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ORIGINAL ARTICLE

What makes a space safe? Consumers' perspectives on a mental health safe space

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Abstract
The provision of community-based space for people experiencing a mental health crisis is regarded as a favourable alternative to the emergency department. However, the only non-emergency department safe spaces in Western Australia are located within hospitals or hospital grounds. This qualitative study asked mental health consumers in Western Australia with experience of presentation at the emergency department during a mental health crisis to describe what a safe space would look and feel like. Data were collected through focus groups and thematically analysed. The findings present the voices of mental health consumers through the framework of health geography and the therapeutic landscape. These participants articulated important physical and social features of a therapeutic safe space and their symbolism as inclusive, accessible places where they would experience a sense of agency and belonging. Participants also expressed a need for trained peer support within the space to complement the skilled professional mental health team. Participants' experiences of the emergency department during mental health crises were described as contrary to their recovery needs. The research reinforces the need for an alternative to the emergency department for adults who experience mental health crises and provides consumer-led evidence to inform the design and development of a recovery-focused safe space.

KEYWORDS
community, mental health consumer voice, mental health crisis, recovery, safe-space, therapeutic landscape

INTRODUCTION

For individuals experiencing a mental health crisis, the Emergency Department (ED) is restricted in its ability to provide a safe space for recovery (Wilson & Zeller, 2012). Existing ED protocols for managing such presentations are limited in their capacity to meet the needs of these individuals, a situation that leads to poor outcomes, including relapse (Ceniti et al., 2020). While the need for an alternative community-based space to support people in mental health crisis is evident (Consumers of Mental Health WA (CoMWHA), 2019), few such 'spaces'

are available Australia-wide. Within Western Australia (WA), the first hospital-based safe spaces opened in 2021 (Life in Mind, 2021). None as yet exist in the WA community setting.

Since the 1970s, health geographers have recognized the importance of 'place' to human health and wellbeing (Gesler, 2003). For Gesler, this place, or therapeutic landscape, has an important influence on physical, social and emotional outcomes for the people within it. Doroud et al. (2018, p. 11) define place as a 'lived environment … interpreted by the individuals and constructed through social interactions, cultural values and shared

meanings'. Place in the context of the current study refers to a 'safe space'- a therapeutic landscape within the community where people experiencing a mental health crisis can interact and seek support. This paper describes the first step in the codesign of this space. The co-design process was collaborative, involving mental health consumers and university researchers in the disciplines of nursing, public health, social work and health sciences, and 'WellbeingWA'—a non-profit organization that works to prevent suicide through counselling and support services for people in crisis. This paper presents the mental health consumer voice on the design of a safe space that meets their needs. In doing so, it provides evidence to inform future design of safe spaces for mental health consumer recovery.

BACKGROUND

The Mental Health Commission (MHC) report 'Suicide Prevention 2020' has outlined the urgent need for proactive mental health community-based services, informed by service users, families, carers and clinicians (MHC, 2020). The report's key principle, "allocating resources where they are most needed and in a coordinated way", details the requirement for primary health care community and multiagency services to prevent, identify and support mental health consumers and their families (p. 11). More recently, the National Mental Health and Suicide Prevention Plan (Australian Government, 2021), cites 'prevention and early intervention' as its first of five pillars. The plan highlights an intention to develop mental health services in the community, 'where Australians work, learn and live'. The following discussion details evidence of best practices in the development of such services and current service provisions for people experiencing a mental health crisis.

Best practice: Consumer-informed recovery-oriented mental health services

Since the mid to late 2000s, mental health consumers have increasingly advocated for a consumer-oriented recovery model of care that considers the life experiences of individuals who have been historically marginalized or silenced by the medical model of mental health (Beresford, 2019). This movement has increasingly influenced mental health policy (Beresford, including the National Mental Health Policy 2008; Commonwealth of Australia, 2009). The Policy outlined a vision for Australia in which all individuals with a mental illness could have 'access to the right care at the right time', with community care deemed the 'treatment of choice wherever appropriate' (p.17).

