Community-Led Safe Spaces for U.S. Communities?

Needs, Considerations, and Next Steps

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University of Rochester SafeSide Prevention

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Executive Summary

The establishment and high utilization of the 988 Suicide and Crisis Line has brought into focus the need to expand options for mental health crisis support in the United States. “Community-led Safe Spaces” offer an innovative approach to expanding options for mental health crisis care. Safe Spaces provide non-clinical, peer-led emotional and practical support in accessible community spaces rather than hospitals or clinics. The model, which was pioneered in Australia, has common features with peer-led alternatives from the U.S. and holds promise for supplementing America’s crisis care continuum.

To explore the need for, interest in, and feasibility of establishing local community Safe Spaces in the U.S., we conducted surveys, group listening sessions, individual interviews, and document reviews. (e.g., literature review, agency reports, etc.) We engaged with individuals with lived experience, mental healthcare providers, community members, and legal/policy experts.

Key findings of this preliminary work include:

- Individuals with lived experience of suicidal distress and mental health crisis expressed the need for services that provide non-judgmental support, active listening, and a sense of community. They articulated preferences for peer/lived experience staff, welcoming and comfortable environments, a range of support options, and separation from clinical procedures, including risk assessment and involuntary hospitalization, that can deter help-seeking.
- Mental healthcare providers recognized the potential benefits of Safe Spaces as an additional point of access and support, but also had concerns about risk management, relationships with clinical care, and adequate training for peer staff.
- Community leaders and potential partners saw value in having another tool for mental health crisis assistance in their communities, but emphasized the importance of local partnerships, education, and stigma reduction for successful implementation.
- Legal experts identified options regarding licensure requirements, liability protection, insurance coverage, and funding mechanisms that could support the viability of Safe Spaces in the U.S. while retaining their accessibility and community-rooted ethos.
- All stakeholder groups consistently emphasized the central role that individuals with lived experience must play in the process of conceptualizing, co-designing, evaluating, and ultimately co-leading Safe Spaces.

Next steps include:

Further work sharing results with participants and raising public awareness, as well as additional steps such as augmenting the knowledge base with further research, identifying potential pilot locations, resolving legal and regulatory issues, maintaining continuous co-design with individuals with lived experience, communicating with healthcare systems to build collaborative relationships, and conducting community awareness campaigns.

Background

The United States is making significant investments to address crises arising from mental health, suicide, and substance use challenges. The current crisis care continuum[1,2] has inadequate options for people who cannot access, or prefer not to access, healthcare services to address their distress. This is particularly true for those living in rural communities.[3] Alternative solutions are needed. The launch of the 988 Suicide and Crisis Line in 2022 provided a vital way for people in crisis to connect to the National Suicide Prevention Line; however, while the 988 service has helped reach more people,[4,5] options for those who call to receive support in their own communities and on their own terms remain limited.

The traditional expectation is that people in the midst of a mental health or suicide crisis will seek help at an emergency department. However, some features and common procedures in emergency settings can be challenging or even traumatic for individuals in emotional or suicidal crisis.[6,7,8] The busy, chaotic environment of an emergency department coupled with a lack of specialized behavioral health spaces may feel unwelcoming or even unsafe for those in crisis. Visits are also expensive for society and often also for the person seeking support.[9,10] Individuals can be "psychiatrically boarded" while awaiting placement at a psychiatric facility, leading to extended stays that are both expensive and, in many cases, unhelpful.[11,12] For those in rural areas, access to emergency departments with specialized mental health services is a particular challenge, as these facilities are typically found in urban centers.[13] Furthermore, the mismatch between emergency department capabilities and the needs of people with mental health crises raises important therapeutic concerns. Traditional emergency department responses, potentially including coercion and restraint,[14] can increase distress for those in crisis.[15] These kinds of negative experiences may then discourage individuals from seeking care at an emergency department, perpetuating the cycle of inadequate support.

Crisis Stabilization Centers (CSCs) offer a promising emerging alternative within healthcare systems. CSCs are designed specifically for people experiencing mental health and suicide crises, offering both a more suitable environment and a more cost-effective way of delivering care. There are now more than 600 CSCs in operation across the U.S. Still, like traditional facilities, most CSCs are located near urban centers due to healthcare logistics and staffing requirements, and most of these facilities are bound by clinical models and regulations that are similar to those found in other parts of the healthcare system. Thus, the quest continues for alternative options that can meet the support needs of those who do not live near urban centers, and those who are unlikely to seek mental health care, or who would be better supported in a less formalized, regulated, and professionalized environment.[16]

Promising examples of less professionalized options can be found across the U.S. in the form of peer-led programs like drop-in centers, the Living Room model, and peer respites. Such options vary regarding when they aim to engage people. For example, drop-in centers are generally spaces for people who are not in active crisis and who are looking for a space to gather, use resources, build community, and take part in support groups. Peer respites, by contrast, are designed to support people in crisis who do not need immediate medical attention, offering short-term overnight stays in a homelike environment.[17,18] Although there is a preference for peer respites to be independent of clinical systems, not all are.[19] Another community crisis respite program is the Living Room model. Living Rooms are alternatives to emergency departments for individuals in crisis that are, ideally, available 24 hours a day but do not include overnight stays. They typically do include clinical care and oversight.[20]

The University of Rochester Recovery Center of Excellence and SafeSide Prevention are working together to explore another option to meet these needs: community-run Safe Spaces. Inspired by the Community-led Safe Spaces model currently being trialled by Roses in the Ocean in Australia, these small-scale spaces are one of a variety of Safe Space service models that have been established in Australia (and elsewhere) which aim to provide an alternative to conventional supports, like EDs and CSCs, for individuals experiencing a suicidal crisis.

Community-Led Safe Spaces

The University of Rochester Recovery Center of Excellence and SafeSide Prevention are working together to explore one option to meet these needs: community-run Safe Spaces. These types of Safe Spaces have already been established in Australia by Roses in the Ocean, the country's national lived experience suicide organization, and are known as "Community-led Safe Spaces". Like other Safe Spaces, they aim to provide an alternative to conventional supports, like emergency departments and CSCs, for individuals experiencing a suicidal crisis. They are "community-led" in that each space is co-designed with the individual community in which they are located and are governed and operated by local working groups.

Co-design is "a process where a range of experts, including people with lived experience, collaborate to identify an issue and [find an agreed solution to it]." Co-design "encourages a sense of collective ownership and community 'buy-in'" and can help overcome barriers to implementation and sustainability, among other beneficial outcomes.[23]

Roses in the Ocean's Community-led Safe Spaces are run by local steering groups and staffed by volunteers who have personal lived experience of suicide and are trained to use this experience to support others, fostering a sense of understanding and empathy. Typically located in residential or storefront areas, these spaces are designed to be easily accessible and less stigmatizing for individuals seeking support. It is important to note that Safe Spaces do not provide healthcare interventions or hospital referrals, making them an inviting option for many in need who feel a clinical setting is not a good fit. Instead, they offer non-clinical support, such as emotional support (e.g., listening, a comfortable space) and practical support (e.g., information about other services, support connecting with other services, and self-care resources). Community-led Safe Spaces do not have conventional eligibility requirements, and guests can come and go as they need, except in circumstances where a person is disengaging from the service and has communicated an immediate intention of acting on a plan of suicide. They also emphasize confidentiality, gathering information from guests only to support them in connecting with other services and to follow up with caring contacts after the guest has left. Community-led Safe Spaces are intended to provide a welcoming, approachable service that is an alternative or addition to other services that may not be immediately available or that may not be the most appropriate fit for a person's needs at the time. Safe Spaces may be especially impactful in rural communities with sparse health and mental health services. Community-led Safe Spaces thus have commonalities with other options (e.g., peer respite, Living Room) that are being applied successfully in the U.S., but also have distinct characteristics which could address gaps and complement other services.

“(Safe Spaces) Need to have people with lived experience there - so I know I’m going to my people, so I don’t feel judged.”

- Listening Session Participant

Project Objectives

We explored the needs and preferences of people who might use Community-led Safe Spaces, as well as broader considerations for their implementation. Our aim was to explore individuals'—and particularly rural individuals'—reactions to and thoughts about peer-led and non-clinical community crisis support without being overly prescriptive about what such a resource should look like. We therefore structured our project objectives around relevant topic areas to explore the broader issues rather than leading with an emphasis on describing Community-led Safe Spaces as implemented in Australia. Through consultation with Roses in the Ocean, we identified several areas on which to focus and shaped our project objectives around them.

Identify the needs of potential guests and their family members.

If Community-led Safe Spaces are to be person-centered and distinct from existing crisis services, their development should begin from careful consideration of the experiences, preferences, and expressed needs of those with lived experience of suicidal or emotional distress. "Person-centered care…means [individuals] have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual.[24]"

We set out to explore questions such as:

- What specific needs do people experiencing emotional distress or suicidal crisis have at various points during their period of distress/crisis?
- What are the preferences for support among potential guests, family members, and carers?
- What gaps do potential guests, family members, and carers perceive in existing crisis services?
- What would the Safe Space need to offer for people to feel comfortable and confident accessing the service?
- What would lead people who are not otherwise likely to go to existing services to utilize Community-led Safe Spaces?

Explore perspectives of healthcare providers.

Although Safe Spaces are, by design, situated apart from healthcare systems, healthcare providers remain interested parties who will want to know about alternative resources. We thus aimed to engage with healthcare providers to discuss topics like:

- What do healthcare providers perceive to be gaps in existing services?
- How might healthcare providers be kept informed about the service and develop a relationship with the Safe Space to establish connection pathways?
- What concerns might healthcare providers have about crisis resources that are wholly independent of healthcare systems?

Understand the perspectives of potential interested parties in rural communities.

Safe Spaces will be led by communities, rather than existing healthcare systems, and will be located in non-healthcare settings. Consequently, we also sought to explore the perspectives of interested community parties. Questions to consider included:

- Who are the community partners who should be involved directly? Indirectly?
- What would collective ownership look like in the context of a community-led, non-clinical, peer-staffed model?
- What concerns might community partners have about the community-led nature of Safe Spaces?

Identify relevant legal and policy considerations that may support Safe Spaces or present design challenges.

In order to identify potential legal and policy considerations, we drew on the health services policy expertise of our team and consulted with legal experts in areas such as protection and advocacy work, malpractice litigation, and public mental health policy. We explored considerations such as:

- Will regulation be needed to establish the legitimacy and authority of Safe Spaces?
- What potential liability issues exist? How might licensing regulations (e.g., insurance requirements) impact Safe Space volunteers? How might regulatory requirements (e.g., site licenses) impact Safe Space locations?
- What training needs to be provided for volunteers to ensure that they are well equipped and confident in their ability to support people in distress?

“One gap I see is we do not have a place for someone who is feeling suicidal, but does not feel that inpatient care is needed.”

- Listening Session Participant

Project Method

The process for conducting this preliminary exploration was informed by a co-design process developed by Roses in the Ocean and used in state and national projects in Australia. Roses in the Ocean prioritizes the involvement of people with lived experience of suicide in their approach to co-designing intervention programs.[21,23] They center and support the input of people with lived experience throughout the process in order to ensure their genuine involvement, overcome power differentials, engage people with low levels of trust, and recruit a diverse range of lived experience perspectives. The objectives of this preliminary exploration were preparatory to undertaking research, design, and piloting in a future stage. Thus, the emphasis on meaningfully engaging individuals with lived experience was relevant to our ability to effectively engage potential guests and family members as we conducted our needs and feasibility assessment.

We used several methods for connecting with relevant people and collecting their input, including surveys, listening sessions, and individual conversations. In each instance, we kept geography in mind in order to ensure participation by individuals in rural areas.

For online surveying of potential guests, family, and healthcare providers, we purposively sampled through collaboration with organizations related to suicide, distress, and behavioral health, as well as through a survey platform (Pollfish) that allowed for geographically focused dissemination of the survey. We asked organizations such as United Suicide Survivors International, Vocal Virginia, and Wildflower Alliance to distribute a link to the online survey. In addition, agencies such as the Tennessee Department of Mental Health and Substance Abuse Services and the Virginia Department of Behavioral Health and Developmental Services, specifically its Office of Recovery Services, were asked to circulate the email inviting participation in the survey. The same email invited participation in the listening sessions.

For conversations with other interested community parties and businesses, as well as supplemental conversations with healthcare providers and attorneys, we undertook targeted outreach through established connections (e.g., healthcare providers connected to SafeSide through past activities, attorneys identified by collaborators) and to relevant organizations (e.g., business bureaus in rural areas).

Ultimately, we received 353 completed surveys and spoke with 46 people in the listening sessions. We conducted five listening sessions with people with lived experience, each of which included two to three small "breakout rooms" to maximize comfort and participation. We reached participants in Alabama, Alaska, Arkansas, Georgia, Kentucky, Michigan, Minnesota, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

The group of individuals surveyed for this project does not constitute a representative sample of those who might use Community-led Safe Spaces. We partnered with people who were interested in contributing and who were, almost without exception, sympathetic to the Safe Spaces vision. Future design work will need to take account of the statistical makeup of the population these services would aim to serve. For instance, working-aged men from high-risk industries such as manufacturing and construction may have specific access and environmental requirements that will need to be addressed. In addition, while we continue to use the language of "Community-led Safe Spaces" throughout this report, implementation of this approach in the U.S. context and culture may call for different language. For example, the terminology of "Safe Spaces" is already associated with other initiatives, such as spaces on college campuses that are free from discrimination and harm toward LGBTQ+ students. At the same time, words like "safe" are also loaded for many individuals who have had poor experiences with involuntary mental health interventions. This language may also be perceived as not aligning well with harm reduction approaches, which aim for "safer" environments and outcomes but cannot and do not guarantee an absolute experience of safety.

