people are slipping through daily and dying as a result.

Developing the concept of safe spaces: the journey to now

As a result of Roses in the Ocean's Investment Priorities submission in February 2018, developed through national consultation with people with lived experience of suicide, a Roundtable was hosted by Minister Greg Hunt on 28 November 2018 to explore the concept of alternatives to clinical care as outlined by Roses in the Ocean as being a vital investment priority.

The Roundtable was chaired by Lucy Brogden, National Mental Health Commissioner, and attended by numerous national suicide prevention organisations, including Roses in the Ocean, Suicide Prevention Australia, Beyond Blue, Wesley Mission Queensland, Australian Institute for Suicide Research and Prevention (AISRAP) and Everymind, as well as State Government and Mental Health Commission representatives and Australian Red Cross. Unanimous support was given to the trial of a National 'Safe Spaces' network to provide community with a range of safe spaces that are connected together under one visible umbrella. Each trial site would provide a 'tier' of safe spaces including a Safe Haven Cafe and a Safe House.

The concept was then presented at the Suicide Prevention Summit convened by Minister Greg Hunt on December 3rd 2018 and again at the final meeting of the year for the 5th Mental Health and Suicide Prevention Plan Implementation Committee on December 17th 2018, where the concept was once again supported in principle.

Roses in the Ocean convened a coalition of sector organisations to consider the feasibility of trialling a National Safe Spaces Network, including Wesley Mission Queensland, Beyond Blue, Australian Red Cross, Everymind and Australian Institute for Research and Prevention (AISRAP).

Suicide Prevention Australia (SPA) is the national peak body for the suicide prevention sector. SPA is committed to driving continual improvement in suicide prevention policy and programs to achieve better outcomes for all Australians. SPA has been consulted during the development of the Safe Spaces concept model. We support the trial of the Safe Spaces model as it is consistent with our view that suicide prevention requires a multifaceted approach including non-clinical alternatives to care.

The Safe Spaces Network trial

A tiered model of support

The National Network of community based Safe Spaces is designed to better meet the needs of people experiencing suicidality. Using a mix of existing infrastructure and newly designed settings, the Network takes a whole-of-community approach. By involving government, PHNs and local services, the Network is consistent with suicide prevention as a whole-of-government priority.

The trial would test the cost effectiveness and operational implementation of networked safe spaces across 3 trial sites in reducing presentations and waiting times in emergency departments and other community-based services. The network would adopt a model of tiered Safe Spaces, offering an increasing level of support and expertise from Tier 1 to Tier 5.

Tier 5 a residential safe house where people in crisis can stay for multiple days.

Tier 4 a safe alternative to emergency departments e.g. 24/7 Safe Haven Cafes.

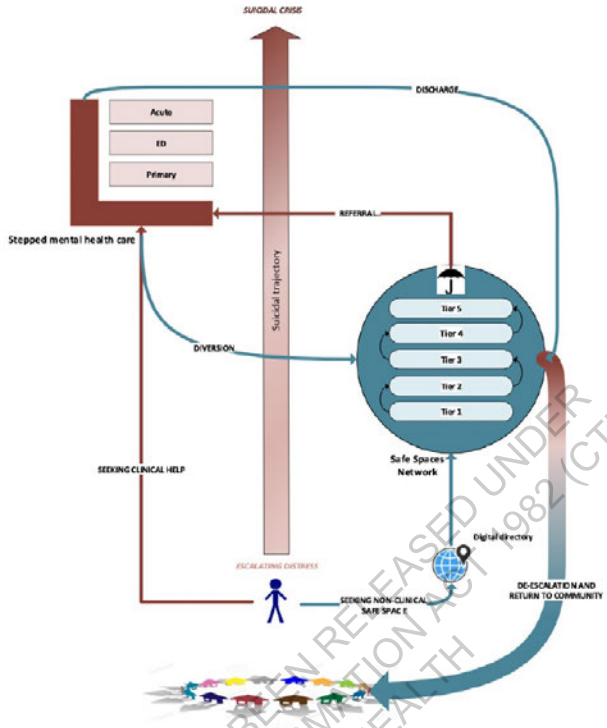
Tier 3 a safe space to access psychosocial support and safety planning e.g. PHN commissioned services.

Tier 2 a safe space to talk to someone and access a referral e.g. community centres/services/chemists that are already operational, with staff who are gatekeeper trained.

Tier 1 a safe 'refuge' to sit e.g. library, coffee shop, hairdresser.

The Safe Spaces Network consists of a tiered system of settings designed to meet the needs of community members experiencing suicidality. As depicted in Figure 21, the Network fits within a stepped care model, whereby people can access the level of non-clinical support that meets their experience of suicidality.

Figure 21: The Safe Spaces Network in the stepped care model



Aims and objectives

The National Safe Spaces Network would aim to:

- make it easy for people to know where to go and how to access the appropriate level of support they need when experiencing suicidal crisis or distress;
- offer a national level intervention in suicide prevention that would be cost effective, linked to existing services, and complements existing clinical services, providing multiple pathways to care;
- foster a multi-pronged approach through partnering at the state level, engaging State and Commonwealth governments to work together, including central agencies such as Attorney General's offices and Coroners;
- engage LHNs and PHNs in mapping, disseminating information, educating about and scaling the Safe Spaces network;
- allow specific communities to create their own Safe Spaces, including LGBTQI+, ATSI and CALD;
- recognise the many rural communities already employing parts of this model unofficially and bring greater visibility to Safe Spaces;
- create opportunities for community capacity building as groups provide Tier 1 Safe Spaces and receive training to meet accreditation requirements;
- mobilise lived experience of suicide peer involvement within community networks
- be easily implemented as an adjunct to other programs;
- complement existing clinical services, providing multiple pathways to care.

Target group

The proposed Safe Spaces Network is directed at people who are experiencing suicidality but do not need immediate medical attention, and who would benefit from a compassionate welcome to a safe space. It may include those who would otherwise attend emergency departments, those who choose not to attend emergency departments or other clinical care, those on a suicidal trajectory, and those at risk of migrating to a suicidal trajectory.