The Australian National Framework for Recovery-Oriented Mental Health Services expanded the idea of recovery-led mental health (Australian Health Ministers' Advisory Council (AHMAC), 2013). Based on the premise that mental health consumers are experts in their own condition, the Framework is predicated on the active participation of mental health consumers in their own care and the collaborative decision making with mental health consumer groups and individuals to foster motivation, self-empowerment and self-management. The Framework (AHMAC, 2013) lists five domains and capabilities of a recovery-oriented practice and service delivery: a holistic-person first service, promoting recovery through the promotion of autonomy, supporting social inclusion and advocacy and the active challenging of stigmatizing attitudes and behaviours.

The emergency department

Across Australia, ED presentations of people experiencing a mental health crisis have increased in number and acuity (Liddicoat, 2019). It is clear from research on the lived experience of mental health consumers that the ED cannot provide recovery-focused care as conceptualized in the National Mental Health Policy 2008 (Commonwealth of Australia, 2009) or the Framework for Recovery-Oriented Mental Health Services (AHMAC, 2013). Several aspects of the ED function as barriers to recovery. The ED often represents a 'holding place' for people presenting with acute mental illness who may be restrained physically or pharmacologically until a more appropriate place of care is secured. This situation enhances the mental health consumer's distress as they navigate a frightening, overstimulating and disempowering environment (Harris et al., 2016; Wilson & Zeller, 2012).

Individuals presenting with mental illness in Australian EDs also wait longer for treatment than those with physical illness (Australian Institute of Health and Welfare, 2022). Due to the episodic nature of mental illness, mental health consumers are also more likely to be frequent attendees (Shattell et al., 2014). This cyclical behaviour, the comparatively long treatment time and the lack of appropriate mental health training or facilities, are reasons clinicians sometimes report a 'dislike' of mental health consumers (Wilson & Zeller, 2012).

A scoping review of the international literature on enhancing the ED for people in mental health distress by Liddicoat (2019) identified a clear need for a therapeutic built environment within the ED but found little evidence this exists. Within Australia, Judkins has called for 'all Australian Governments [to] act urgently to engage people with lived experience in reforms that deliver timely access to appropriate mental health care, with an immediate focus on after hours care in the community' (Judkins et al., 2019, pp. 616–617).

Community-based safe spaces as emergency department alternatives

A range of community-based care and support services for people with mental health issues are currently operating in the UK and the USA. The UK-based 'Safe Haven' service, for example, is a drop-in, self-referral service, offering peer well-being support in the community for people experiencing a mental health crisis. A 2017 evaluation of this service found a 46% overall decrease in local ED attendance at 12 months follow-up, and police call-outs to people in distress reduced by 42% between 2013 and 2016 (Wessex Academic Health Science Network, 2017). Consumers described how, unlike at the ED, they were able to maintain autonomy, as appropriate, regarding the help they received and they found the experience overwhelmingly positive.

In Australia, the adoption of a recovery-focused safe space community model is increasingly evident. In Victoria, the Safe Haven Café project opened in 2018 in the grounds of Saint Vincent Hospital, Melbourne (Saint Vincent's Hospital Melbourne, 2021). In New South Wales (NSW), 19 community spaces now exist. These 'safe havens' are also 'based on or near hospital grounds' (NSW Government, 2022). Similarly in WA, two hospital-based 'safe haven cafes' run from hospital bases, but none as yet exist in the community setting (Life in Mind, 2021).

Health geography as a conceptual framework for the 'safe space'

The exploration of the physical, social and symbolic requirements of a therapeutic environment (a 'safe space') can be guided by the concept of health geography. This concept evolved as a way of understanding the relationship between the individual and the environment. Dummer (2008) describes health geography's two main interests as health epidemiology and the planning and provision of health services. Research in both areas informs health policy. The main constructs of health geography, a broad discipline, are place, health and well-being (Kearns & Collins, 2009).

In health geography, place is viewed not only in physical geographical terms, but also as the interaction between the physical place and 'place in the world', that is, status and expected roles, influenced by history, culture, tradition and issues of equality. From a health geography perspective, health is viewed holistically through a psycho-socio-ecological lens, while well-being refers to the state of feeling well and the importance of the therapeutic landscape and associated human emotions (Kearns & Collins, 2009). According to health geography 'places and health have mutual effects on each other, in that states of mind and mental illness can also influence the ways that places are identified and interpreted' (Curtis, 2010, p.6).