“When my feelings and thoughts were validated as real and worthy. The things I had been through had been hard, and when someone validated that, it lifted the heav[iness] of it all … that was the most helpful.”

- Individual with lived experience

What We Have Found So Far

Tables 1 – 6 summarize key themes that emerged from analysis of the survey responses, listening session discussions, and individual interviews.

Appendix A contains illustrative comments and notes captured using virtual whiteboards during the listening sessions.

Appendix B contains details about the survey participants and a quantitative summary of their responses. To encompass the range of interested parties, the broad term "service provider" is used to refer to healthcare providers, peer specialists, counselors, and other roles. Many of the participants categorized as "lived experience + service provider" were peer support specialists, but this group also included professionals like counselors and case managers who identified as having lived experience in addition to their provider role. The table organizes findings by topic, providing representative quotes to illustrate themes in participants' own words while noting which stakeholder groups mentioned each theme. This format aims to synthesize findings while maintaining the human voices that shaped the results.

TABLE 1: Needs and Preferences During Emotional and Suicidal Distress

Key Themes	Representative Comments
Non-judgmental, validating support; active listening and respect Well over 100 individuals described the fundamental importance of services and providers, of any sort, actively listening to them. Notably, the majority of individuals who described clinical settings and providers as being helpful stated they were particularly helpful when they engaged non-judgmentally, actively listened, and collaborated in care, etc. **Heard from:** --Individuals with lived experience --Healthcare service providers	"Someone non-judgmental that listens in a safe space." – Individual with lived experience "Having a non-judgmental person to talk with." – Individual with lived experience "When my feelings and thoughts were validated as real and worthy. The things I had been through had been hard, and when someone validated that, it lifted the heav[iness] of it all ... that was the most helpful." – Individual with lived experience "I found just having someone to listen, judgment-free, helped more than anything. Seems problems don't seem quite so big once said out loud." – Individual with lived experience "Being able to talk about what led me down that path, finding ways to better my situation and being taken seriously." – Individual with lived experience "My doctor listening to me [helped me the most]." – Individual with lived experience "Just having someone to talk to who understood and didn't belittle me." – Individual with lived experience

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TABLE 1: Needs and Preferences During Emotional and Suicidal Distress

Sense of community, being with others The idea of having someone else present, of not feeling alone, and feeling connected in one or more ways often came up in conjunction with the idea of active listening but was a clear theme of its own across dozens of responses. Heard from: --Individuals with lived experience.	"Talking to someone about it and realizing that I'm not the only one to feel lost. And it's ok to feel that way." – Individual with lived experience "Being around others who were experiencing some of what I was and sharing." – Individual with lived experience "Connection to others, not feeling alone, reminders that things can change." – Individual with lived experience "These non-clinical spaces are community building spaces. Most of the suicidality I encounter has to do with feeling alone and unsupported." – Healthcare service provider with lived experience
Relatable and relevant supporters, providers Potential guests and healthcare providers both converged on the need for services and providers to be more representative of, or relatable to, people with lived experience and/or people of color and LGBTQ+. **Heard from:** --Individuals with lived experience --Healthcare service providers --Legal experts	"[What helped me most in the past was] talking to people who had been where I had been. Who had the same experience." – Individual with lived experience "Having someone available to talk to that could understand what I was experiencing because they have had similar experiences in the past and could sit in their own discomfort of what I was experiencing without an expectation that they needed to do something to fix what was going on or trying to decide for me what I need to do." – Individual with lived experience "[One of two big barriers] for our communities is—especially in brown and black communities—that finding spaces or people that we can call them and that they look like us. That's been a really big barrier for getting people in our community to engage in mental health, especially in hospital settings. You know, there's a lot of mistrust around some of the hospitals." – Healthcare service provider with lived experience "We serve a large LGBTQ community here, and I really think there's gaps in trans health care, mental health care, and gender-affirming care in these settings." – Healthcare service provider with lived experience

TABLE 2: Barriers to Care in Existing Services

Key Themes	Representative Comments
Judgment, lack of dignity, not listening People recounted a wide range of negative experiences with judgment, not listening, and loss of dignity, which they saw as barriers to seeking care from health services. **Heard from:** --Individuals with lived experience --Healthcare service providers	"Being given medication and being told it's in my head [was the least helpful]." – Individual with lived experience "People that judge you or brush off why you are feeling the way you do [are the least helpful]." – Individual with lived experience "Gaslighting and demoralizing, belittlement and talking down [are the least helpful]." – Individual with lived experience "People trying to fix me without my input [was the least helpful]." – Individual with lived experience "Removing my shoelaces and hoodie strings and they never help you put them back in." – Individual with lived experience
Clinical procedures and spaces Potential guests, as well as many service providers, described how clinical procedures and spaces can deter people from seeking services. **Heard from:** --Individuals with lived experience --Healthcare service providers	"Uncaring, disrespectful, humiliating, cold environment in ED [was least helpful]." – Individual with lived experience "Loud noise, judgments, repeating myself [for intake, paperwork, etc. were the least helpful]." – Individual with lived experience "Overly scripted lethality risk questions [were the least helpful]." – Individual with lived experience "Paperwork and procedures that give an impression of 'systems before people' [were the least helpful]." – Individual with lived experience "I think statewide policies … as well as perceptions of suicide and mental health are a big thing in Louisiana. When people are put under an involuntary hold, they're observed by what are called 'coroners,' which is terrible to hear if you want to kill yourself, to be examined by somebody who's supposed to examine people who were dead. Which can be really stigmatizing and prevent somebody from seeking care." – Healthcare service provider

TABLE 2: Barriers to Care in Existing Services

Fear, trauma, lack of trust Potential guests shared the experiences that led them to distrust and even fear traditional healthcare systems. Service providers also acknowledged both historical factors (e.g., research on people of color without their consent) and contemporary factors (e.g., emergency protocols entailing law enforcement and/or restraint) that inform people's feelings and decisions about seeking care. **Heard from:** --Individuals with lived experience --Healthcare service providers	"The stigma and judgmental attitudes of ED staff about being weak and lacking courage because I wanted to die. That made me not want to ask for help again." – Individual with lived experience "I know—it's like my only one thing—that just automatically is no law enforcement. ... I mean, they should first ask questions ... We even had the state [Department of Justice] investigating stuff like that, and we have quite a few that it was a mental health call [to which law enforcement responded] and someone who was distressed got killed [by the officers]." – Individual with lived experience "[Ideal crisis services would be] not connected to any carceral system, like not allowing police in places like that." "I think the part that [she] just said about the carceral systems is really important to acknowledge as well because the police have been documented as being extremely harmful to the point of murder when there are mental health issues. So we cannot ignore that. That has to be taken into account." – Two healthcare service providers "So, each time is going to be different and I hope that, you know, I don't have another time, but if there is, I want a peer there and I don't want the police there necessarily, because that just sends my anxiety and fear [way up]. But a lot of times in these towns, they're the first responders." – Healthcare service provider with lived experience "We see that when police come in, they'll put them into custody, which how terrible is that if you're going through a really terrible time, you know, you're wanting to die and then at the end of it, somebody put you in handcuffs and put you into holding for 24 hours or drops you off in an emergency room and says, good luck." – Healthcare service provider

TABLE 2: Barriers to Care in Existing Services

Lack of resources; wait times Potential guests in rural areas, and even in more densely populated areas, described how having too few resources and/or resources located far away created barriers to receiving timely care. In many cases, a lack of resources led to not receiving care at all. In other instances, potential guests highlighted how having so few resources meant there was a lack of intermediate services, which contributed to individuals essentially having to wait until they are in crisis. **Heard from:** --Individuals with lived experience --Healthcare service providers	"Going to a person to get help or medication takes way too long." – Individual with lived experience "One [barrier] is access because the waiting times to get to see a therapist or anybody [are] horrendous. And so, [for example,] I brought one young lady because we couldn't even get in, the emergency room was full—I brought her home and she stayed with me for a weekend until we could get her connected back up with her own doc." – Healthcare service provider with lived experience "So being in a rural area, we have a local mental health authority. And then we have our ER. ... But we don't have facilities where they can go and continue with treatment. They can go to the emergency room [but] there's just a list of waiting beds and hospitals they can't go to [and if they can go to a hospital it's] three or three and a half hours away." – Individual with lived experience "[The least helpful in my experience is] being removed from my existing support systems in the community, lack of access to resources in a rural community which means potentially long waits for access to crisis services in another community." – Individual with lived experience "If I would be concerned enough to send the patient to the ER for assessment, and almost a hundred percent of the time they would be sent back home. Which is not clinically what I would have chosen for them but there just isn't—the resources are up in Anchorage and whether or not they have a bed, whether or not they have someone to transport them. And logistically health care is very different because we live on an island, the only way to get off is a plane and we don't have a lot of resources." – Healthcare service provider

TABLE 3: "Musts" for Safe Spaces to Fill Gaps and Needs

Key Themes	Representative Comments
Lived experience The unique value of and need for staff with lived experience was endorsed in every listening session and referenced approximately 40 times in the survey open responses. **Heard from:** --Individuals with lived experience --Healthcare service providers	"Need to have people with lived experience there—so I know I'm going to my people, so I don't feel judged" – Individual with lived experience "They are run by people with lived experience! Who could understand any better?" – Individual with lived experience [Regarding what ideal crisis services would look like] "Things that I had written down focused on services being created by and for people with lived experience of suicidality. Like the nuances that kind of go into that—regarding communities that we come from or intersectional kinds of identities." – Healthcare service provider "So I think that having more accurate representation of mental health recovery could really change people's lives and having lived experience right there. If somebody that just walked that walk and will walk yours with you, you know what I mean? That would have been really, really cool to be able to have." – Individual with lived experience "I've had 4 or 5 different crises before and you know every single one of them I needed something different at the time of the crisis but I can also agree every single one of them would have been better served with a peer response and not necessarily a law enforcement response." – Healthcare service provider with lived experience "When I was on a crisis team as a peer, we went out on a call and the gentleman that was there would not talk to the police, wouldn't talk to the therapist. And I walked up and I said, 'Look. On my wrist here, this scar, that's my last suicide attempt.' Then he finally calmed down and he let me sit there and talk to him for a few and then I said, 'Look, that doesn't mean that they're gonna take you anywhere. Let's just talk to them.' Because that was his big fear was going away in handcuffs and his neighbor seeing things. So he was more open and willing because I could show that I had that lived experience." – Healthcare service provider with lived experience

TABLE 3: “Musts” for Safe Spaces to Fill Gaps and Needs

Welcoming, comfortable, with reduced barriers to access (e.g., no ID required) Listening session participants uniformly stated that for crisis services to be ideal, they need to be welcoming and comfortable. This was consistent with survey results; over a third of survey participants selected “warm and welcoming” as important to feeling comfortable when seeking support. Feeling welcome and like there was “no wrong door” had the highest average rating of key features of Safe Spaces. Participants described a wide range of ways Safe Spaces could be welcoming and comfortable, including comfortable furniture; warm welcomes by staff that do not emphasize signing in, paperwork, or a front-desk approach; an environment that feels “homey” or like a coffeeshop; staff in casual attire; a kitchen space, food, and beverages; etc. Importantly, they noted how a welcoming setting that does not emphasize administrative and assessment steps will reduce barriers to care for individuals who may not have insurance, identification, etc. **Heard from:** --Individuals with lived experience --Healthcare service providers	“I have to say, just a complete and utter lack of any judgment whatsoever. It’s gotta be a completely judgment-free zone. You know, radical acceptance, unbounded empathy. I can’t, I don’t wanna walk in and walk up to a desk and have to sign in and feel like I’m being looked down on because I’m looking for services.” – Healthcare service provider with lived experience “And a very important word and what I was thinking about is what does the physical structure look like? Is it cold and clinical or is it warm and welcoming as far as the ambience?” – Individual with lived experience “Just the comfortable space where it doesn’t feel like you’re going into a clinical setting.” – Individual with lived experience “We have to walk around with our badges on all the time. You know, maybe remove that aspect or, you know, take the certificates and the licenses off the wall.” – Healthcare service provider with lived experience “I just have all of the ideas floating in my head now of what everyone has been saying and it really does sound wonderful when you think of the difference of walking into someplace where you know a peer can meet you and there’s just this inviting environment with activities. It’s so much different than walking into an emergency room or, you know, an urgent care. Because anywhere else you’re going to go, you’re gonna wait and you still can’t always find someone that can help you, or then you get referred and referred and you’re waiting and you’re going all over the place.” – Healthcare service provider with lived experience “We don’t do referrals … [these sorts of spaces] need to be open access environments, people can gather and learn and share. You can give us the name Daffy Duck … we don’t take any payment, insurance, Medicaid, anything.” – Healthcare service provider with lived experience “Having resources after 5 o’clock is very important. A lot of resources, they close at 5 and they act like people don’t have a nervous breakdown after 5 PM.” – Healthcare service provider