Quantifying and characterising this cohort is notoriously difficult. A proxy for the most likely feeder population for the network is the population presenting at emergency departments for self-harm, suicidal ideation and behaviour, and self-poisoning. Extrapolating from NSW hospital data for the five calendar years 2010 to 2014 would suggest there are at least 36,000 attendances at Australian emergency departments for these three conditions each year (including repeat presentations) – or just under one half of the estimated 75,000 persons who attempt suicide in Australia each year.

Beyond emergency department attendees lies the extended cohort of persons who are on suicidal trajectories but averse to seeking clinical help, and those at risk of migrating to suicidal trajectories.

These dynamics defy quantification at the national level. At a regional level, some dimensions may be better known – those with severe mental illness, those most resistant to seeking help, those in particularly high-risk communities, and those most vulnerable to social or economic triggers of otherwise non-presenting risk. Within the broad parameters of high distress and suicidal crisis, target cohorts will be best defined according to need, opportunity and resources at the regional level.

Trial design

A trial of the Safe Spaces Network would be premised on assuring:

- the quality and safety of participating spaces through training and accreditation;
- the visibility of participating spaces through branding, promotion and digital listing on the Life in Mind portal and a dedicated phone app;
- the tiered integration of participating spaces within a trial site;
- the integration of sites within local systems of stepped mental health care; and
- the ongoing quality improvement and evaluation of the network.

In each trial site, a Safe Haven Café (Tier 4) and Safe House (Tier 5) will be established. To maximise government investment and to provide a critical linking component, a major driver of site selection will be considering co-location with an existing 'The Way Back Support Service' providing integrated support for community and families.

Whilst there is potential for premises to be gifted to the trial, this proposal is based on rented premises, refurbished to be fit for purpose.

To complement the establishment of Tier 4 and 5 settings, the trial would seek to mobilise existing spaces classified as Tier 1-3, which may include non-clinical public and not-for-profit facilities such as community centres, community mental health centres, faith-based facilities, NGO facilities and commercial facilities such as pharmacies, cafes and hair dressers, and commercial franchises that might include, for example, petrol stations and fast food franchises.

A role of the Implementation Committee will be to engage the corporate and philanthropic sectors in the Safe Spaces Network, with a view to their potentially joining the SSN and providing safe spaces and/or investment to expand the network.

The binding paradigm would be one of 'networked connectivity', both in the visibility of the network to the potential users, and in the capacity to refer users to preferred options within the network and, as appropriate, to clinical and social services outside the network. In this context, the network would be best understood as reticulating within itself and between itself and external services to address the fluctuating nature of suicidality.

The foundational principles of the trial are that it:

- be lived experience led and co-designed;
- be collaboratively driven;
- use existing infrastructure where available;
- be scalable both locally and nationally;
- provide flexibility for different geographical communities, population groups and needs;
- invite and encourage innovation;
- apply a blended funding model;
- provide for real time data collection and dissemination;
- create a brand that people want to opt in to that is outside the health system but is intrinsically connected;
- gather existing programs under the umbrella, not competing against each other;
- provide strong governance without becoming bogged down by criteria; and
- require of the sector a change of mindset to one of serving community, in line with the mindset held by people with a lived experience of suicide.

Intended outcomes

A National Safe Spaces Network has the potential to offer:

- the first integrated non-clinical approach to relieving distress and de-escalating suicidality in spaces accepted as safe by those in distress;
- clear entry points into the system for people in the community that otherwise do not exist;
- ready discovery through Life in Mind portal and a phone app;
- confidence in the safety and quality of safe spaces, and transparency in their level of support, through accreditation;
- engagement and development of the lived experience of suicide peer workforce;
- effective integration into the stepped model of mental health care; and
- national reach into the cities, towns and regions of Australia, and into those sub-populations most at risk of suicide.
- collaboration between amongst suicide prevention sector organisations, NGOs, community, government, and the philanthropic and business sectors.

The concept also offers potential benefits to the provision of services, including:

- relieving the pressure on existing clinical services, especially emergency departments;
- providing a safety net for people following discharge from emergency departments;
- collaboration between clinical and non-clinical services;

- accessible, highly visible entry points for the community; and
- collaboration amongst suicide prevention sector organisations, NGOs, community, government, and the philanthropic and business sectors.

Behind this proposal: Collaborating organisations and expertise

The Safe Spaces Network would not be owned by any one organisation but be driven by a collaboration of organisations in the sector, including:

Roses in the Ocean

The coalition of organisations supporting the Safe Spaces Network has determined that this initiative must be led by lived experience, and have nominated Roses in the Ocean to take this lead role. As Australia's leading lived experience of suicide organisation, Roses in the Ocean's extensive lived experience expertise in areas of consultation, co-design, capacity building, and consultancy will drive the Safe Spaces Network.

Wesley Mission Queensland

Wesley Mission QLD (WMQ) has been the lead agent responsible for the development of the Safe Space Network Strategy that forms the basis of the model proposed in this submission. WMQ have led the collaborative cross sector response in the Brisbane North region since 2016, including project management of the two Tier 3 sites currently operational and chairing of the multi-agency steering group leading implementation. WMQ will provide expert consultancy on the model and community development principles, as well as operational experience in both community and residential service delivery. WMQ have the capacity and expertise to implement Tiers 3-5 sites across QLD.

Everymind / Life in Mind

Life in Mind can support the scoping study of the project through the provision of service mapping the safe spaces network in Australia. Working collaboratively with the foundation members, Life in Mind has current research ethics approval to conduct consultations with stakeholders engaged in suicide prevention in Australia.

Life in Mind presents an existing hub and recognised digital gateway to host and promote the safe spaces network, connecting all participating spaces to each other and the community. Life in Mind is a national initiative, co-designed with the suicide prevention sector and funded through the Australian Government's National Suicide Prevention Leadership and Support Program to provide web-based information, resources and best practice case studies such as the safe spaces network. Life in Mind can add or develop infrastructure or architecture to accommodate the national implementation of the safe-spaces network.

Beyond Blue

Beyond Blue is one of Australia's largest not-for-profit mental health organisations. As a Safe Spaces Network partner, Beyond Blue will contribute its expertise in developing and maintaining national programs for suicide prevention and mental health. Beyond Blue also has extensive experience in large-scale, non-clinical aftercare, having designed and implemented The Way Back Support Service and coordinated its current roll out to up to 25 sites across Australia.