Health geographer Gesler (2003) coined the term 'therapeutic landscapes' to describe how environments can be viewed as healing places across physical, social and symbolic dimensions. Since Gesler, other researchers have explored such spaces in locations including the home, hospital and natural environment (Bell et al., 2018; Kearns & Milligan, 2020). These researchers consider concrete and sensory aspects of the physical space, the relationship dynamics and social elements that promote a sense of belonging and inclusion within the social space, and the symbols of power, hierarchy, trust and culture within the symbolic space. The interaction between the physical, social and symbolic environment underscores the need for the mental health consumers' voice to be included in the design of a recovery-oriented, mental health consumer-centred safe space (Dare et al., 2021).

The idea of the therapeutic landscape is well-placed to explore and understand the perspectives and experiences of marginalized groups including mental health consumers (Wilton & DeVerteuil, 2006). As such, the application of therapeutic landscape principles to the design and codesign of in-patient mental health care facilities is gaining attention in the scholarly literature (Muir-Cochrane et al., 2013; Wilson et al., 2022). In this study, a 'safe space' in the community setting is the focus. This study aims to understand what a safe space would look and feel like from the perspective of the mental health consumer with lived experience of presentation at the emergency department during a mental health crisis. In doing so, the study aims to give voice to mental health consumers and provide evidence to inform the future development of a safe space.

METHOD

Study design

A qualitative approach was used to achieve meaning and understanding through the participant's perspective (Denzin & Lincoln, 2000). Focus groups were held where participants with a shared experience could give voice to these experiences and share ideas and suggestions about a mental health safe space.

The West Australian mental health support service 'WellbeingWA' (names and identifying information have been changed) worked with the research team to recruit a convenience sample of people who had prior contact with their organization. All these individuals had lived experience of mental health difficulties and/or crises and had attended an ED during a mental health crisis within the past 5 years. These individuals were sent the recruitment email asking them if they were interested in attending a focus group to discuss their ideas for a safe space. The research comprised of two, 2-h focus groups with mental health consumers ($n = 7$). Two researchers facilitated each focus group;

the first session consisted of four participants and the second included three participants. The COREQ checklist for interviews and focus groups guided the method (Tong et al., 2007). All participants were given a $50 (Australian dollar) e-shopping voucher to acknowledge their time and effort.

Procedure

Prior to recruitment, ethics approval was granted by the University Human Research Ethics Committee (2019-00581). Informed consent was obtained prior to data collection and all data were de-identified. Due to the COVID-19 pandemic restrictions, focus groups were completed online via Zoom (www.zoom.us). Potential risks associated with conducting research with mental health consumers were mitigated through individual contact with all participants prior to the focus group session to explain their potential involvement in the study and the process of data collection, the employment of a specialist counsellor and the provision of mental health support helpline information.

Participants were sent information emails with weblinks to the Zoom sessions. Two researchers facilitated the sessions, explaining communication protocols such as using the 'hands up' icon and 'chat' tool. Ground rules were also discussed.

Participants were asked—with respect to a space that they could go to during a mental health crisis – what they felt would make them feel safe in this space, what it would look or feel like, what its essential qualities or features would be, and what ideal qualities or features they would like to see in such a space. They were also asked about sounds and smells in this space and their ideas for the running and management of the safe space. The reasons behind these ideas were explored throughout these conversations. Mindful of the difficult areas covered, the counsellor met briefly with individual participants after each session. The recorded focus group discussions were transcribed verbatim and sent to participants to confirm accuracy.

Data analysis

The transcripts were co-coded by two researchers, one of whom had facilitated the focus group sessions. The analysis process was inductive and iterative; transcribed texts were revisited on numerous occasions to ensure authenticity. The data were initially open-coded and organized under the categories of what the participants voiced as the features a safe space 'should contain' and 'should not contain.' These were then organized under either the physical or social domains of the therapeutic landscape model (Table 1). These codes were then clustered, merged and developed into six themes: Avoiding the clinical setting; homeliness and belonging; inclusivity

and accessibility; lived experience of support staff; skill mix and training; staff attitude and approach.