TABLE 3: "Musts" for Safe Spaces to Fill Gaps and Needs

Theme	Quotes
Range of options, support making connections to services Across all listening sessions, lived experience and service provider participants described potential ways in which Safe Spaces could offer non-clinical support. Common across all such suggestions was the necessity of having a range of options because individuals have varying needs and coping preferences. Non-clinical support options included talking one-on-one with staff, in group sessions, and, importantly, informally with other guests, which is often discouraged in medical emergency settings. Participants valued space and materials for physical activities that do not require talking (breathwork, yoga, craft supplies, writing materials, gardening), and opportunities for self-care (laundry, travel-size hygiene items available). Participants frequently stressed the importance of such options for supporting the individual's dignity. Several participants also saw possibilities for Safe Spaces to contribute to ensure connections to other services or between services. **Heard from:** --Individuals with lived experience --Healthcare service providers	"And what I see more so often than not, even if it is like a warm hand off, it's filling in the gaps [because people still fall through]. So, so many people get lost through the gaps." – Healthcare service provider with lived experience "As soon as they're released from the hospital—I guess I've always just dreamed and wished for that medium place when they come out [of the hospital and] they feel welcome and they're not judged and they're not diagnosed. I get so tired of that because I've seen the success stories on the other side where we just connect as human beings and sure we have diagnosis and things, but it's really empowering them and giving them a safe space." – Healthcare service provider "Do these spaces get creative with experiential activities rather than just talking, since many struggle with that—especially when depressed or suicidal? I have found this to be very effective." – Healthcare service provider with lived experience "I think having, I don't know another way to say it, but kinda like 'comfort bags' [with a range of materials or options for things to do] or like there could be things to color or a painting area or something that's doing a coping skill. That you know just is helping get your mind off of it, some soft music playing or something. Because sometimes it's not about talking to somebody. Sometimes it's about being in the space with others and doing something." – Healthcare service provider with lived experience "Having support for family or friends who were there. Whatever the case may be because everybody, you know, it could be helpful for them too. Cause I know with me and my recovery it's been like a whole village sort of approach to you know, my healing." – Individual with lived experience

TABLE 3: "Musts" for Safe Spaces to Fill Gaps and Needs

Risk tolerance Dozens of participants with lived experience implicitly underscored the role of greater risk tolerance when they wrote or spoke about the need for a space in which people could speak honestly, openly, and without fear of emergency procedures being invoked. Listening session participants, including individuals with lived experience and service providers, spoke directly to why greater risk tolerance would be valuable for approaches like Safe Spaces. **Heard from:** --Individuals with lived experience --Healthcare service providers	"Not treating them like a landmine or something that's about to go off like a risk or a threat. ... I worked in an emergency department for a year and the first thing they taught us was self-defense measures when someone comes in that's activated... And if you're automatically training people to be in defense mode and considering these people as safety risks to you and your person, how are you going to treat anybody that walks through the door [if that's how you've been trained to view them]?" – Healthcare service provider "I think also it looks like not treating people with suicidality like they are a risk. And that they don't know how to determine their own needs. That it values autonomy and self-determination and is more of a relational process rather than paternalistic, I guess is the best word." – Healthcare service provider "I think people might feel safer entering into a space like this, as there is often a fear about being hospitalized or having providers react out of fear and not provide the space to talk through the emotions." – Healthcare service provider with lived experience "My experience overall has been that, if I reach a point to where I'm at a peer center or a safe place, I'm willing to talk about what's going on with me and a lot of times that [risk] assessment is not necessary. I'll usually let you know, "Hey, I'm not okay." I can tell you that I'm not okay." – Healthcare service provider with lived experience "So many people don't have that support when they get out [of the hospital]. And then it's all on me as the clinician to carry everything [but] I only see them once a week if they can even afford that or if they even show up. So, I'm always pushing for that 'middle place' but [mental health settings/agencies] won't allow it. They won't allow me to create any kind of group setting for that. They're like, 'Oh, no, no, [that'd be] too high risk.' ... [B]ut people are even more at risk [after hospitalization] because they possibly were traumatized while hospitalized or because they don't have support when they get out." – Healthcare service provider "That's always been a big issue, you know. It's such a sensitive topic that you can't exactly go around talking to certain people about, especially [about suicide] ideations. Because the average person that hasn't had any training or knowledge of it is gonna hear that word and think crisis and overreact. And so to have a space to actually be able to share and not have somebody assume that you need to go to a psychiatric hospital would be amazing." – Healthcare service provider with lived experience

TABLE 3: “Musts” for Safe Spaces to Fill Gaps and Needs

Separation from traditional clinical procedures In addition to distinguishing Safe Spaces from clinical spaces through differences in physical environment, participants described how and why Safe Spaces should aim to avoid practices and policies that mirror clinical procedures. Approximately 36 survey participants and participants across all listening sessions described how having distinctly different approaches not based in existing services would provide valuable alternatives, increase likelihood of individuals seeking services, and even potentially combat stigma. Several participants highlighted the desirability of confidentiality. Many participants also described why alternatives to existing emergency psychiatric protocols are needed. **Heard from:** --Individuals with lived experience --Healthcare service providers	“I like non-mental health/non-Clinical solutions. I like that it’s in the community as that helps with stigma and makes it easier to ask for help.” – Individual with lived experience “Pairing Safe Spaces with the EmPATH* model, we could see a major decline in inpatient hospital stays, which we overutilize in the U.S. because we providers are not comfortable with lower levels of care once someone mentions suicidal ideation.” – Healthcare service provider [*Emergency Psychiatry Assessment, Treatment and Healing] “I think it would be really important for these spaces to not tell people there’s something wrong with them. Because you know how there’s different theories about suicidality and then there’s the pathological model and then the sociological model and different models. And I would imagine it would be really important to make sure that when people come to these spaces, they’re not told there’s something wrong with them, so they feel welcome. Nobody wants to be told there’s something wrong with them, right? Because it would make people avoid coming there. That’s why a lot of people avoid mental health services in general, because they don’t wanna be told there’s something wrong or they have a brain disease or whatever.” – Individual with lived experience “I think the totality of it is great but I think the one major thing is: They’re not gonna tell anybody and I can go there and I don’t have to worry about the police breaking the door down. I don’t have to worry about the hospital system there. … I think the idea that ‘nobody is gonna know it unless I say they know it’ is going to be huge for drawing people because most of us have [had bad experiences]. They don’t want to go to a hospital because they don’t trust those systems, they’ve had a bad time, so they don’t want anything to do with that. And so for this space to be totally separate is key because people that are not trustful and skeptical because they’ve had bad experiences, the first thing [they’ll] want to know is: ‘Who are you connected to? Is anybody gonna know, who are you gonna talk to about me? Did [the hospital system] send you? Is this really a trick for them to get me there?’ You know, so I think that the whole idea of real confidentiality, it’s all about you and we’re not puppets for anybody else, [is key].” – Individual with lived experience “It was like, I didn’t want to give up my family or my job or whatever, but I knew I needed help, but then if I go get this help, it’s gonna cause me to lose these things. And so I was stuck in this kind of turmoil and … had I known that I could have went to a place where ‘we’re not going to ask you to give up any of that stuff. We’re not diagnosing you, we’re not committing you. We’re just here to talk to you and listen about how we can help you …,’ maybe it wouldn’t have gotten as bad as it got.” – Individual with lived experience

TABLE 3: "Musts" for Safe Spaces to Fill Gaps and Needs

Separation from traditional clinical procedures (continued)	"What should not be [part of crisis services is law enforcement], there should be as little engagement with law enforcement as possible. I know sometimes that happens either in the hospital setting or like if it's a crisis where they're called to the home and for some reason law enforcement is there. I don't know why that is, when it's like someone is calling for crisis support. But [law enforcement] always seems to be more harmful than good." – Healthcare service provider with lived experience "So I was thinking about my last time that I was in crisis. What helped me through that was the fact that I had a peer specialist right there with me, and it wasn't right away with the cops, you know, in fact the cops didn't even come, which was the first time in my life cops didn't come." – Healthcare service provider with lived experience "So I guess the first [barrier I think of] is living in a rural community is that when 911 is called, the police come. And they were really helpful because my son was in a dangerous situation but it'd be great to also not have people with guns show up. So that's kind of, I guess, a no-brainer, but I just wanted to say that, you know, is still happening." – Individual with lived experience

TABLE 3: “Musts” for Safe Spaces to Fill Gaps and Needs

Transparent statement of what Safe Spaces do and do not do, of behavioral expectations Several listening session groups stated that Safe Spaces should have clear statements of what they do and what they do not do regarding what supports are available, what behavior is expected of guests, etc. Participants described how such statements may help engage individuals who typically avoid other services and will also help to clarify where Safe Spaces fit into the continuum of supports and services generally available. One of the attorneys also spoke to the importance of making such parameters clear in order to avoid “untoward expectations” that could contribute to liability. **Heard from:** --Individuals with lived experience --Healthcare service providers --Legal experts	“One of the things that makes me feel comfortable is just establishing rules just like this [listening session], there were a couple of rules at the very beginning so that you know what to expect.” – Individual with lived experience “For lack of a better term, I don’t know what to call it, but a mission statement. A clear like ‘this is what this, is why we’re here and if you come here this is what you can expect.’ Because a lot of times you just don’t know, it’s real cloudy. ... [B]ut so that you know like this is where I’m going and this is what we do here and this is who is here.” – Healthcare service provider with lived experience “To me that’s safer, where I can read what, you know, read and understand what the bylaws are with confidentiality and autonomy. And what [would] indicate some conflict of interest.” – Healthcare service provider “Are there guidelines about what can happen at the drop-in center? What about alcohol/drug use? Behavioral guidelines?” – Healthcare service provider “Can you occupy this space without untoward expectations; can you communicate the limits in a way that is transparent but not off-putting?” – Legal expert

TABLE 3: “Musts” for Safe Spaces to Fill Gaps and Needs

Emotional safety; holistic, trauma-informed[23]* care Emotional safety was selected as a “most important characteristic of crisis care” by 40% of survey participants, making it one of the two most endorsed characteristics (being available outside usual business hours was also selected by 40% of participants). Listening session participants with experience providing services highlighted the importance of taking a holistic approach to wellness, especially in terms of trauma-informed practices. Heard from: --Individuals with lived experience --Healthcare service providers	“Recovery language, trauma-informed care. You can tell which people [are genuinely] using [those terms] and doing [those practices]—that it’s just the way that they live and … I think people can really tell.” – Healthcare service provider with lived experience “So understanding the different intersectionalities of lived experiences and knowing that it’s beyond just a diagnosis but you know chronic pain, suicide, there’s all sorts of lived experiences. Have it be holistic in what services or resources are being offered. … [M]aking sure that we’re focusing on those 8 dimensions of wellness and not just kind of getting down to one versus the other. You know, all 8 are important and they all intersect to kind of make us where we’re at at that point. And so, being able to not just say those things, say we’re trauma-informed, say we’re culturally humble, say all of these great buzz words but being actually able to show that in practice as well.” – Healthcare service provider with lived experience “[When designing an ideal crisis support service, you] also have to make it trauma-informed, even in the building design. [It should have] more individually based care … and limit re-traumatization.” – Healthcare service provider with lived experience “I think the ideal crisis service uses trauma-informed care. … Now that I know what [trauma-informed care] is, I can look back and see the difference it made—the negative [impact] when I didn’t have [trauma-informed care].” – Healthcare service provider with lived experience

*A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[23]

“I would imagine it would be really important to make sure that when people come to these spaces, they’re not told there’s something wrong with them, so they feel welcome.”