Through its development of Australia-wide, collaborative programs such as The Way Back, NewAccess and Be You, Beyond Blue has established networks throughout the country in the mental health and

suicide prevention sectors, working with all levels of government. It also brings strong communication networks, through traditional media contacts and vast social media audiences.

Australian Red Cross

Australian Red Cross can bring their trusted brand and footprint in all cities and many regional and remote locations to this project. Further, as they have a strategic focus on addressing extreme vulnerability, they can bring:

- experience working with a range of people and communities across Australia, including Aboriginal and Torres Strait peoples, people seeking asylum, people impacted by disasters and trauma, people in the justice system, people with mental health challenges and many communities impacted by intergenerational disadvantage;
- 20,000 volunteers in communities and expertise in mobilising many others to take humanitarian action;
- experience in working partnership and a track record of working in collectives/consortiums to effect social and community change at scale;
- place-based and community development expertise with communities at the centre of driving change; and
- co-design and agile experience in creating solutions with people with lived experience and an appetite to test different ideas and solutions to drive change and impact.

Australian Institute for Suicide Research and Prevention (AISRAP)

Expert suicide prevention scientific content and evaluation consultant. Developed in 1996, the Australian Institute for Suicide Research and Prevention (AISRAP) is a national and international suicide prevention research centre. The institute is the leading Australian centre for research, clinical practice, education and community action for suicide prevention, sought after for the quality of the advice and the outcomes it provides in linking research and practice.

AISRAP conducts public health surveillance of suspected suicides and conducts individual studies with government, industry bodies and non-government organisations. The core of this research is derived from the Queensland Suicide Register which is the oldest standing comprehensive register of its type in Australia; including hosting of suicide cases since 1990. AISRAP's evaluation and implementation research as well as epidemiological and intervention research is published extensively.

AISRAP's scientific expertise and extensive experience in suicide research is a critical component of its status as a World Health Organisation (WHO) Collaborating Centre in Suicide Training and Prevention (appointed in 2008). Since 2004, AISRAP has operated a specialised outpatient clinic for people with a history of suicidal ideation or behaviour. AISRAP also provides education and training for health and allied health professionals, offering postgraduate programs in suicidology (Master of Suicidology; Graduate Certificate in Suicide Prevention Studies) and gatekeeper and specialised licensed suicide risk assessment protocol training.

Investment

Table 20: Investment costs

Project area	Description	Details	Year 1 2019-20 ($)	Year 2 2020-21 ($)	Year 3 2021-22 ($)	Year 4 2022-23 ($)	Total ($)
Governance*	Secretariat	0.5 FTE	62,500	62,500	62,500	62,500	250,000
	Travel and Accommodation	10 pax x $1,500 x 4 trips/year	60,000	60,000	60,000	60,000	240,000
Scoping study	Consultancy OR in house	Consultancy OR 5.0 FTE^ + travel & accommodation @ \$10k/FTE	675,000	0	0	0	675,000
Infrastructure	Development: Brand, logo, digital platform (app), promotional materials, accreditation (utilise Life in Mind portal – no extra cost)	2.0 FTE contractors @ $250k	0	500,000	0	0	500,000
	Ongoing maintenance and administration of the Network	1.5 FTE	0	93,750	187,500	187,500	468,750
Trial Sites	Establishment, Induction	6.0 FTE + travel @ $10k/FTE	0	810,000	0	0	810,000
	Ongoing network expansion, maintenance, support	6.0 FTE + travel @ $10k/FTE	0	0	810,000	810,000	1,620,000
	Tier 4 – Safe Haven Cafes x3 - Establishment	$50k x3 in 2019/20 – Governance and Steering Committees + fit for purpose refurbishment of space	150,000	0	0	0	150,000
	Tier 4 – Safe Haven Cafes x3 – Operational	$500k per site/year – for extended hours 7 days/week – staffing – Lived Experience Peers and Professionals	0	150,000	150,000	150,000	4,500,000
	Tier 5 – Safe Houses x3 - Establishment	$1,000,000 per site – Governance Committee; Quality Assurance subcommittee, Research Committee, Recruitment of volunteers, paid Lived Experience Peers and professional staff	3,000,000	0	0	0	3,000,000

Project area	Description	Details	Year 1 2019-20 ($)	Year 2 2020-21 ($)	Year 3 2021-22 ($)	Year 4 2022-23 ($)	Total ($)
	Tier 5 – Safe Houses x3 – Operational	$1,250,000 per site/year – Ongoing operations of Safe House including provision of psychosocial activities / programs for clients	1,875,000	3,750,000	3,750,000	3,750,000	13,125,000
	Tiers 1-3 - Establishment	Seed funding $200k per site (rolled out across 2 years)	0	300,000	300,000	0	600,000
	Tiers 1-3 - Operational	Maintenance, accreditation	0	100,000	100,000	100,000	300,000
Evaluation	Consultancy	$750,000 / 3 years	250,000	250,000	250,000	250,000	1,000,000
Total Implementation Investment	-	-	6,072,500	7,426,250	7,020,000	6,720,000	27,238,750
Fund holder & Project Manager overheads	-	Costs x 20%	1,214,500	1,485,250	1,404,000	1,344,000	5,447,750
Costs + Overheads	-	-	7,287,000	8,911,500	8,424,000	8,064,000	32,686,500
Contingency	-	(Costs + Overheads) x 10%	728,700	891,150	842,400	806,400	3,268,650
Sub Total Investment	-	-	8,015,700	9,802,650	9,266,400	8,870,400	35,955,150
Apply CPI increase	-	Sub Total x 3%	0	240,471	301,294	287,031	0
TOTAL Safe Spaces Network Investment	-	-	**8,015,700**	**10,043,121**	**9,567,694**	**9,157,431**	**36,783,945**

*Governance of Coalition of Organisations
^ All FTE costed at average $125k/FTE

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Appendix C: Consultation methodology and stakeholder list

The stakeholder consultation sample was developed in partnership with the Department. It was refined and further developed following input from the National Safe Spaces Network Scoping Study Expert Advisory Group. Stakeholders were selected based on their expertise in one or more of the following areas:

- Lived experience of suicide
- Suicide prevention
- Mental health
- Public sector healthcare delivery and governance.