The findings describe each theme, which touches on aspects of the recovery-oriented practice and service delivery framework (recovery framework) they align with, namely: a holistic-person first service, promoting recovery through the promotion of autonomy, supporting social inclusion and advocacy and the active challenging of stigmatizing attitudes and behaviours (Australian Health Ministers' Advisory Council, 2013). The ensuing discussion is organized under the therapeutic landscape framework of physical and social space. This discussion offers an interpretation of the symbolism of these spaces through the lens of the recovery framework.

Reflexivity

The research team included individuals with lived experience of mental health crises and interaction with the emergency department. One researcher in the team had experience of working as a nurse with mental health consumers in the acute hospital setting. This subjectivity and its potential to bias the process and outcomes of the study were discussed across the team. A clear consensus was that, while these experiences supported researcher communication with participants and sensitivity to issues raised by these participants and related theory, they would not be used to lead focus group conversations or data analysis. The focus of the study was the participant's perspective.

FINDINGS

Participants were all mental health consumers and WA residents. Five identified as women and two as men. To protect participant anonymity, no other demographic data were collected, and direct quotes were anonymised. The findings section describes the six themes developed from the analysis of focus group data.

Avoiding the clinical setting

Participants' historical experiences in the hospital environment clearly influenced discussions about the requirements of a safe physical and social environment. A consistent idea within this theme was the need to avoid a clinical environment, which was perceived as unsafe, frightening, disempowering and de-personalizing:

> Walking into an [ED] is flipping scary because you're thrown into a mixture. And all you need is just one thing, to see, hear, smell, something that could set you off.

'Clinical' colours including 'hospital white' and grey were to be avoided:

TABLE 1 Initial coding of physical and social landscape 'should have' and 'should not have'.

Therapeutic landscape	Should have	Should not have
Physical		
Inside space	Sofas and beanbags. 'Non-uniform' furniture	Clinical 'uniform' furniture
	Warm colours	Clinical posters White walls Too bright or too neutral
	A bell to say you have arrived, but no one to 'let you in'. Free access or a buzzer intercom to let you in	Physical barriers between staff and clients such as reception
		Staff uniforms
	Functional spaces	'Clinical' labelling of spaces
	Board games, videos colouring	
Outside space	Plants and tables	Tinted windows
	Signs that welcome in a number of languages	Signs that mention mental health
Sensory space	Pet therapy/ fish tanks	
	Calm and tranquil, low stimulus atmosphere	Clinical smells
	Patient/client arts and crafts displayed-cushions etc.	
Social		
Amenities/Activities	Hot beverages Food (not essential)	
	Creche	
Ground rules and regulations	Hotline to A and E	Triggering discussions such as past crises, medication, diagnosis
	Inclusive to individuals under the influence of alcohol and other drugs (contentious)	Bureaucracy-form filling. Recording of past visits (except demographics)
	Alcohol and other drugs protocols	
	Smoking area	
	Open in unsocial hours	
Staffing/people	Peers as staff. Mental health consumer as part of recruitment panel	
	Professionals, multidisciplinary clinicians	
	Mental health training/upskilling for all staff	
	Staff of all genders	
		No 'clinical' uniform

Nothing that screams clinical… that bloody bright white.

Other clinical symbols to be avoided included clinical posters and signs, clinical smells, tinted windows, physical barriers such as reception desks, and 'uniform' furniture. Participants described a safe space as one where individuals experiencing mental distress or crisis were respected, heard and validated. The clinical setting in contrast was described as an unsafe space because of participants' experiences of being seen as 'a condition', with their personal needs not considered:

Having that safe space where they're going to see the person not the condition, not the diagnosis, but the person, and actually listening to them.