- Individual with Lived Experience

TABLE 4: Questions and Concerns about Safe Spaces

Key Themes	Representative Comments
Handling emergencies outside scope; what role clinical care plays Approximately 34 survey participants had questions about how medical or safety emergencies would be handled. Similar concerns were raised by some listening session participants, including individuals with lived experience and experience working in healthcare settings. In the listening sessions, where participants had greater opportunity to describe the scope of their thinking, they noted support for emphasizing non-clinical supports, but thought it was important to have some structure or procedure in place to enable quick connection with clinical services. **Heard from:** --Individuals with lived experience --Healthcare service providers	"You know, not to say that [clinical services have] to be forced on anyone. I just would feel much more comfortable seeing that with something in place, for a continuum, you know, if things were to escalate. Or if things were worse than I initially thought when I went in there. I just feel like the connection [with clinical systems] doesn't need to be completely severed." – Healthcare service provider with lived experience "And then also the same concern that [he] had is what if things did get so bad that somebody did want that clinical support? So [a Safe Space] doesn't necessarily need to be a part of [a healthcare system], but definitely [needs to have a way to connect people with] something that has some resources for you if you do need that." – Individual with lived experience "My concern is a physical threat and being unable to handle it." – Individual with lived experience "That medical personnel are not available for a medical crisis." – Individual with lived experience
Hurdles in rural/remote areas Although participants from rural areas were generally interested in the idea of Safe Spaces, several listening session participants noted that some hurdles in rural and remote areas may be particularly hard to overcome. **Heard from:** --Individuals with lived experience --Healthcare service providers	"A storefront here, in [this extremely rural county], the storefront would be a bait shop. I can't think of what else might be there ... an auto parts store." – Healthcare service provider "And I think especially in a neighborhood, you know, people are just, attached, very protected, even in the worst neighborhood. So [they're] still attached, still protective of their neighborhood. It means something that they know people, you know, and so that could be a barrier—it's my neighborhood and I don't want everybody in my neighborhood to know my business" – Healthcare service provider with lived experience "But I find the biggest barrier in a small community like this is the lack of trust and everyone knows everything. It's amazing to me how quickly information can travel. And that is a huge barrier with anything I do, there's people who will meet me later on, somewhere else and say, 'I really was going to go to that, but I was afraid that [people would find out].'" – Healthcare service provider

TABLE 4: Questions and Concerns about Safe Spaces

Training standards Participants in the listening sessions, including those who worked as peer support specialists, had questions about the training peer staff would undertake. They identified a need for relevant training for people who may be new to a support role, and also pointed out the role of training and supervision in supporting peer staff themselves. Approximately 25 survey participants voiced concerns about the kind of training peer staff would have. **Heard from:** --Individuals with lived experience --Healthcare service providers --Legal experts	"Providing the appropriate support and training for the peer supports who are leading so that they are not put in an unfair or unsafe position, that they have somewhere to go when they are triggered or overwhelmed." – Healthcare service provider with lived experience "I would be willing to bet that different Safe Spaces might offer inconsistent levels of help." – Individual with lived experience "I feel that individuals not trained in healthcare or emergency services might find that suicidal patients are more difficult than they had imagined, and that despite their good intentions, people may end up injured as a direct result." – Healthcare service provider with lived experience "[Thinking about training,] of course there's an issue about safety and the fact that we need to make sure that people don't get hurt. But on the other side of that: What about the people that are working there? If somebody comes in and says that [they are going to harm themselves] then walks out the door and does something. How do [the staff] deal with it? Having that burden on them. How do they deal with those feelings associated with that? You know, were they prepared to handle something like that? Do they have a place they can turn to if they have to deal with something as heavy and burdensome as that?" – Healthcare service provider with lived experience
Liability and security (see also TABLE 6) Many listening session participants, and particularly those with experience providing services, highlighted that the U.S. healthcare culture focus on liability may pose a substantial barrier to implementing Safe Spaces. Concerns about liability, and particularly on-site safety, were raised by about a dozen survey participants. **Heard from:** --Individuals with lived experience --Healthcare service providers	"It's so appealing to hear. And then immediately I cringe. Because if something like this were to happen in Georgia. First off, it would be immediately incorporated into the peer system we have now. There's no question in my mind about it. Which means now you have peer specialists that are going to be running this. They have mandatory reporting requirements as peer specialists [in Georgia]." – Healthcare service provider with lived experience "[E]ven with our wonderful group [that we used to hold], we're having them sign a waiver that if they did do anything, we're not responsible." – Healthcare service provider with lived experience "I think it also excludes certain professionals, such as myself, who, if we hear something, we are mandated to report. … [I couldn't volunteer or work there] because if somebody says I'm about to kill myself and walks out the door, I could lose my license if I don't go do something about it." – Healthcare service provider "In the U.S. this will be a big issue: what kind of liability is there for the peer lived experience staff member? Is there a way they can be covered - is there a way they can not be worried about it?" – Healthcare service provider

TABLE 4: Questions and Concerns about Safe Spaces

How are Safe Spaces different than ____? Although not a very frequent question, some participants, especially those who were knowledgeable about the U.S. "crisis continuum of care" and/or peer-led approaches, asked how Safe Spaces differ from certain existing service approaches in the U.S. **Heard from:** --Individuals with lived experience --Healthcare service providers	"What is the difference between these or is there a difference between these Safe Spaces and something like a peer respite model?" – Individual with lived experience "That was at the National Association of Peer Specialists [sic] Conference this past year. And they had a presenter that was presenting on something like this. From Arizona. Is there one already up and running?" – Healthcare service provider with lived experience "Is this a homeless hangout like a day treatment?" – Healthcare service provider
Coverage of other groups In a few listening session groups, participants asked questions about important areas that require additional consideration moving forward, namely, whether and how Safe Spaces could serve youth and/or individuals experiencing both emotional or suicidal distress and problems with substance use. **Heard from:** --Individuals with lived experience --Healthcare service providers	"How do youth fit in?" – Individual and healthcare service provider with lived experience "It's a dicey question—many privacy rights for minors—much cannot be disclosed to parents without permission from the minor." – Healthcare service provider "I'm seeing that not only with people who have suicide but also with substance abuse. We've got a definite issue. At least where I am that it's almost impossible to get admitted to a long term or rehabilitation facility unless you're actively using or in crisis. And you know, we have people who are genuinely willing to do the work and put the time in. They just can't get the access." – Healthcare service provider with lived experience "And it's kind of odd because you know as [Certified Peer Recovery Specialists (CPRSs)] is in the state of Tennessee, we are either recovering from substance use and mental health or one of each. But if you look at how our CPRSs are delegated where our CPRSs are utilized, it's almost all substance use." – Healthcare service provider with lived experience

TABLE 5: Communication and Collaboration

Key Themes	Representative Comments
Community partnering Several listening session participants with lived experience who also had first-hand experience working with and in communities provided insights about what will be required for successful implementation. They also noted that co-designing and integrating with the community would provide opportunities for raising awareness of Safe Spaces and would support sustainability. Approximately 10 survey respondents also noted having Safe Spaces integrated in communities is a worthwhile advantage. **Heard from:** --Individuals with lived experience --Healthcare service providers	"I think that these spaces would be very helpful, but I think initially people—there have been experiences with other services that, you know, they would be skeptical. And I think that it will take time for trust to be built up. But I think [some are] gonna try it and then [others] wait to hear word of mouth." – Individual with lived experience "If it's gonna be community-led, there's going to have to be some buy-in, which means there's going to have to be some stigma breaking. There's gonna be some partnerships, some education. This is not something that we say, 'alright, we're gonna implement this next year.' No, this is going to be a couple of years down the road because there's a lot of foundation work that has to go in before something like this could be genuinely successful." – Healthcare service provider with lived experience "Needs to be endorsed by the whole city—all health care systems, i.e. a community effort." – Healthcare service provider "But I think in preparation to do something like this, some town halls happen in the communities that want to do it or are wanting to explore to do it. So that way we're not going to one community that just we think needs it. But do they think they need it and want it?" – Individual with lived experience "It's kind of almost impossible to do what I feel you need. I would feel that I would need complete anonymity entering and exiting the space. Which would mean that the space would not have to be advertised kind of hidden and tucked away, which means no one would know about it, which means I wouldn't know how to get there. … I think if you found some way to maybe combine it with I guess a dissimilar service. Like I have to go in this building to pay my water bill or I can be going to seek counseling. That would be probably the way I could think to address it." – Healthcare service provider with lived experience "For me, it's partnership with law enforcement. As wonderful as quick [mental health] response teams are, they're not always feasible or realistic or in the budget. One of the things that I do is I teach classes in mental health and de-escalation techniques and recognizing you know, the difference between somebody who's actually a danger to you and somebody's who's in mental distress. And it's not just for law enforcement, it's for entire communities. Health care workers, judges. And the people who are the most engaged and active in the classes every single time is law enforcement. And they always come up and express appreciation because it's just not in their training, and they don't know what to do and they don't know how to handle it. So really if we're putting these things into communities, having that partnership with them so they're going to maybe let people know about [the Safe Space] and just strengthening that relationship and providing them educational opportunities." – Healthcare service provider with lived experience "The biggest barrier in my community here: Politics, red tape, politics, red tape, politics, red tape, politics. Run around rhetoric. You know, whose district is it in, who's the representative, who's gonna be up for election, all of that, getting the permit, all of that stuff would actually be the biggest barrier." – Healthcare service provider with lived experience

TABLE 5: Communication and Collaboration

Community partnering (continued)	"Our faith community. I know within some of our faith communities, [a person with distress] may not go to whoever's in charge or they may not bring it up to their congregational care group or whatever. But if ... there was a safe space where nobody could know it who didn't have to know, they probably would utilize it as a first step. I mean, I think that would be such a great place for those that are still struggling with the shame and stigma about feeling any kind of way at not being okay, whatever that is. But to have that space ...where I'm not known by a number diagnosis already. I'm not known at all. I'm just feeling bad and I wanna go and it's okay. So I think engaging a clergy around that, as a resource and also just as a place to inform so that they can share [information about] that space." – Healthcare service provider with lived experience "I think [co-responding is] absolutely a piece of the puzzle. I think it's not the answer alone, though, because the problem that I've seen with it is you have one response. We're getting a ton of positive feedback from both law enforcement and the citizens that we're interacting with. ... But, without a safe place to be able to take someone to that's not necessarily a hospital, sometimes it falls a little short, I guess, of being able to really support, to kind of shore people up in these really vulnerable times." – Healthcare service provider "The resistance that comes when, why are people so afraid of [peer-led approaches]?—and I remember trying to work with law enforcement and fire and EMS, the hard to reach population of helpers, and many, many successful peer groups have [been run]—but when they try to do them in a [peer-led] model like you're talking about, this is what I hear from people: 'Smells like a lawsuit to me.' You know, that thing that they don't want it out of their hands. They don't, they can't let someone else in but the someone else is who needs to run it. Who needs to be there." – Healthcare service provider
Buy-in from healthcare systems Several healthcare providers foresaw the need to generate endorsement of and support for Safe Spaces from state entities and professionals. It also appeared that there may be different levels of readiness to refer to Safe Spaces across healthcare setting types. For example, "mainstream" healthcare settings may have more reservations than organizations that operate outside of large healthcare systems. **Heard from:** --Individuals with lived experience --Healthcare service providers	"The Safe Spaces idea has merit but it will not work well until these technical issues [concerning referral processes and relationships between Safe Spaces and healthcare systems] are resolved." – Healthcare service provider "Looking at this model, it would have to have MOUs in place with the local mental health authorities. So that way there can be that quick ease to access if needed, and not just 'Oh, okay, so you're here and it's worse than what you thought. What do we do now?' So there needs to be those means of access available. Definitely." – Healthcare service provider with lived experience

TABLE 6: Other Policy Considerations

Key Themes	Representative Comments
Funding The role and potential challenges of funding were noted by several listening session participants familiar with working in healthcare systems or government agencies. A few survey participants also noted questions and concerns about cost, payment of staff, etc. among their top worries about Safe Spaces. One of the attorneys also noted the need to gather information to report to funders (as described by a listening session participant in the first quote here). **Heard from:** --Individuals with lived experience --Healthcare service providers --Legal experts	"I love it. You know, it's amazing. My brain is like, how do we fund this? Though I don't know, you know, I feel like it always comes back to that, which makes these things so tricky. Because … I work for a harm reduction program, right? And it's like we have these values in harm reduction that are really important to us, but we get funding from the health department. So we have to do certain things, like collect demographic info, which we hate doing, and doing stuff like that in order to get our funding." – Healthcare service provider with lived experience "Thinking realistically because of the society and culture we live in here in the United States—it's very legit— you know, if someone feels that they've been wronged in some way, we're going to court and there's gonna be dollars thrown around and because of that, you know, then my next concern is, well, no one's gonna wanna put their name behind this or back this as a business in the community or put dollars and funding towards it because it can be a liability issue, if nothing else [being] perceived [as a] liability issue [will be a barrier]." – Healthcare service providers with lived experience "Funding for Safe Spaces shouldn't take away from other things that need funding in suicide prevention work like 988, mobile crisis units …" – Healthcare service provider The attorneys we spoke to also raised questions about how Safe Spaces would be funded, with one noting that "one lawsuit could wipe out" their funds. In our review of existing services in adjacent spaces, we learned of a poignant example of how policy and funding decisions can undermine peer-led approaches. Peer-led organizations had advocated for funding from their state to support more peer respite centers. However, when the state agency put forward a request for proposals, it was open to a wide range of interpretations, including models led by non-peer organizations that would not have embodied the core structure and values of peer respite centers.

TABLE 6: Other Policy Considerations

Liability Concerns about liability from listening session and survey participants are covered above. Here we summarize some additional insights from the attorneys with whom we spoke. **Heard from:** --Legal experts	Unexpectedly, the attorneys we spoke with did not assume that specialized licensure would be necessary, and even noted that it might be counterproductive. One attorney suggested that it may be possible to seek licensure as a service rather than a facility, which could alleviate some of the administrative burden involved. Additionally, some states are moving toward streamlining their licensure procedures, which may bode well for Safe Spaces if licensure should indeed be part of their administration. Another attorney reflected on the stated non-clinical, peer-led focus of Safe Spaces and on how requiring more regulation, certification, and licensing would move them further from those roots, while simultaneously creating a greater expectation of or duty on them. This could, in turn, place Safe Spaces in greater legal jeopardy. He noted that the foundation of many liability cases is a sense of a broken promise or expectation, so being very transparent about what Safe Spaces can and cannot do would be important for averting untoward expectations. Regarding the concern about conflicts for service providers who have a duty to act when aware of a threat to the safety of another, one attorney noted that the duty is very narrow, typically applying only to specific, imminent threats. She reflected that such instances may not arise as often as we might worry they would.
Insurance Potential guests and healthcare providers raised questions about whether insurance would cover costs for Safe Spaces. In addition, our conversations with attorneys raised considerations around how insurance may interact with liability. **Heard from:** --Legal experts	"It wouldn't just be that I can't imagine a health insurer insuring these, if it was a pop-up space, the business owner's property insurer is not going to cover damage to property that might occur during that time." – Legal expert Another attorney noted that, presuming Medicaid coverage could be established for Safe Spaces, the idea of complete confidentiality would bump up against the need to gather identifying information for a Medicaid-approved benefit. On the other hand, states tend to have a degree of latitude in deciding what can be covered by such funds, including peer services, which may allow for general funding of a Safe Space program rather than requiring that they seek reimbursement for individual instances of use.