In identifying appropriate stakeholders from these domains of expertise, care was taken to include stakeholders with specialist experience in suicide prevention, health and mental health care delivery for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and LGBTQI+ Australians. KPMG also worked to ensure there was appropriate representation of stakeholders across each of Australia's states and territories, and from both metropolitan and rural and regional areas.

Stakeholder engagement

KPMG conducted 61 semi-structured interviews with stakeholders across Australia. As these consultations were undertaken during the period of COVID-19 restrictions, the majority were conducted using phone or videoconference to support social distancing.

Participants were primarily invited to participate through a one-hour semi-structured individual interview. Each session was delivered by two KPMG team members: an interviewer and a scribe.

To maximise the number of perspectives that could be included, some participants were invited to participate via:

- A roundtable discussion with other related stakeholder groups
- A written response to a series of closed and open questions.

The option to provide a written response was primarily provided to stakeholders who were heavily involved in the COVID-19 emergency response and therefore were likely to be restricted for time.

Two roundtables were ultimately conducted: one drawing together expert suicide prevention researchers, and the other engaging community mental health peak organisations. No stakeholders opted to submit a written response in lieu of being interviewed.

Consultation coding and thematic analysis

To minimise the level of subjectivity involved in the assessment of feedback obtained through the consultation interviews, KPMG employed established qualitative analysis methodologies. This first involved coding all interview notes according to a standard code book developed specifically for this project, to classify and categorise the content of each consultation interview in a consistent way. This code book was developed using a deductive approach, with the codes of interest reflecting priority information needs and gaps identified through the risk assessment and document and data review phases of the study.

The content categorised to each code was systematically analysed to identify key themes and common patterns emerging across the stakeholders consulted. The outputs of this analysis were fed into a findings summary paper that was shared with the Department and the Expert Advisory Group.

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Appendix D: Service mapping methodology and jurisdiction results

Methodology

This appendix details KPMG's approach to mapping suicide, mental health, alcohol and other drug services across Australia. In particular, KPMG has mapped over 2,000 physical service locations across Australia to better understand how services are distributed and where Australians may already be able to access face-to-face support. As such, this service mapping is intended to provide a general indication of the availability of health services relative to population need, as well as provide an indication of current gaps or limitations in the service landscape.

KPMG's service mapping is based on a desktop review of publicly available information, including the websites for each of:

- The 31 PHNs across Australia
- The 8 state and territory government health departments and health services
- The individual Aboriginal Community Controlled Health Services across Australia
- The large mental health and suicide prevention service providers (e.g. Lifeline, Beyond Blue and headspace)
- Online directories of health services that are government funded.

For the purposes of KPMG's analysis, the following services with physical locations across Australia were identified as part of the desktop review:

- Residential safe houses specifically for people experiencing suicidality
- Residential services and supports for people experiencing mental health and/or alcohol and other drug concerns (e.g. Step Up Step Down services, Prevention and Recovery services, and residential alcohol treatment centres etc.)
- Alternatives to emergency departments (e.g. Safe Haven Cafes)
- Aftercare services and supports following suicide attempts (e.g. the Wayback Service)
- Psychosocial supports and counselling services specifically for people experiencing suicidality
- Psychosocial supports and counselling for people experiencing mental health concerns and/or alcohol and other drug concerns (headspace, Wellways, Neami, Lives Lived Well and Salvation Army etc.)
- Safe places for people experiencing suicidality to seek assistance and to access referrals (e.g. Lifeline Crisis Centres)
- Social and emotional wellbeing services and supports for Aboriginal and Torres Strait Islander people
- Suicide prevention networks and suicide bereavement groups
- Suicide gatekeeper training services (e.g. providers delivering Applied Suicide Intervention Skills Training).

Where providers delivered more than one type of service at a specific location (e.g. psychosocial supports and gatekeeper training), each type of service was recorded and incorporated into KPMG's analysis.

In order to map services that are available to the general public, services with specific eligibility criteria and services delivered by private providers were excluded from KPMG's analysis. As such, the following services were excluded KPMG's service mapping:

- Services specifically for people experiencing homelessness or at risk of homelessness
- Services specifically for participants of the NDIS
- Services specifically for older adults affected by dementia or other neurological disorders
- Services specifically for victims of violence or sexual assault
- Services provided by private practices or facilities which are not funded by state or territory governments or by PHNs (e.g. GP clinics, psychologists and private hospitals etc.)
- Services only available via online platforms or telehealth.

As part of KPMG's service mapping, the target cohorts of each mental health, alcohol and other drug service were identified and analysed through a desktop review. These target cohorts included:

- Aboriginal and Torres Strait Islander communities
- LGBTQI+ communities
- Culturally and linguistically diverse communities
- Young people
- Older adults.

Where providers targeted more than one cohort or section of the community at a specific location (e.g. Aboriginal and Torres Strait Islander people and young people), each target cohort was recorded and incorporated into KPMG's analysis.

State and territory results

The results of KPMG's service mapping have been consolidated for each state and territory in Table 24 overleaf. These results are based on KPMG's review of publicly available information and provide a high-level indication of the number and range of face-to-face services that are available for people experiencing suicidality, mental concerns and/or alcohol and other drug concerns.

Table 24: Service mapping results for each state and territory

Type of service	TAS	SA	WA	NT	ACT	QLD	VIC	NSW
Residential safe houses specifically for people experiencing suicidality	0 services	0 services	0 services	0 services	0 services	0 services	0 services	0 services
Residential services and supports for people experiencing mental health and/or alcohol and other drug concerns	7 services	13 services	28 services	10 services	6 services	41 services	71 services	78 services
Alternatives to emergency departments	0 services	0 services	2 services	0 services	0 services	3 services	1 service	1 service
Aftercare services and supports following suicide attempts	1 service	5 services	0 services	1 service	1 service	9 services	9 services	21 services
Psychosocial supports and counselling services specifically for people experiencing suicidality	10 services	35 services	12 services	6 services	4 services	21 services	30 services	28 services
Psychosocial supports and counselling for people experiencing mental health concerns and/or alcohol and other drug concerns	70 services	207 services	160 services	51 services	34 services	319 services	353 services	452 services