Participants agreed on the idea of dividing spaces according to functions. They discussed a treatment space for people who had self-harmed, a group discussion space, a socialization space and a calming space for individuals experiencing distress. The importance of privacy was highlighted, with separate rooms for individuals who were receiving treatment for self-harm or were in extreme distress: Participants' experiences of judgement and stigma in previous ED self-harm presentations informed this decision:

So if I go to ED, I know when I'm being judged. "Just treat her wounds or whatever and get her out of here".

The desire to avoid clinical signage of such rooms was also associated with fear of being judged:

> If I walked into an AOD room, alcohol and other drugs room, I'm going to think, "shit those people saw me walk into that room, they're going to think I've got a massive problem with alcohol and other drugs".

Homeliness and belonging

Participants wanted a space reminiscent of home. Words such as 'warm', 'nurturing' and 'low stimulus' were used. Beanbags and couches were suggested as more comfortable and less formal alternatives to clinical furniture. The importance of all five senses in the creation of a symbolically safe space was clear. As well as visual appearance, participants discussed smell. One participant suggesting the use of essential oils:

> I would say using essential oils to create a calm environment and stuff as well.

The importance of creating a sense of belonging was discussed. The use of the consumers' own art and craft work as decoration was suggested:

> There's handmade cushions and that sort of thing; so, it feels like your space when you're going into it, it just is a little bit more settling in that way.

The use of the personal, rather than the impersonal could support a sense of familiarity and ownership for service users.

Inclusivity and accessibility

The creation of a safe space that was welcoming to all sectors of society was universally desired:

> I think inclusivity for mental health is really important.

A sign with the word 'welcome' in multiple languages, and a message indicating a safe space for LGBTQ+ individuals was agreed on in one of the focus groups. Both groups highlighted that a crèche was essential to ensure accessibility for parents.

Ideas of inclusivity and advocacy sometimes conflicted with that of safety. Although none of the participants felt the use of alcohol and illicit drugs on the premises was acceptable, some expressed the need to welcome individuals who were under the influence:

> I'd rather not turn them back.

Others felt a safe space needed to be an alcohol-free 'dry space'. However, tobacco smoking was unanimously supported. Participants felt smoking in a designated space outside was important. For these participants, smoking symbolized autonomy. Many discussed their own history of smoking in past mental health crises and its importance during these times:

> For older people like me, when you're in hospital and if you were in distress a lot of the nurses used to say, 'just go have a smoke'. So, you don't want to take that away from people, you really, really don't.

Service opening hours were discussed. Participants felt that at the very least the service should be open at times when other mental health services, and family and friends, may be unavailable:

> I don't go into crisis till at least midnight, or a bit after and I have no choice other than [ED].

Participants discussed the importance of choice in their use of the safe space, including freedom to choose if or how they interacted, and when to leave:

> It's up to the person whether, if they're feeling better, it helps for them to just stay and chat, or whether once they're feeling better they just want to leave and go home and sleep, or whatever it is that they want to do.

While participants felt the collection of demographic (de-identified) data was acceptable for service evaluation, none wanted the safe space service to hold their medical notes or detailed record of their visits. Reasons behind this included the idea that staff would have the opportunity to stigmatize, judge and make assumptions about an individual from their notes, which would detract from the person-centred approach:

> All these notes written about you, and when you access them again, there's already pre-conceived ideas of who you are, and judgments based on what they read.

Participants raised concerns that any compulsory maintenance of mental health consumer notes would reduce the acceptability and therefore accessibility of the safe space service.

Lived experience of support staff

All participants agreed that peer support staff (individuals with personal experience of mental health

difficulties), whether paid or volunteer, were essential in support, leadership and management roles. Including mental health consumers in staff selection procedures was recommended to ensure the right 'fit' of staff:

> When you're hiring staff I think it's very, very, very important that there's a consumer or two in there as well.

The personal experiences of peer support workers were also described as a potential limitation if those experiences were narrow.

Skill mix and training

Although participants did not want a 'medically-led' service, some wanted an on-call or physically present medical practitioner to manage self-harm issues. Nurses, counsellors and social workers were also considered important. A mix of staff was preferred, with complementary skills. The need for rigorous training of staff was a strong consensus:

> We need people skilled in mental health first aid, maybe skilled in ASIST [Applied Suicide Skills Intervention Training (Living Works, 2014)] or some sort of suicide prevention training. Something like that, that they've got those extra skills above and beyond what a peer worker might have.