Next Steps

The findings from this initial exploration of the need for, interest in, and feasibility of establishing community-based crisis services like Community-led Safe Spaces in the U.S. suggest a) that there is strong interest in such services, and b) that this approach may have significant value for addressing gaps in the current crisis care continuum.

Individuals with lived experience expressed needs that Safe Spaces may help to address. They also identified desired features for Safe Spaces that could make them more appealing than existing clinical options. In summary, these needs and features are:

- Research
- Non-judgmental, validating support through active listening
- Sense of community and connection
- Relatable staff with lived experience
- Welcoming, comfortable environment
- Range of options for support
- Separation from clinical procedures, including risk assessment and the attendant concern about involuntary procedures

Healthcare providers and community members also recognized the merits of Safe Spaces while raising thoughtful questions and concerns that warrant ongoing consideration. In summary, these are:

- Handling emergencies outside of Safe Space capabilities
- Training standards for peer staff
- Accessibility and anonymity in rural areas
- Liability and risk management
- Distinction from existing peer respite models

Several next steps emerge from this preliminary exploration:

- **Share findings with participants and stakeholders**. We will prepare summaries of the results tailored to key groups, including potential guests, healthcare providers, community partners, and legal/policy experts. Sharing what we learned is critical to acknowledge their contributions, address outstanding questions, and lay the groundwork for ongoing collaboration. This will include a workshop at the upcoming Living Beyond Suicide Summit hosted by United Suicide Survivors; the theme of this year's summit is, 'Suicide and Community in the Context of 988.'
- **Raise public awareness**.
  For Community-led Safe Spaces or similar models to be adopted in the U.S., significant work is needed in raising awareness in the general public, in the professional healthcare community, among policy and advocacy groups, private and public funders, and government leaders. We recommend developing a communications plan for targeting these groups with communications such as peer-reviewed articles, presentations, social media posts, influencer partnerships, webinars, and community-based communications.

  Although not an exclusive or even primary focus, maintaining open communication with and cultivating endorsements from healthcare providers will be critical to ensure that they understand Safe Spaces as a collaborative resource to support community mental health.

- **Commit to co-design**. Moving forward, individuals with lived experience must remain at the center of any steps toward Safe Spaces including in the evaluation of findings, shaping of implementation, and co-leading of Safe Spaces. Their insights and needs should direct each stage.
- **Conduct participatory research**. Critically evaluate Roses in the Ocean's Community-Led Safe Spaces S as part of a broader project to develop an evidence base for local community Safe Spaces in the U.S. Findings from preliminary exploration can be used to generate research questions and designs to advance knowledge, on the one hand, and evidence regarding the need, design, funding, and effectiveness of Safe Spaces, on the other. Larger-scale research could also quantify the population likely to use Safe Spaces and help model cost effectiveness.
- **Identify and launch U.S. pilot locations**. As interest grows, and funding becomes available, it will be critical to engage with communities—both those that demonstrated interest during the project and others—to explore readiness for piloting Safe Spaces. Assessing local resources, partnerships, physical spaces, staffing models, and funding will clarify viable locations for initial implementation. Fit can be assessed through publicly disseminated expressions of interest.
- **Conduct further examination of the role of training**. There is a mixture of interest in and concern about training for persons with lived experience in the context of Safe Spaces, so this is a topic that needs further exploration. Training curriculums tailored to Safe Space staff could draw on best practices for peer specialists and crisis intervention, as well as growing the experience base with suicide lived experience advocacy. Training could prepare staff to handle responsibilities confidently and appropriately while maintaining the lived experience ethos. On the other hand, some lived experience advocates oppose training that is overly "professionalized," preferring alternative approaches that focus on empowering people to share and use their experience rather than implementing "best practices." One of our legal experts expressed the concern that "professionalizing" could actually increase liability risks because it creates an expectation of a professional encounter, rather than informal support.
- **Explore legal and regulatory issues**. Further consultation with legal experts can outline options regarding licensure, liability, insurance, and funding mechanisms. Solutions will aim to legitimize Safe Spaces while retaining their accessibility and community roots.

The enthusiasm around Community-led Safe Spaces warrants advancing this concept prudently and energetically. It is our hope that dissemination of this preliminary report will engage interested parties in taking next steps in exploring this innovative approach to filling some of the gaps in America's crisis care continuum.

Appendix A.

1. Gaps in and barriers to existing support sources

Workforce shortages.

NAMI- has a presence - pandemic shifted - state to state license for BH providers, staying licenced is expensive. Lack of supervision for up and coming providers.

Stigma in small communities. People are dying.

ER handoffs - lack - if people are not in inpatient bucket - resource - referral offload, wait, family had no idea how to support and no training to help with reduction to means.

One gap I see is we do not have a place for someone who is feeling suicidal, but does not feel that inpatient care is needed.

Just building opportunities for human connection and relatability about our lived experience.

Rural areas: to get healthcare or ER - is another state - ER mental helath is 2 hours away, "no place to go", "why should I bother?".

In some communities, if they have to be hospitalized they have to be flown out.

Many of the highly experienced and sought after therapists in our area do not take insurance.

State to state.

Stigma in general, in all communities.

Lack of Trust.

I see where persons with lived experienced do not feel comfortable talking about suicide. Many of us are afraid to hear about or talk about suicide.

A lack of safe group spaces in mental health settings that allow you to discuss suicide openly.

2. What would an ideal crisis service look like?

Nowhere near anywhere where there are doctors or a hospital.

Homey feel—not medical feel.

Have a place to go after M H discharge that's not where you came from if that's triggering/ destabilizing for you.

Need to have people with lived experience there—so I know I'm going to my people so I don't feel judged.

Safe space where there is support

Offered option with calling or coming in person, 24/7 with counselors available and mental health first aid training available.

Importance of being 100% in control.

We don't have lived experience—we have lived EXPERTISE.

I know people who want to go to the hospital and also have the autonomy to go elsewhere. To eliminate feeling that you are losing control.

Bridging from discharge through follow-up appointment(s).

Giving individuals autonomy—focus on de-escalating, no police, no sirens.

Integrated health: peer support, care management, BH, addiction, treatment, primary care.

Team of people with one mental health person, one medical person, one person with lived experience, among others.

Care providers that also share lived experienced.

Having peers there.

NO LAW ENFORCEMENT.

Each person is attended to and engaged in a caring conversation. A "companion" paired to you.

Lock boxes for guns or medication—things they might have at hand and can ask the service to hold for awhile.

3. Reactions to the Safe Spaces Approach

I would use this.

Space to just get away and decompress.

Trauma informed.

Something like the PHQ-9, but not. I'm so tired of taking it. Alternative option needed.

Question: how get the word out yet have confidentiality?

Is this across the board resource—for addiction and other?

Coffee shop, room with comfortable chairs and book; wellness center feel that is calming and safe.

CAMS-trained clinician to reduce suicidality post-suicide crisis.

In some communities, if they have to be hospitalized they have to b[e] flown ou[t]

I would recommend this; I don't promote 988 because change of involuntary hospitalization."

I like it.

Who is going to know about this? e.g., Is that from the university, if so not intereted in going. Who is going to get my information, if will share, with whom?

Are peer leaders paid a salary, with benefits?

Are there guidelines about what can happen at the drop in center? What about alcohol/drug use? Behavioral guidelines?

Go and get an assessment of needs and not be kept against their will.

For people that come, they should know it isn't a homeless shelter. Setting a boundary and limit is a great idea.

How do youth fit in?

Even across communities in the USA, there will be different needs.

What happens with individuals in elevated crisis?

Physical location—how do you ensure equity and accessibility.

Get an assessment of your needs to figure out how they could help.

Not sure if this is helpful—hard to go anywhere.

Who is going to know about this? e.g., Is that from the university, if so not intereted in going. Who is going to get my information, if will share, with whom?

Could be really great for rural areas.

Funding would be an issue.

Can they handle people with behavioral problems?

Do these spaces get creative with experiential acivities rather than just talking since many struggle with that—especially when depressed or suicidal? I have found this to be very effective.

Is this totally grant funded?

Accessibility—people with different disabilities. Social determinants, finances, transportation, ability to take off work.

How can we train the peers?

4. What would a safe space need to offer for people to feel comfortable and confident accessing the service?

Balance of counseling and LE - I don't need e/o to be LE. I don't want a bunch of volunteers getting hours in.

Knowing that police are not involved.

Listening is so important.

None -Judgmental

Building trust in community through working with the early guests who give it a try

Coffee, tea, water, and good food.

Integration, trust-building time initially; people will be skeptical given experiences of past.

Centrality of peers in design and running

What contributes to dignity?

Meeting you where you're at.

Not here to diagnose or label.

Laundry, shower can = dignity.

Their own space to be on their own, and a space to engage with others (about choices).

Comfy chairs, not a hospital setting. Weighted blankets.

Offered warm hand off from ER discharge - connection with person.

Dress code, no scrubs or business casual; power differential to dress.

Ask people what they want. You lead me, tell me what you want.

Having safe spaces in areas, neighborhoods where needed; with assurance that no police.

Staffed 24/7.

Comfortable furniture, like in a home; get rid of office equipment.

Clear hours - when is it accessible. Regular consistent hours.

5. How might Safe Spaces meet a need for people who avoid engaging with traditional support services when they are in emotional or suicidal distress?

Community outreach.

Language matters- "Crisis stabilization unit" is terrying vs. Safe Space people there to help, hang out, talk.

No insurance, no money, walk in- just come.

Appreciate that it is low barrier.

Comfort of knowing there will not be a diagnosis - figuratively and litteraly, "we're not here to diagnose you".

Those with negative ER experience: if I knew about a safe space, I would be more comfortable there.

Having it in one's community, part of the community may help it be more acceptable idea (though may also be a barrier for some to have it in community).

Appreciate that it is low barrier.

Will be important to make it clear that we are this, not that (re services offered, information collected).

Something that feels like accomplishment - chore night - something that is investment or giving back to the community, give people a boost.

Space for spiritual practice.

No boxes to check to get you in the door. No screening forms.

Some kind of contribution that helps people feel part of this.

What if partners/ vendors contributed free services.

Engages Community.

I see where persons with lived experienced do not feel comfortable talking about suicide. Many of us are afraid to hear about or talk about suicide.

Key difference: that is truly confidential no one will know about it unless I want them to; totally spearate from hospital, police, etc.

Creativity, empowerment, strength-based.

Haircuts. Something small but gives dinity back.

Had I known I wouldn't be diagnosed and have to give things up, would have helped me seek support services and avoid things getting as bad as they got.

Appendix B.