Type of service	TAS	SA	WA	NT	ACT	QLD	VIC	NSW
Safe places for people experiencing suicidality to seek assistance and to access referrals	3 services	0 services	2 services	2 services	0 services	8 services	2 services	9 services
Social and emotional wellbeing services and supports for Aboriginal and Torres Strait Islander people	8 services	7 services	15 services	16 services	2 services	33 services	24 services	21 services
Suicide prevention networks and suicide bereavement groups	8 services	46 services	20 services	9 services	4 services	32 services	25 services	36 services
Suicide gatekeeper training services	4 services	6 services	5 services	9 services	2 services	12 services	19 services	22 services

Source: KPMG (2020)

Appendix E: Summary of existing exemplar services

Table 25: Service model elements of exemplar services

Service	Eligibility	Opening hours	Staffing	Supports offered	Referral mechanism
St Vincent's Hospital Safe Haven Café (Tier 4 equivalent)	People over the age of 18 who are not under the influence of drugs or alcohol. Guests presenting with a medical issue will be referred to appropriate care including the St Vincent's Hospital Emergency Department.	Friday 4pm to 8pm; Saturday and Sunday 2pm to 8pm	2x Lived Experience Peer Workers; 1x Mental Health Clinician; casual and volunteer workers	Provision of a space to talk to peer support workers. Support guests to identify relevant local services. Support guests to develop self-management skills.	Guests may self-refer without prior contact from a clinician or other service provider, or be invited to participate in the service upon presentation to the St Vincent's Hospital Emergency Department
Brisbane North Safe Spaces (Tier 3 and 4 equivalent)	People aged over 18 and classified as low risk, self-identifying with distress related to psychosocial needs. People with active imminent plans for self-harm or suicide, people immediately post a self-harm attempt and people who are verbally or physically aggressive are not within the service's scope. Guests can self-refer at any time during opening hours.	Caboolture site open Friday, Saturday and Sunday 10am to 3pm; Redcliffe site open Monday, Tuesday and Friday 3pm to 8pm	2x staff allocated per daily shift – drawn from existing staff of Aftercare and Richmond Fellowship Queensland; mix of peer and recovery workers, generally with a Certificate IV in Mental Health, psychology training or social work qualifications	Provision of a space to talk to peer support workers. Access to a sensory modulation room. Build independence of guests. Provide guest skills and ability to build distress tolerance. Support guest's capacity to alleviate and manage future psychosocial distress. Provision of safety planning and referral pathways. Provision of direct links with local non-government organisations, GPs	Guests may self-refer without prior contact from a clinician or other service provider

Service	Eligibility	Opening hours	Staffing	Supports offered	Referral mechanism
				and other services allowing for individualised support plans.	
Living EDge (Tier 4 equivalent)	People experiencing suicidal distress who present to the Emergency Department of the Redlands Hospital	4pm to 8pm each Monday, Tuesday and Wednesday	Peer support workers	Provision of a space to talk to peer support workers. Provision of relaxing activities. Provision of ongoing guidance and support.	Guests may self-refer without prior contact from a clinician or other service provider, or be invited to participate in the service upon presentation to the Redlands Hospital Emergency Department
Aldershot Safe Haven Café (Tier 4 equivalent)	People aged 18 an over who are experiencing a mental health crisis	6pm to 11pm Monday to Friday and 12:30pm to 11:00pm year-round	3x mental health workers; 2x support workers and 1x clinician. Support workers primarily assist in development of crisis plans; the mental health clinician can provide assessment and referral to other services as needed	Provision of a space to talk to peer support workers. De-escalation services. Support local people to improve their own health and wellbeing. Encourage self-management and independence for guests in crisis. Access to a range of community information on mental health.	Guests may self-refer without prior contact from a clinician or other service provider
The Living Room (Tier 3 and 4 equivalent)	People aged 18 and over who are experiencing a mental health crisis sufficiently severe that they are at	3pm to 8pm on Wednesdays, Thursdays and Sundays	1x counsellor, 1x psychiatric nurse and 3x peer counsellors	Mental health and health assessment.	Guests may self-refer without any prior contact from a clinician or other service provider

Service	Eligibility	Opening hours	Staffing	Supports offered	Referral mechanism
	risk of an Emergency Department presentation			Provision of de-escalation and empathic listening. Building the coping skills of guests. When a guest determines that he/she is ready to leave a counsellor meets with him/her for a final assessment to ensure the guest is indeed safe to leave and to determine if the guest's distress level has decreased.	
Maytree House (Tier 5 equivalent)	People aged 18 and over who do not have a history of violence towards others, are not in a severely disturbed mental state that impairs their capacity to be responsible towards self and others, and do not have a severe drug or alcohol dependency. Guests may be admitted after a recent suicide attempt or as a result of suicidal ideation, anxieties or threats.	Four-day, once-only residential stay – strictly time limited	4x full time staff and 3x part-time staff along with 141 rotating volunteers working 3.5-hour shifts. The permanent staff have qualifications in psychotherapy or counselling, or a lived experience of suicide.	Initial telephone "befriending" service, through which people can discuss their suicidal thoughts. Provision of a four-night, five-day stay. Non-medical, therapeutic approach which allows its guests to explore their thoughts and feelings, and feel heard with compassion and without judgement. Guests are required to talk to one member of staff and one volunteer each day. Maytree actively communicates with the mental health team associated	Guests may self-refer without prior contact from a clinician or other service provider; in practice a majority of referrals come from clinicians and social workers

Service	Eligibility	Opening hours	Staffing	Supports offered	Referral mechanism
				with the guest, such as the GP, psychiatrist or mental health worker. In the first two weeks after their stay, guests will receive a follow-up call and a reflection letter from a member of staff (with input from volunteers) that validates their strengths and qualities.	