Staff who were highly skilled in de-escalating techniques were also perceived as important to the safety of all.

Staff attitude and approach

It was evident throughout discussions that the 'attitude' of the health professional team was especially important. Hierarchy was to be avoided in a safe space:

> You don't want to feel more inferior because when you're in crisis you know things can be heightened as well, and it can be quite difficult to come forward and ask for help.

The staff uniform was seen as a symbol of hierarchy and was therefore unwelcome:

> If it had been someone in normal general clothing, piercings, tattoos whatever. It would have been more welcoming for me to open up more, because I would see them as just another person, not an authority of some sort.

DISCUSSION

The discussion interprets the symbolism of the physical and social aspects of a safe space, doing so through the lens of the recovery framework.

The physical dimension of the safe space and its symbolism

The interpretation of the physical dimension of the safe space includes its design and features. This rejection of any representation of the clinical environment, including the dislike of staff uniforms, reflects the findings of previous mental health consumer experience studies (Chu et al., 2020; Harris, 2016). The symbolism of these clinical features of power, dominance and hierarchy also concur with the findings of these studies. The participants' strong desire to avoid the clinical setting and all it symbolized to them also reinforces the importance of the National Mental Health Policy's expectation of community-based care away from the hospital setting (Commonwealth of Australia, 2009). This finding may have implications for the accessibility of the newly opened WA and NSW safe spaces which have been based within established hospitals or their grounds (Life in Mind, 2021; NSW Government, 2022).

Participants' perspectives around the division of the safe space facility into private and more specific areas appear to be influenced by a number of issues. The requirement for private spaces during a crisis seemed to be symbolic of the need for a respectful space, where individuals are not shamed or stigmatized. According to Oeljeklaus et al. (2022), however, a balance needs to be met between privacy and security in the physical therapeutic environment, with privacy increasing the likelihood of hidden abuse or harmful interactions.

The participants' descriptions highlight the importance of the five senses in the design of the physical aspect of the therapeutic landscape. As well as visual aspects of the safe space, and the need to avoid clinical and uniform materials and colours, the participants discussed smells and tactile aspects (such as aromatherapy and comfortable furniture). Brown (2016) has previously discussed the need to consider these wider senses, in particular touch, in the understanding of what makes a therapeutic landscape. For our participants, having a say on the sensory features of the safe space is symbolic of agency and belonging.

The achievement of the National Mental Health Policy 2008 (Commonwealth of Australia, 2009, p. 17) vision, 'the right care at the right time', requires a service that is physically accessible to the individual in need. A prerequisite of accessibility is availability. Like Judkins et al. (2019), the participants in this study argued that, should a restricted hours service be the only option, this

should be run during unsociable hours when other mental health services, friends and family would not be available. Currently, the two WA safe space services available are open from 3 pm to 7.45 pm Friday to Sunday (Life in Mind, 2021). This study suggests the extension of these services to later in the night-time would be beneficial.

The social dimension of the safe space and its symbolism

The interpretation of the social dimension of the safe space includes the social interactions and relationships within the space, and the management of this space. For these mental health consumer participants, who represent a group known to be marginalized and socially excluded across many sectors of society (Lloyd et al., 2006), the creation of a safe space that welcomes all sectors of society was important. For some, however, this did not extend to individuals under the influence of alcohol and other drugs because of personal safety concerns.

In contrast, tobacco smoking in the safe space was not a contentious issue with participants who tended to associate smoking with their personal history of coping behaviours during a mental health crisis. This perception is contradicted by public health experts who report a lack of evidence to support the idea that smoking helps mental health recovery (Malone et al., 2018). Mental health consumers are estimated to smoke up to three times more than the general population and diseases associated with smoking are similarly more prevalent (Greenhalgh et al., 2018). In this situation, participant self-determination, a key principle of recovery, clashes with the research evidence on the benefits of smoking cessation to individual and population health. Other therapeutic landscape-focused research, this time in a psychiatric hospital (Wood et al., 2013) has found smoking areas symbolize inclusive, welcoming and sharing environments for mental health consumers.