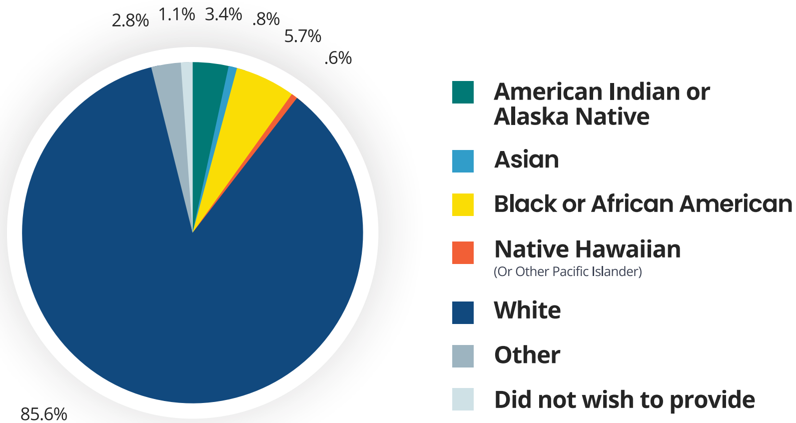


Figure 1. Self-reported *race* of survery participants (N = 353)

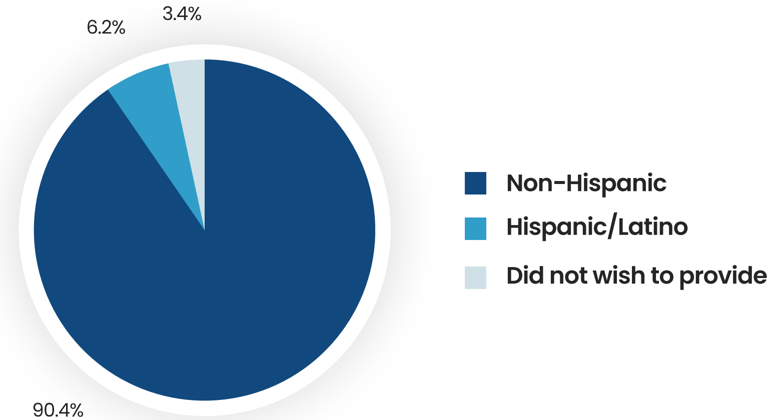


Figure 2. Self-reported *ethnicity* of survery participants (N = 353)

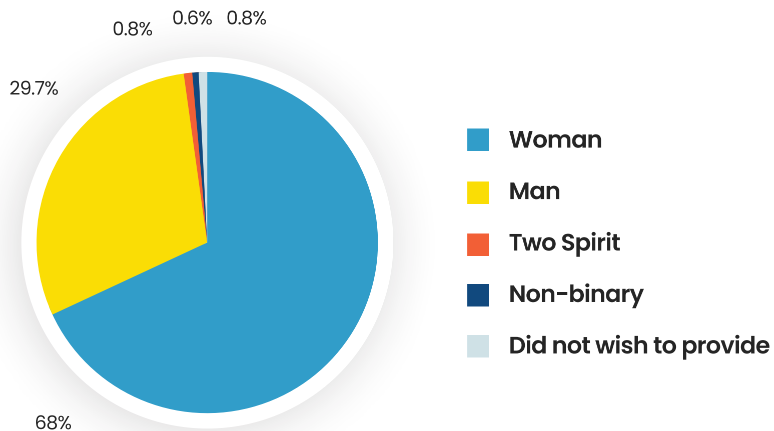


Figure 3. Self-reported *gender identity* of survery participants (N = 353)

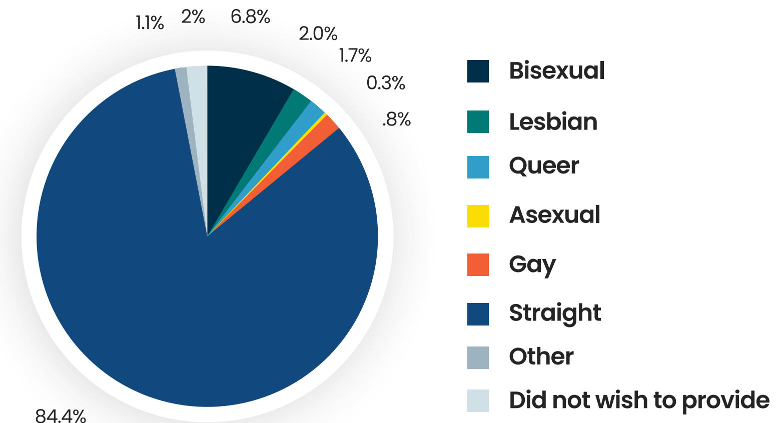
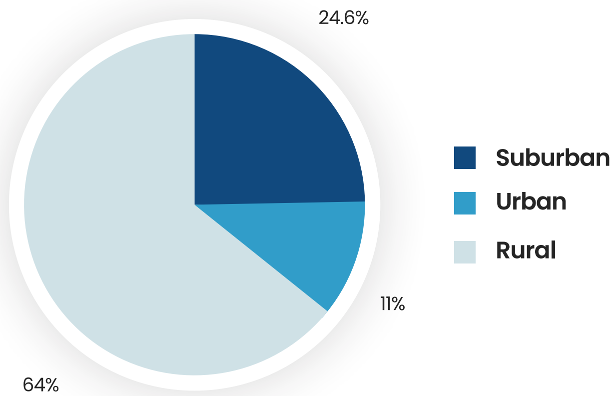


Figure 4. Self reported *sexual orientation* of survery participants (N = 353)



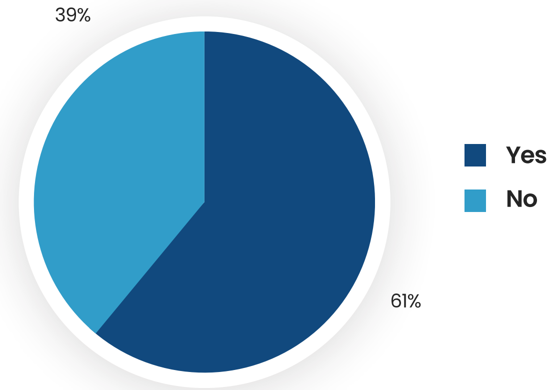
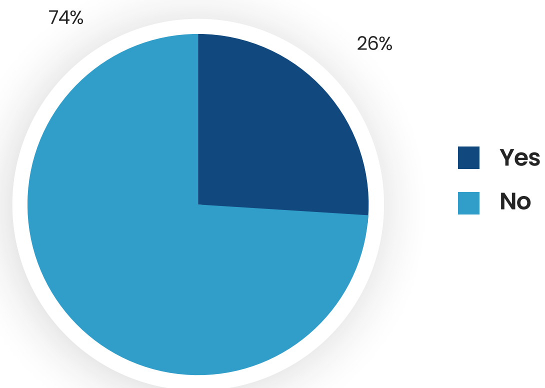


Figure 5. Self-reported *locale type* of survery participants (N = 352)

Figure 6. Self-reported *identification* as having lived experience with suicide (N = 353)



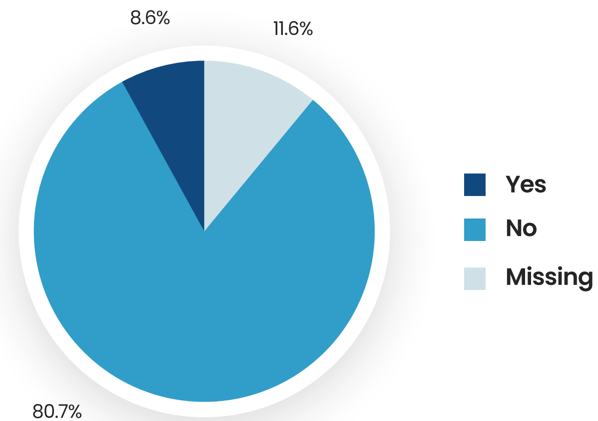


Figure 7. Self-reported identification as *healthcare services provider* (N= 353)

Figure 8. Self-reported identification as *business owner* (N = 353)

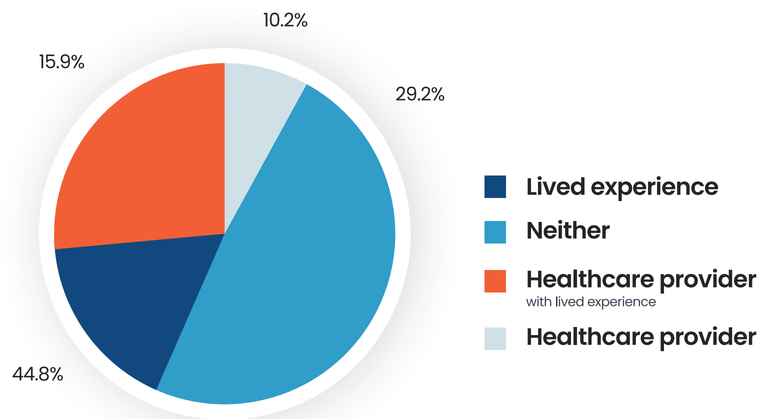


Figure 9. Combined self-reported *identifications* as having lived experience and/or being a healthcare services provider (N = 353)

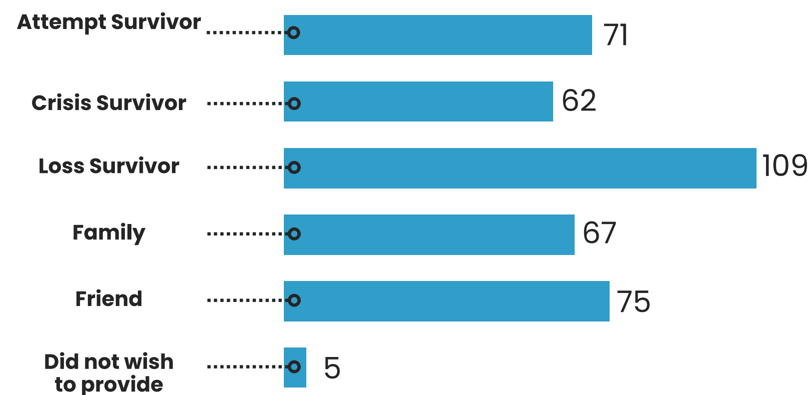


Figure 10. Self-reported *type* of lived experience with suicide (N = 214)

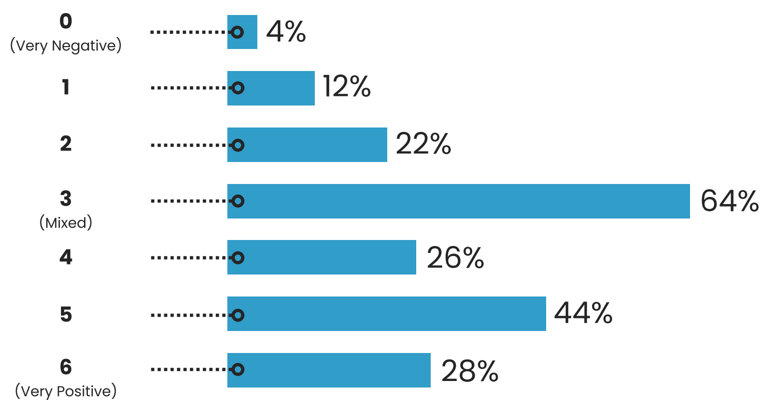


Figure 11. Rating of experience with peer support specialists in general (N = 200)

Table 1.
Average rating of experience with peer support specialists (0 to 6), by type of experience with peer support.

Participants	Average	N	SD
All with experience WITH peer	3.7	200	1.5
With experience AS peer	4.1	33	1.8
With experience WITH peer	3.6	134	1.4
With experience WITH and AS peer	3.6	33	1.8

*See figure 11. for range of values

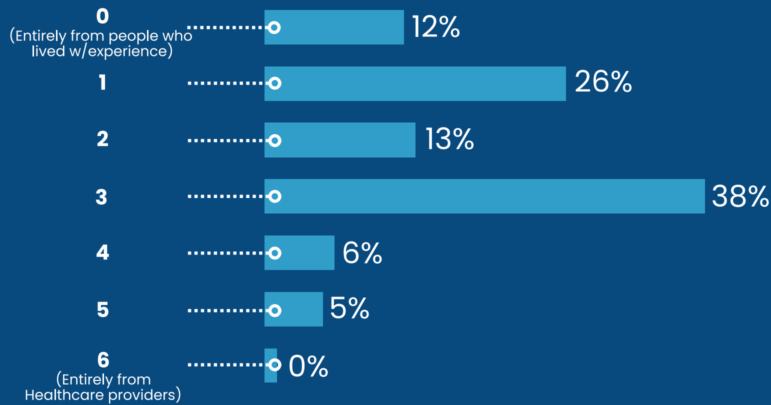


Figure 12. Rating of who should have the most say in how new emotional and suicidal distress supports are delivered (N = 353)

Table 2.
Average rating of who should have the most say in new supports, (0 to 6) by participant lived experience and healthcare provider types

Participants	Average	N	SD
All	2.2	353	1.4
Participants with lived experience	2.0	158	1.4
Healthcare provider participans	2.8	36	1.4
With experience WITH and AS peer	2.2	56	1.1
Without lived experience and not healthcre provders	2.2	103	1.4

*See figure 12 for range of values

Participant Lived Experience and Healthcare Provider Types

- Individual with Lived Experience
- Healthcare Provider
- Healthcare Provider with Lived Experience
- Neither

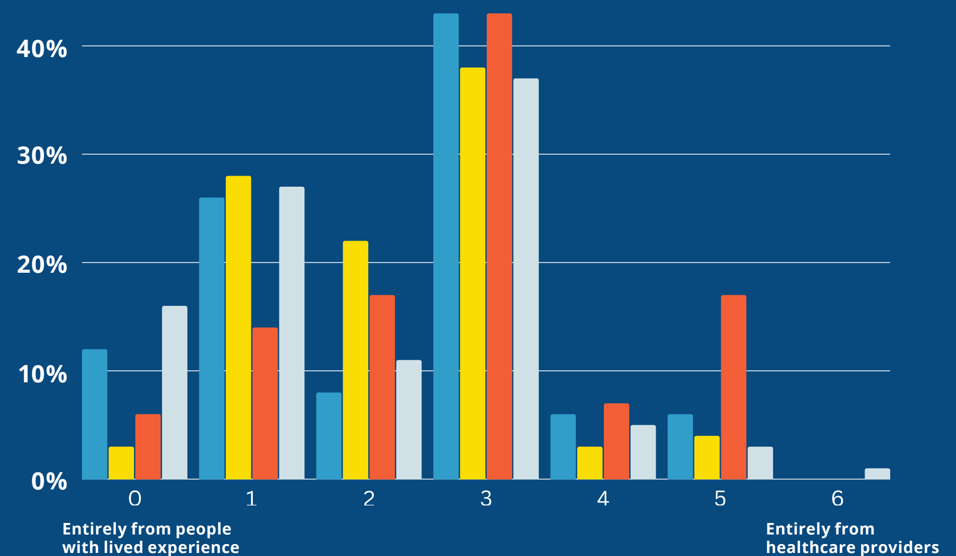


Figure 13. Rating of who should have the most say in how new emotional and suicidal distress supports are delivered, *by participant lived experience and healthcare provider types* (N = 353)