Table 26: Target outcomes and measurement indicators for existing Safe Spaces-type services

Service	Target outcomes	Measurement indicators
St Vincent's Hospital Safe Haven Café [109]	Create a physical environment that is regarded by consumers as a place of safety and respite, and a place they feel comfortable returning to	Reported satisfaction of guests
	Ensure consumers are aware of the existence of the Safe Haven Café, as an alternative to presenting to the ED	Self-reporting by guests of how they became aware of the service
	Enhance the capacity for self-management and improve the resilience of consumers	Guest qualitative consultation forums
	Reduce the number of ED presentations for non-emergency mental health issues, releasing capacity in the system and providing more appropriate care	St Vincent's Hospital Melbourne Emergency Department data on non-emergency mental health presentations
Brisbane North Safe Spaces Network [110]	Reduce the frequency of emergency department presentations	Emergency Department presentation data for hospitals in Brisbane North catchment area (Redcliffe and Caboolture)
	Support individual development of self-recognition of symptoms and management planning	Self-reported guest experience collected through surveys
	Promote awareness and develop skills to promote individual responsibility and control	Self-reported guest experience collected through surveys
The Way Back Support Service [111]	Levels of engagement and measures of service utilisation	Self-reported guest wellbeing collected through surveys Self-reported guest experience collected through surveys
	Reducing rates of hospital-treated deliberate self-poisoning readmissions in the 12 months following hospital admission	Hospital admissions data for treatment and control groups in the relevant catchment area
	Provide a service to support people as part of their crisis pathway	Qualitative and quantitative guest information collected through surveys

Aldershot Safe Haven Café[112]	Reduced frequency of emergency department presentations and police mental health callouts	Emergency Department presentation data for hospitals in the Surrey and Borders Partnership catchment area; police service data provided by Hampshire Constabulary
Maytree House[113]	Specific target outcomes not publicly stated	Self-reported guest wellbeing as reported through use of the CORE screening questionnaire

Appendix F: Summary of evaluation findings from comparable services

Presented below is a summary of findings from evaluations of comparable existing services. This relates to the discussion of the evidence base for Safe Spaces-type services presented in Section 4.3.

Table 27: Evaluation findings for existing Safe Spaces-type services

Service	Location	Tier equivalent/s	Evaluation findings
St Vincent's Hospital Safe Haven Café [114]	Victoria, Australia	Tier 4	At time of evaluation 100 per cent of surveyed guests reported feeling safe in the environment; 80 per cent of guests made a return visit. Participating guests indicated they were able to use the café as part of their coping plan until their confidence in self-management improved. At time of evaluation 90 per cent of guests attending the café were referred from the Emergency Department. Data reporting issues made it difficult to determine the impact of the Safe Haven Café on Emergency Department presentations. Guests self-reported attending the Café on nights when it was open while still attending the Emergency Department on nights that it was not.
Brisbane North Safe Spaces Network [115]	Queensland, Australia	Tier 3 and 4	Significant improvements in levels of self-reported distress were reported through guest surveys. Guests reported an average 50 per cent reduction in distress levels between arrival and departure at the Safe Spaces. Smaller reductions in distress where also reported at post-visit follow up after 72 hours and at 10 days. 72 per cent of surveyed guests indicated they had used tools and strategies learned at the Safe Spaces to self-manage distress levels. 96 per cent of surveyed guests reported finding their visits to the Safe Spaces useful. 87 per cent indicated they would attend a Safe Space again in future as part of self-managing their distress. Available data was inconclusive on the impact of the Safe Spaces on ED presentations during the trial period.
The Living Room [116]		Tier 3 and 4	Guests reported an average decrease of 2.13 points on the Subjective Units of Distress Scale.

Service	Location	Tier equivalent/s	Evaluation findings
	Illinois, USA[10]		Generally positive sentiment towards appropriateness and quality of services expressed through qualitative interviews. 93 per cent of guests attending The Living Room were able to be supported to address their crisis onsite and return to the community without referral to an Emergency Department.
Aldershot Safe Haven Cafe[117]	Surrey, UK	Tier 4	90 per cent of guests indicated they felt better equipped to manage their distress after visiting the Safe Haven. 85 per cent of guests agreed that the Safe Haven Cafe had prevented them from being in crisis and 89 per cent agreed that the service had helped them to manage a difficult time. 94 per cent agreed the service offered them a safe place to go; 83 per cent felt more able to make informed choices about their support needs. Of guests who had previously accessed an Emergency Department, 53 per cent showed a decrease in hospital attendance in the months after using the café; 19 per cent of guests showed no change in their use of Emergency Departments and 28 per cent increased their attendance. Calls to police identified as mental health-related had decreased by 42 per cent within the service's catchment area. Police detentions under the UK's Mental Health Act also fell within the catchment area after the Safe Haven Café opened, and were consistently lower both than other parts of the region and national averages from 2014-15 to 2016-17.
Maytree House	London, UK	Tier 5	Guests who undertook the CORE assessment saw a statistically significant improvement in perceived wellbeing and functioning and reduced perception of risk and problems between a pre-test undertaken at time of admission and a post-test delivered at time of leaving Maytree. Among a subset of the evaluation cohort who participated in follow-up screening between 3 and 6 weeks later, further improvements were also observed but not found to be statistically significant.

[10] The Living Room model has been adopted at multiple sites throughout Illinois and in some other US states. The findings presented here are based on the services delivered in the original site in Skokie, a suburb of Chicago.

Appendix G: Suicide Prevention Australia Standards for Quality Improvement

Component	Intent	Key tasks
Needs assessment	To establish if there is a need for the program within the community in which the program is intended to be delivered.	To meet this standard, the following must be completed: documentation of a recent needs analysis/assessment having been conducted, which has considered if the program fills a gap in service delivery and has undertaken engagement with relevant stakeholders and assessment of available evidence.
Alignment	To ensure that the program aligns with the organisation's purpose through its mission and/or vision and values.	To meet this standard, the following must be completed: demonstration of alignment between the program delivery, and the mission, vision and values and/or strategic direction of the organisation.
Lived experience of suicide	To ensure that the program has, where possible, been co-designed with people with lived experience of suicide.	To meet this standard, the following must be completed: • Documentation of people with lived experience of suicide engaging in program development, design, implementation and review • Provision of training for people with lived experience of suicide who are involved in the program development, design, implementation and review • Provision of training to program team members and volunteers on how to encourage and facilitate involvement of people with lived experience in the design of the program.
Stakeholder engagement	To ensure that the program has, where possible, been developed in collaboration with others and that these partnerships are well planned, clearly communicated and have a common clear purpose.	To meet this standard, the following must be completed: • Development and maintenance of a policy on the engagement and review of partnerships and collaborations • Documentation of agreements for all formal collaborations and partnerships that clearly articulate their purpose, roles and responsibilities • Development of a framework for communication, meetings and monitoring outcomes of partnerships and collaborations.
Program plan	To ensure that program has clear aims and objectives to meet identified outcomes.	To meet this standard, the following must be completed: • Documentation of clear program aims and objectives • Development of clear measures for the objectives • Documentation of regular monitoring, review and evaluation of the aims and objectives.