The importance of peer-led services in this study was valued because of its potential to inform practice from lived experience while offering peer advocacy. A further strength of peer worker involvement is the self-validation they themselves receive as acknowledged members of the mental health team in the recovery environment (Mental Health Commission New South Wales, 2021). The participants' requirement for highly skilled mental health practitioners is particularly pertinent considering prior research revealing hospital staff can be insufficiently trained to support the recovery needs of a presenting individual with mental health crisis (Vandyk et al., 2017). Recent research from Ametaj et al. (2021) and Zeng and McNamara (2021) highlights ways in which peer provision can be successfully integrated into existing and future mental health services.

The attitude and behaviours of staff were key conversation topics. Behaviours that demonstrated respect,

inclusivity, non-hierarchy and a mental health consumer-centred approach were highlighted. This further reinforces the requirement for staff that are skilled and trained in contemporary mental health recovery methods to lead and coordinate the safe space service. Harris et al. (2016) describes how mental health nurses need to be able to form 'effective alliances' with mental health consumers. Such therapeutic interactions are often absent in the ED due to lack of training, time and leadership (Harris, 2016; Rayner et al., 2019).

The participants' view was that record keeping, including past medical history and mental health diagnosis, was not acceptable in a safe space. This view conflicts with the standards expected of healthcare staff working in the safe space setting who are bound by the National Safety and Quality Health Service Standards as outlined by the Australian Commission on Safety and Quality in Health Care (2019). For trust and acceptability to be maintained, documentation must be a transparent, collaborative process undertaken jointly with mental health consumers, with clear explanations of the reasons for that documentation (Ivanova et al., 2020). Cutler et al. (2018) have previously highlighted a disconnect in the interpretation of safety between government and mental health service managers and mental health consumers, with the former focusing on eliminating risk. For mental health consumers, the idea of safety is much more nuanced. There is, therefore, a need for a conversation about safe spaces that balances consumer sense of safety with clinician and organization ideas of risk.

STRENGTHS AND LIMITATIONS

The use of focus groups enabled the collection of data from seven participants in just two sessions. The limitations of this approach, namely the possibility that some participants may not contribute or may dominate conversations (Sim & Waterfield, 2019) was not noted by the researcher team. Instead, our experienced facilitators ensured well-prepared participant groups and smooth and inclusive sessions. The number of participants and the local geographical context limit the generalisability of these findings. The study has, however, provided authentic evidence from a mental health consumer perspective. A meaningful understanding has been developed that provides valuable evidence to support recovery-focused service design. The conceptualization of the findings within the therapeutic landscape model supports the transferability of the approach across settings.

CONCLUSIONS

An interpretation of the study's findings through the therapeutic landscape framework and recovery model has revealed practical ideas for the development and

running of a safe space in the community setting that can facilitate recovery. The study has also identified a number of tensions between some of these ideas, including privacy and security and public health and self-determinism. Importantly, the symbolism of these aspects of the therapeutic landscape provides an understanding of why they are important to mental health recovery, from the mental health consumer perspective, thereby offering valuable evidence on which future safe space environments can be developed. This symbolism closely aligns with the principles of autonomy, self-determination, respect and inclusivity, all of which are crucial to recovery.

RELEVANCE TO CLINICAL PRACTICE

A shift in thinking is needed in the design of a mental health recovery setting that extends beyond the idea of risk and practical convenience, to a truly therapeutic landscape that supports recovery. In listening to the voices of mental health consumers, this study highlights practical ways a community-based therapeutic landscape can be achieved and provides valuable evidence to inform mental health safe space research and planning.

AUTHOR CONTRIBUTIONS
All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Lesley Andrew, Shantha Karthigesu, Kathy Boxall and Julie Dare. The first draft of the manuscript was written by Lesley Andrew and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

CONFLICT OF INTEREST STATEMENT
The authors have no relevant financial or non-financial interests to disclose.

DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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