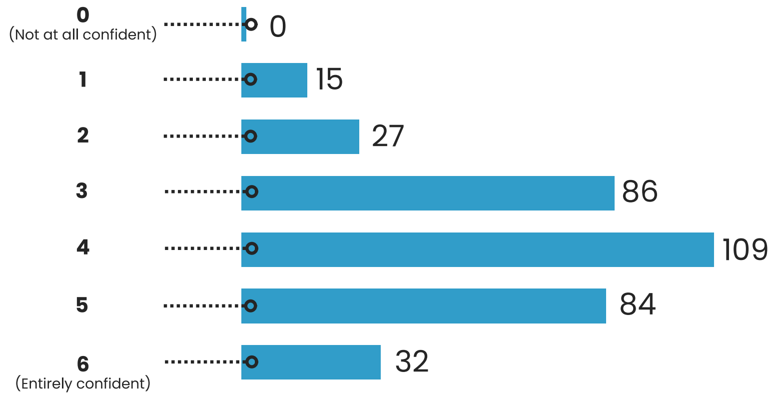


Figure 14. Confidence that *clinical* supports can be effective for people in emotional or suicidal distress (N = 353)

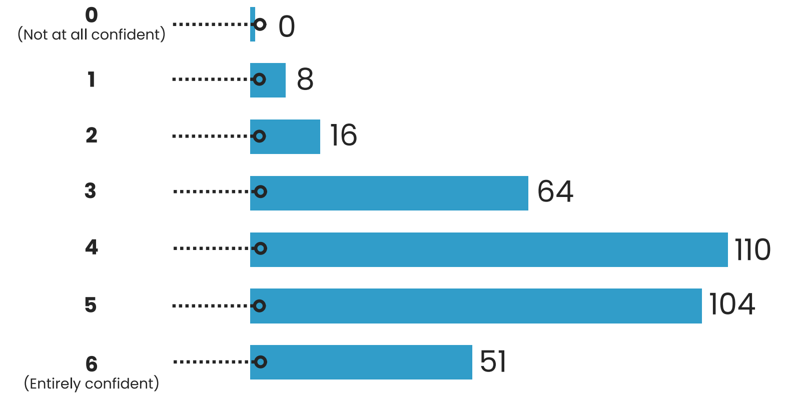


Figure 15. Confidence that *non-clinical* supports can be effective for people in emotional or suicidal distress (N = 353)

Table 3.

Average confidence rating in effectivness of clinical supports for emotinal or suicidal distress, (0 to 6) by participant lived experience and healthcare provider types

Participants	Average	N	SD
All survery participants	3.9	353	1.2
Participants with lived experience	3.8	158	1.2
Healthcare provider participants	4.2	36	1.1
With experience WITH and AS peer	3.9	56	1.3
Neither	4.0	103	1.3

*See figure 14. for range of values

Table 4.

Average confidence rating in effectivness of non-clinical supports for emotinal or suicidal distress, (0 to 6) by participant lived experience and healthcare provider types

Participants	Average	N	SD
All survery participants	4.2	353	1.2
Participants with lived experience	4.3	158	1.2
Healthcare provider participants	4	36	1.3
Healthcare provders with lived experience	4.3	56	1.2
Neither	4.2	103	1.1

*See figure 15. for range of values

Table 5.

Average rating of helpfulness (0 - very unhelpful to 6 - very helpful) based upon past experience by participant lived experience and healthcare provider types

	Total		Lived Experience		Healthcare Proividers		Healthcare Proividers w/Lived Experience		Neither Lived Lived Experience nor Healthcare Provider	
	Average (SD)	N	Average (SD)	N	Average (SD)	N	Average (SD)	N	Average (SD)	N
Medication management	4.0	266	4.0	135	4.5	12	3.7	43	4.0	76
Outpatient	4.0	287	3.8	139	4.6	24	3.8	47	4.2	77
Crisis stabilization center	4.0	186	4.0	92	4.2	7	4.1	24	3.8	62
Residential	3.8	179	3.9	87	4.1	11	3.6	19	3.8	62
Inpatient	3.7	205	3.7	100	3.8	11	3.5	32	3.7	62
Emergency department	3.3	228	3.1	112	4.0	11	2.7	37	3.7	68

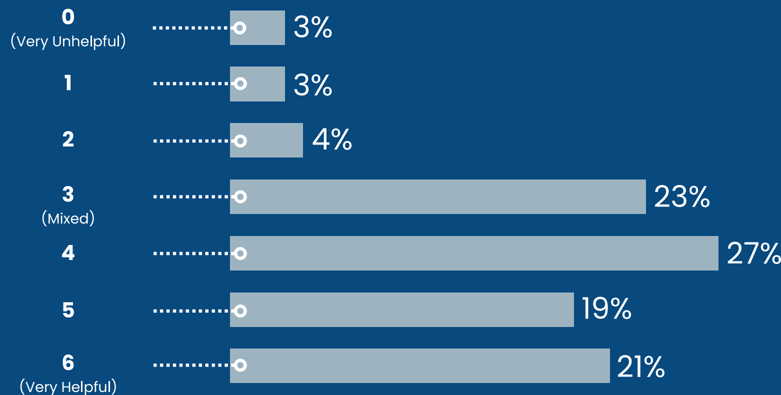


Figure 16. Helpfulness of *crisis stabilization center* for individuals in emotional or suicidal distress, participants with lived experience (including healthcare providers; N = 117)

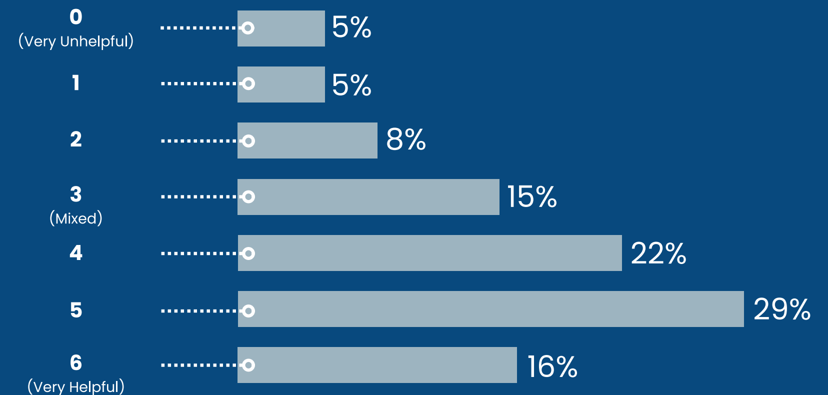


Figure 17. Helpfulness of *medication managagement* for individuals in emotional or suicidal distress, participants with lived experience (including healthcare providers; N = 178)

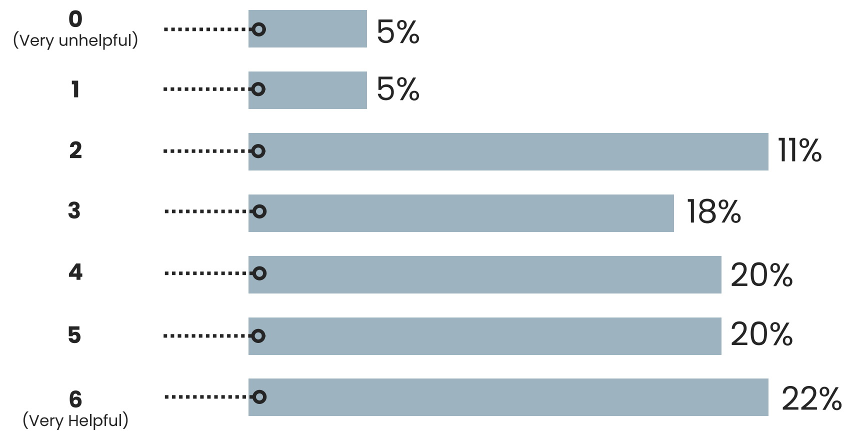


Figure 18. Helpfulness of *residential* treatment for individuals in emotional or suicidal distress, participants with lived experience (including healthcare providers (N = 106)

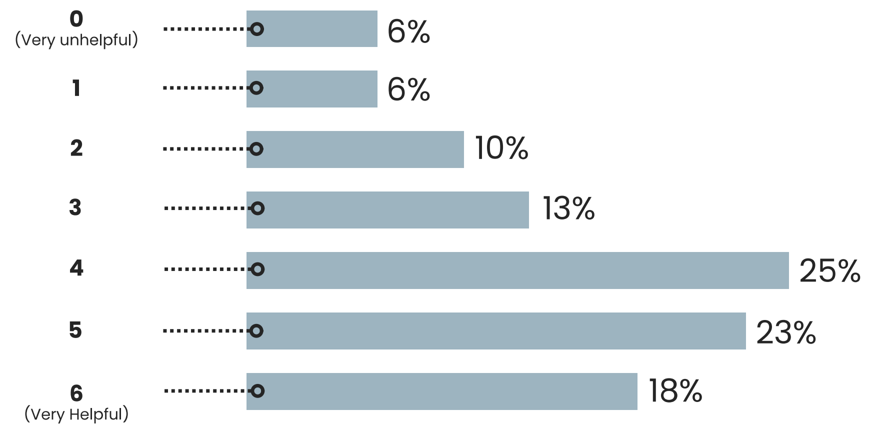


Figure 19. Helpfulness of *outpatient* treatment for individuals in emotional or suicidal distress, participants with lived experience (including healthcare providers (N = 149)

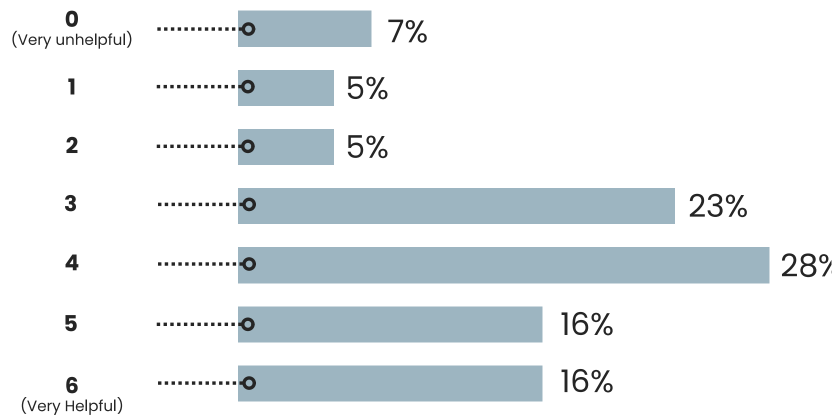


Figure 20.Helpfulness of *inpatient treatment* for individuals in emotional or suicidal distress, participants with lived experience (including healthcare providers (N = 132)

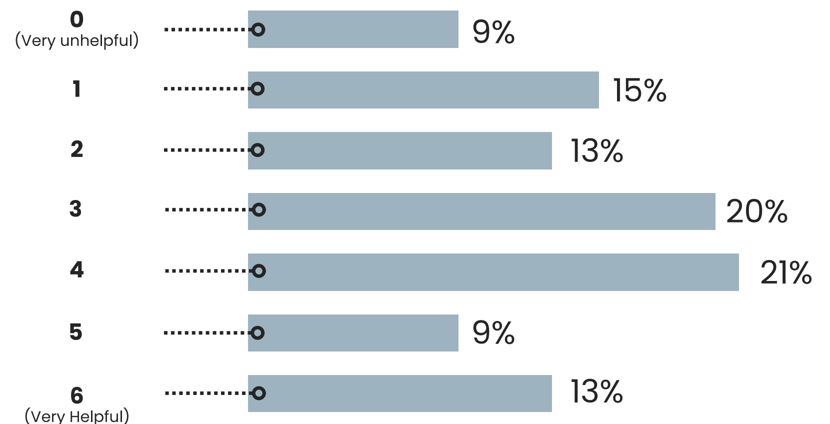


Figure 21. Helpfulness of *emergency departments* for individuals in emotional or suicidal distress, participants with lived experience (including healthcare providers (N = 149)

Table 6.