Component	Intent	Key tasks
	To ensure transparency on program outcomes and impacts and how these will be achieved.	To meet this standard, the organisation must complete the following: • Development of a program logic with clearly documented outcomes and impacts for the program • Documentation of reviews of available evidence and identification of key sources relevant to the program.
	To ensure the program supports diversity and inclusion in relation to the target audience.	To meet this standard, the organisation must complete the following: • Demonstrate that consultation that has taken place with relevant experts and advisors in considerations for diversity and inclusivity • Demonstrate how diversity and inclusion has been considered in program development • Demonstrate how the use of demographic data on the target population has been considered in program development • Demonstrate that resources developed for the program are suitable for the target population.
	To ensure that program data is collected, utilised and stored appropriately.	To meet this standard, the following must be completed: • Documentation of policy and protocols for the collection and safe storage of data • Documentation of measurement tools and outcome measures for data, where appropriate.
	To ensure processes are in place to maintain the privacy of all information collected and developed in accordance with current legislation.	To meet this standard, the following must be completed: • Documentation of a program specific privacy policy and any associated procedures that are reviewed regularly and reflective of current legislation • Provision of training in privacy and confidentiality for program team members, including common privacy issues and limitations to confidentiality • Documentation of a Privacy Collection Statement • Development of a procedure on the process for taking personal information relating to participants off-site and/or between sites • Development of a process for identifying participants of the program when they contact the organisation, to such steps that are reasonable in the circumstances • Documentation of a policy for obtaining and releasing program or service user information at the consent of the individual • Documentation of a duty of care statement/

Component	Intent	Key tasks
	To ensure that the resources required to develop and implement a program have been thoroughly considered and planned.	To meet this standard, the following must be completed: documentation of a resource plan for the safe delivery of the program.
	To ensure that risks associated with the program have been identified, mitigated and reviewed.	To meet this standard, the following must be completed: • Documentation and maintenance of a risk register, including a risk matrix • Documentation of a policy on risk management that is communicated to the program team • Provision of risk management training to the program team • Documentation of strategies to prevent work-related hazards.
	To ensure that financial processes and management support the efficiency and sustainability of the program, and are not subject to fraudulent actions.	To meet this standard, the following must be completed: • Development of an overview of the financial resources required to support the program activities • Documentation of a finance policy including fraud and corruption and budget reporting • Documentation of a conflict of interest register • Documentation of regular reviews of the program budget to ensure sustainability.
	To ensure that programs support the promotion of crisis services, help-seeking and help offering information.	To meet this standard, the following must be completed: • Documentation of all team members and partners having signed the National Communications Charter • Provision of crisis services, help-seeking and help offering information to all program participants • Development of various forms of help-seeking and help offering information • Demonstration of help-seeking information being displayed in the workplace and place in which the program is delivered • Documentation of help-seeking information being included on all program collateral and external communications • Provision of training to program team members on how to recognise and respond to potential suicidal behaviour.
	To ensure the program implements safe language guidelines for suicide prevention.	To meet this standard, the following must be completed: • Demonstration that all program team members are aware of the Language Guide included in the National Communications Charter

Component	Intent	Key tasks
		• Provision of training to program team members in the use of safe and inclusive language in suicide prevention and the use of other safe language that is relevant to the program, such as safe language regarding disability and the LGBTQIA community • Demonstration of safe and inclusive language being used in both internal and external documents relating to the program • Demonstration that participants of the program are aware of safe and inclusive language in suicide prevention.
	To ensure that programs are evaluated to facilitate continuous quality improvement.	To meet this standard, the following must be completed: • Documentation of an evaluation plan • Development of measurable objectives to evaluate against and a baseline data set • Documentation of regular reviews of the program as per the evaluation plan • Demonstration of improvements in the program as per evaluation outcomes • Provision of processes to be put in place for stakeholders, team members, and participants to contribute to the evaluation.
	To ensure that knowledge gained from the program delivery, including the evaluation, is shared with stakeholders to contribute to existing knowledge for the prevention of suicide.	To meet this standard, the following must be completed: • Documentation of a knowledge translation plan • Demonstration of the sharing of reports, evaluation and/or outcomes of the program with stakeholders • Provision of final reports to the wider suicide prevention sector, where possible and appropriate.
Workforce	To ensure that program team members understand and fulfil their roles and responsibilities and have effective support through education, training and supervision.	To meet this standard, the following must be completed: • Documentation of roles and responsibilities for all program team members • Provision of a comprehensive orientation program for all team members • Provision of ongoing relevant training and education for all team members • Provision of supervision and support for all team members • Demonstration of a clearly defined performance review process.
	To ensure that program team members are aware of and supported in self-care.	To meet this standard, the following must be completed: • Documentation of a policy and procedure document related to self-care detailing processes to support

Component	Intent	Key tasks
		health and wellbeing of program team members in the workplace • Provision of self-care information in the induction package to program team members • Provision of ongoing education and training on self-care to program team members • Development of strategies to encourage self-care within the workplace.

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Appendix I: Expert Advisory Group Terms of Reference

The National Safe Spaces Network Scoping Study Expert Advisory Group

The National Safe Spaces Network Scoping Study Expert Advisory Group (the Expert Advisory Group) will provide advice and oversight for the National Safe Spaces Network Scoping Study (the scoping study) to help ensure it meets its agreed objectives.

In 2019 the Department of Health (the Department) received a proposal from a consortia of organisations for a trial of a National Safe Spaces Network. The proposal advocates for alternatives to emergency departments for those in suicidal crisis, and aims to provide community-based safe spaces offering non-clinical interventions to better meet the needs of people experiencing suicidality. The proposed model includes a five-tiered approach which is targeted at people who do not need immediate medical attention, and who would benefit from a compassionate welcome to a safe space.

The Department has engaged KPMG (the consultant) to undertake a feasibility scoping study (the scoping study) for the National Safe Spaces Network proposal.

Role and term of the Expert Advisory Group

The Expert Advisory Group will provide guidance, advice and feedback to the Department and the consultant on aspects of the scoping study and advice to inform the final report and recommendations of the scoping study.

Members will be appointed to the Expert Advisory Group in April 2020 and the first meeting will be held in April 2020. The Expert Advisory Group is anticipated to end on 31 August 2020. The final report for the scoping study is due to the Department in August 2020. The Department of Health will provide the administrative and secretariat support for the Expert Advisory Group.

Terms of Reference

The members of the Expert Advisory Group will:

- provide guidance and feedback on the conduct of the scoping study including the design of the Risk Assessment Framework and criteria being developed by the consultant, and the approach to stakeholder consultation;
- provide advice on specific aspects of the scoping study including needs assessment, evidence base, proposed implementation, intended outcomes, accreditation process, risks, proposed service model and integration with the current mental health system;
- discuss and provide feedback on preliminary document and data review findings of the scoping study;
- discuss and provide feedback on integration of stakeholder consultation outcomes with risk assessment, document and data review findings;
- provide guidance and feedback on proposed findings and recommendations of the draft scoping study report;
- attend video/teleconferences as required;
- engage in at least one individual meeting with the consultant; and
- provide out of session advice as required.

Composition of the Expert Advisory Group

The Expert Advisory Group will be comprised of relevant sector experts and people with lived experience of suicide to provide advice and oversight to the scoping study. The below table details the proposed membership of the Expert Advisory Group:

Table 32: Proposed membership of the Expert Advisory Group

Name	Organisation	Perspective
Sally Bishop	Director, Suicide Prevention Section, Department of Health	Chair
Bronwen Edwards	CEO, Roses in the Ocean	Organisational and industry expertise
Georgie Harman	CEO, Beyond Blue	Organisational and industry expertise
Kris Sargeant	Director of Community Care and Inclusion, Wesley Mission Queensland	Organisational and industry expertise
Jacinta Hawgood	Senior Lecturer, Australian Institute for Suicide Research and Prevention	Organisational and industry expertise
Fran Timmins	Director of Nursing, Mental Health - St Vincent's Hospital Melbourne	Service delivery
Paul Martin	Brisbane North PHN	Service delivery
Carrie Lumby Miller	-	Lived Experience
Vicki McKenna	-	Aboriginal and Torres Strait Islander Lived Experience

Source: Expert Advisory Group Terms of Reference

Expert Advisory Group meetings will also be attended by:

- Representatives from the KPMG scoping study team;
- Representatives from the Department of Health.

Terms of Engagement

Each Expert Advisory Group member holds their appointment at the discretion of the Assistant Secretary of the Suicide Prevention and Mental Health Policy Branch (SPMHP) at the Department of Health.

Expert Advisory Group engagements will generally be until the end of the scoping study (31 August 2020). Members may resign from the Expert Advisory Group at any time providing an email or letter stating their intention to resign to the Assistant Secretary of the SPMHP at least two weeks prior to the date of resignation.

The Assistant Secretary of the SPMHP will consider appointments to vacancies, as appropriate.

The Assistant Secretary of the SPMHP retains the discretion to terminate a member's engagement to the Expert Advisory Group at any time and for whatever reason.

Proxies

Where an Expert Advisory Group member is unable to attend a meeting, proxies may be allowed at the discretion of the Chair.

Confidentiality

Expert Advisory Group members may, on occasion, be provided with confidential material. Members are not to disclose this material to anyone outside the Expert Advisory Group and are to treat this material with the utmost care and discretion and in accordance with terms of their confidentiality agreement.

A Confidentiality Agreement will be provided to members of the Expert Advisory Group by the Secretariat prior to the first Expert Advisory Group meeting. The Confidentiality Agreement must be completed and returned before a member can participate in the Expert Advisory Group meetings or receive papers for them.

Conflict of Interest

Conflict of interest is defined as any instance where an Expert Advisory Group member, partner or close family friend has a direct financial or other interest in matters under consideration or proposed matters for consideration by the Expert Advisory Group. A member must disclose to the Chair any situation that may give rise to a conflict of interest or a potential conflict of interest, and seek the Assistant Secretary, SPMHP and or Chair's agreement to retain the position giving rise to the conflict of interest. Where a member gains agreement to retain their position on the Expert Advisory Group, the member must not be involved in any related discussion or decision making process.

Support for the Expert Advisory Group

The work of the Expert Advisory Group is supported by a Secretariat located within the Suicide Prevention Section, of the Department of Health.

A list of staff members to contact within the Secretariat will be provided to members of the Expert Advisory Group.

The Secretariat is responsible for:

- providing support to and general administration of the Expert Advisory Group;

- developing in consultation with the Chair, the agenda for Expert Advisory Group meetings and other business involving the Expert Advisory Group;
- distribution of meeting agendas and papers;
- distribution of materials prepared by the consultant for Expert Advisory Group consideration, including reports and other deliverables;
- arranging venues for meetings; and
- verifying reimbursement of eligible expenses.

Operation of the Expert Advisory Group

The Chair, and the Assistant Secretary of the SPMHP is ultimately responsible for the operations of the Expert Advisory Group. The Chair will preside at all meetings at which they are present.

Members of the Expert Advisory Group may also need to undertake work on an out of session basis.

A quorum for a meeting is half the Expert Advisory Group plus one. Any vacancy on the Expert Advisory Group will not affect its power to function.

A draft agenda will be cleared prior to each meeting by the Chair. Where possible, the agenda and related papers will be circulated via email to members at least one week prior to meetings.

Due to the current restrictions on travel and group gatherings imposed by the Australian and state and territory governments in response to the global COVID-19 pandemic, all meetings will be held via video or teleconference.

Business between Meetings

The Chair may write and sign letters and conduct business between meetings on behalf of the Expert Advisory Group and with the assistance of the Secretariat.

Members are expected to advise the Chair and Secretariat when they have completed agreed actions arising from previous meetings.

Remuneration

Members representing organisations and continuing to receive remuneration from their employer while attending meetings or undertaking the business of the Expert Advisory Group will not be eligible for additional remuneration relating to Expert Advisory Group duties. Individuals appointed on the basis of personal, consumer or lived experience expertise may be eligible for remuneration for Expert Advisory Group duties, dependent on individual circumstances.

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