Average rating of (1 - very unimportant to 6 - very important) of importance of considerations to experience of care during suicidal or emotional distress, by participant lived experience and healthcare provider types

	Total		Lived Experience		Healthcare Proividers		Healthcare Proividers w/Lived Experience		Neither Lived Lived Experience nor Healthcare Provider	
	Average (SD)	N	Average (SD)	N	Average (SD)	N	Average (SD)	N	Average (SD)	N
Feeling welcome like there is “no wrong door,” and I can access the support whenever I need to	5.1	316	5.2	143	5.3	30	4.5	52	5.2	91
Not having to worry about a provider trying to put me into inpatient treatment	4.7	297	4.8	136	4.8	24	4.0	48	4.9	89
Having support options tailored to my need, as much or as little as I request	4.8	301	5.1	138	5.2	21	4.2	53	4.9	89
Having control over when I arrived and leave	4.5	309	4.6	138	4.6	27	4.1	52	4.7	92
Having control over confidentiality, including whether my information is shared with healthcare providers	4.9	289	5.0	134	5.6	22	3.9	43	5.3	90

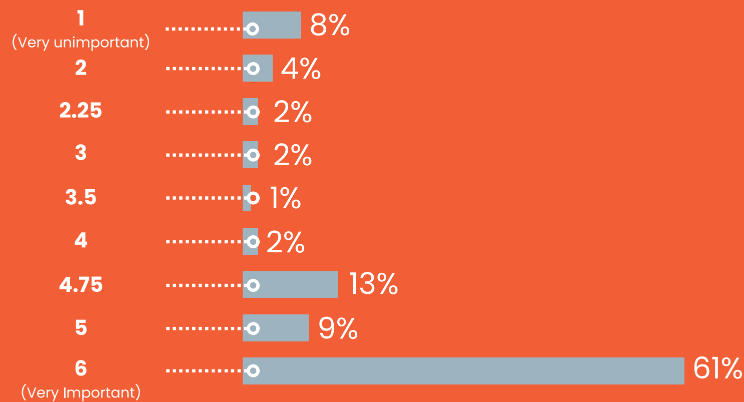


Figure 22. Importance of *feeling welcome, like there is “no wrong door”*, ratings of participants with lived experience (including healthcare providers; N = 195)

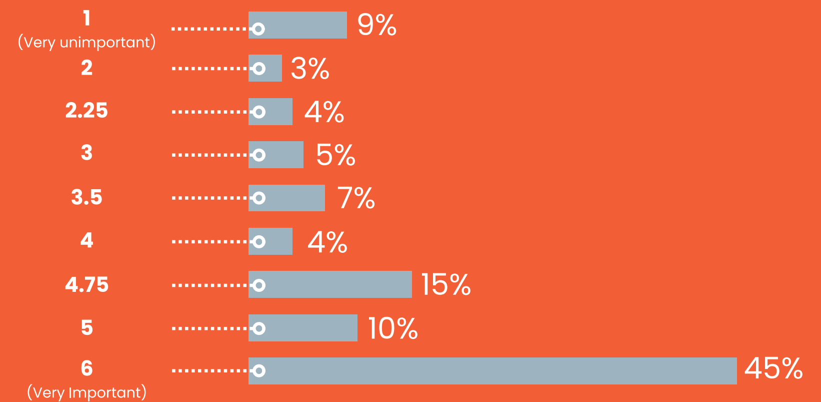


Figure 23. Importance of not *worrying about being put into inpatient treatment*, ratings of participants with lived experience (including healthcare providers; N = 184)

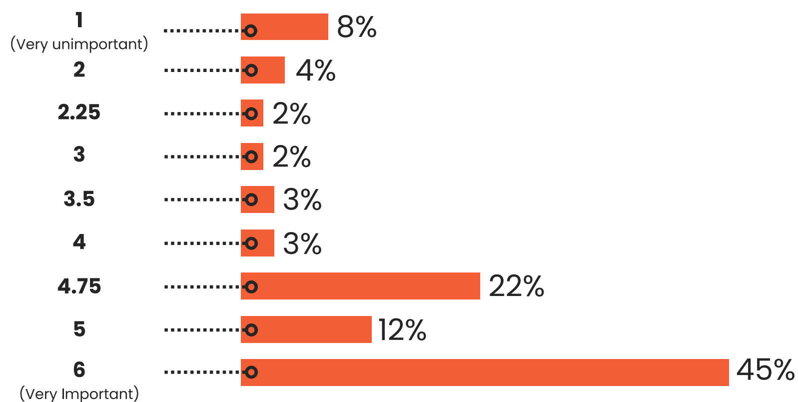


Figure 24. Importance of *having support tailored to needs,* ratings of participants with lived experience (inclding healthcare providers; N = 191)

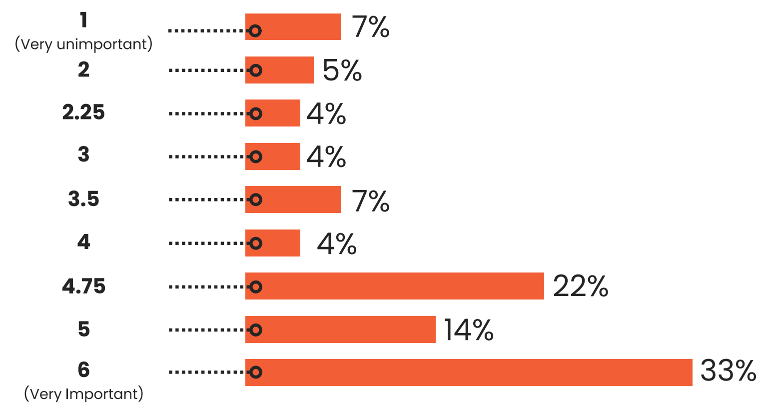


Figure 25. Importance of *having control over when arrive and leave,* ratings of participants with lived experience (inclding healthcare providers; N = 190)

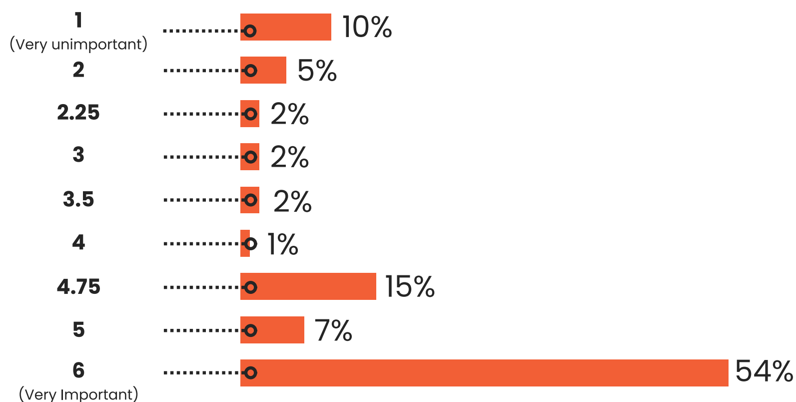


Figure 26. Importance of having control over confidentiality and information sharing with providers, ratings of participants ith lived experience (including healthcare providers; N = 177)

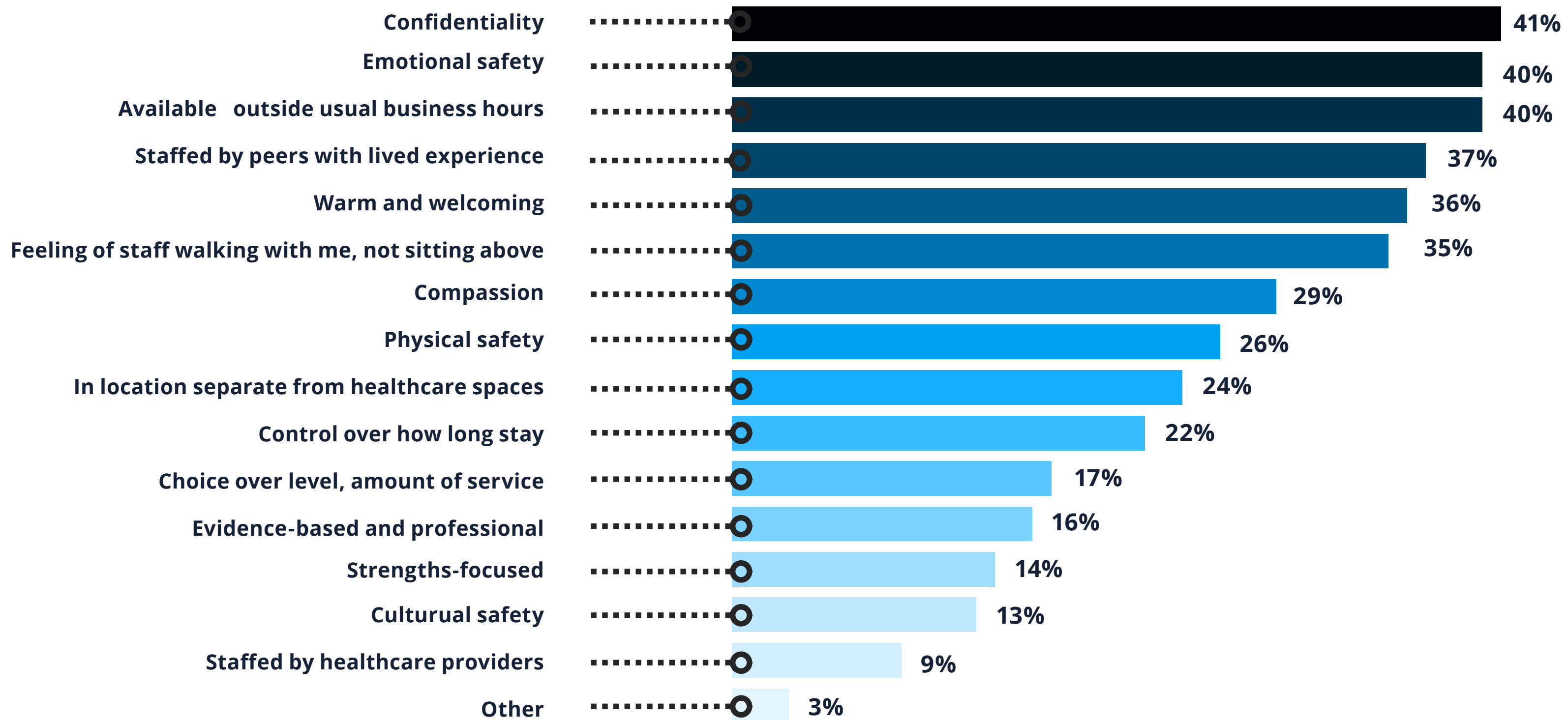


Figure 27. ***Most*** **important characteristics of crisis care for making individuals feel comfortable when seeking support (N= 353)**

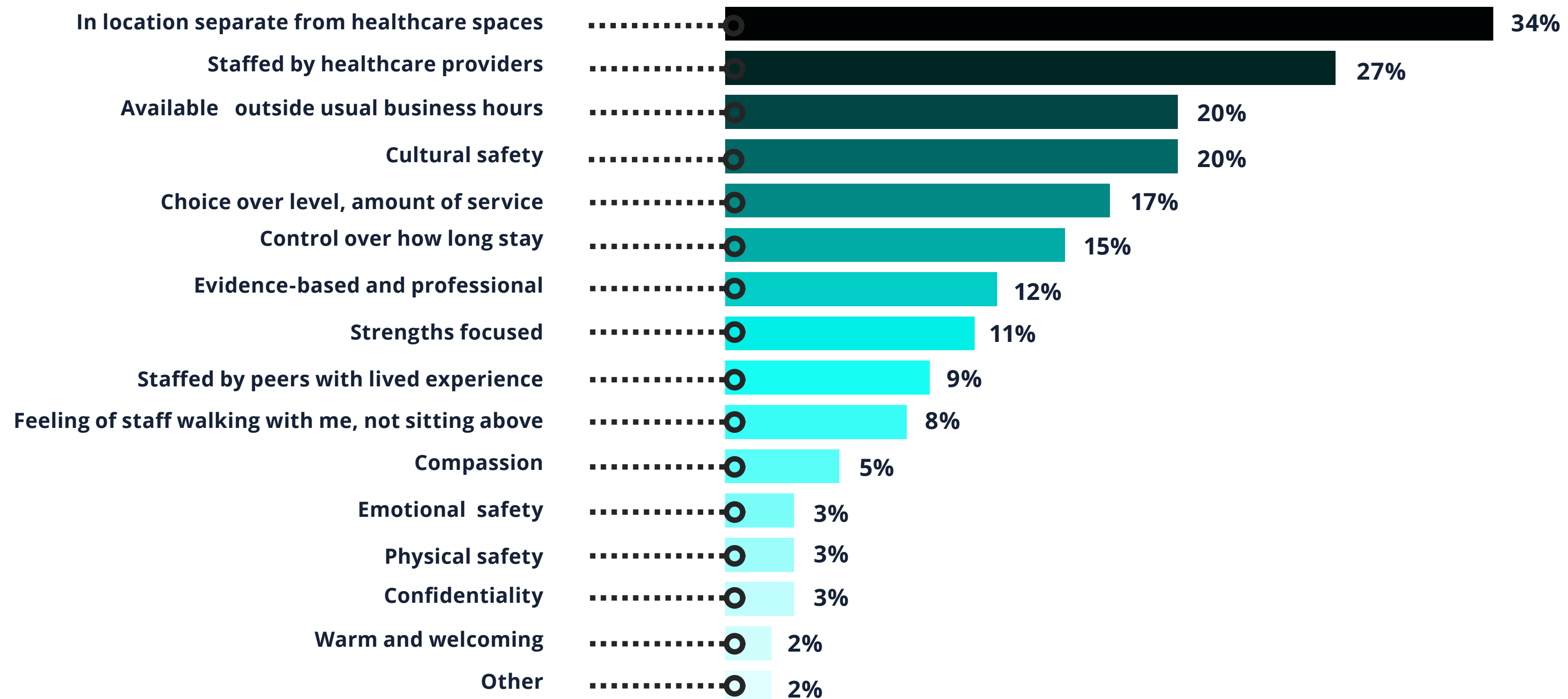


Figure 28. *Least* important characteristics of crisis care for making individuals feel comfortable when seeking support (N= 353)

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