



HOMELESS LINK RESPONSE

CONSULTATION ON PREVENTING SUICIDE IN ENGLAND: A CROSS GOVERNMENT OUTCOMES STRATEGY TO SAVE LIVES

OCTOBER 2011

Homeless Link is the national membership organisation for agencies working with people who are homeless across England. As the collaborative hub for information and debate on homelessness, we seek to improve services for homeless people and to advocate for policy change. Through this work, we aim to end homelessness in England.

INTRODUCTION

People experiencing homelessness are at a considerably higher risk of suicide than the rest of the population. We are therefore pleased to see that they were one of the at-risk groups mentioned in the consultation. This is particularly apposite as the risk factors described in the consultation and the Scottish Government's research¹ are almost identical to the characteristics of people experiencing homelessness. We are also pleased to acknowledge the consultation's proposal to reaffirm the commitment to increase access to talking therapies, an intervention homeless people struggle to access.

However, many of the proposals will see a shift of the commissioning and delivery of suicide prevention activity to local areas. While this will allow greater flexibility, we urge the government to consider that homeless people experience profound health inequalities and are often excluded from mainstream health services.² We would therefore like to see stronger accountability that any prevention services will identify and meet the needs of the most vulnerable.

Below we outline how this can be achieved. Please note we have focused our response to the questions most relevant to our client group and areas of expertise.

AREA FOR ACTION 2: TAILOR APPROACHES TO IMPROVE MENTAL HEALTH IN SPECIFIC GROUPS

3. In your view, are the most appropriate groups considered, including any groups where there are issues relating to equality?

Yes, the most appropriate groups are considered in the consultation. However, given that homeless people are at particular risk of suicide we have highlighted below some additional information about the extent of the risks faced by this group.

- Homeless people experience mental distress at a rate two and a half times greater than the general population³. Homeless Link's national health audit of

¹ Scottish Government (2008) 'Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review' <http://www.scotland.gov.uk/Resource/Doc/251539/0073687.pdf>

² Homeless Link (2011) 'Survey of Needs and Provision 2011' <http://homeless.org.uk/snap-2011>

³ Homeless Link (2010) 'The Health and Wellbeing of People Who Are Homeless: Evidence from a National Audit – Interim Report' http://www.homeless.org.uk/sites/default/files/Interim%20report_HomelessHealthAudit0910.pdf

homeless people indicated that 72% of homeless participants experienced one or more mental health need as opposed to approximately 30% of the general population⁴.

- The Office of National Statistics estimates 4% of people in the general population self-harm. Our data suggest that people who are homeless are three and a half times more likely to self-harm
- The ONS suggests around 10% of the general population experience symptoms linked to anxiety or depression⁵. Our audit suggests a rate around five times this among people who are homeless⁶.
- In addition, a high proportion of homeless people have been identified as suffering from post-traumatic stress disorder (31% from a sample of 967) and a firm link established between this and having attempted suicide in the last month⁷.

The frequency of suicidal ideation in the homeless population is concerning: suicidal thoughts have been shown to affect as many as 61%⁸ of the homeless population. Unfortunately in many cases ideation carries over into action with 36% of respondents in a Salvation Army study having attempted suicide at least once, with women (53%) more likely to have attempted suicide than men (34%) and with 6% of attempts in the last month⁹. This statistic is echoed by research published in October 2011 which found that 38% people experiencing multiple exclusion homelessness had attempted suicide.¹⁰

The table below shows the frequency with which homeless people experience suicide risk factors identified in the consultation document and Scottish Government research into risk and protective factors for suicide¹¹. Homeless people also commonly lack Protective Factors such as coping skills, family connectedness and social support.

	SUICIDE RISK FACTORS	% HOMELESS POPULATION
Salvation Army research ¹²	Drug or alcohol misuse	80%
	Attempted suicide	36%
	Unemployment	96%
	Isolation	51%
Homeless Link evidence from a	Mental illness	72%
	Poor Physical Health	82%

⁴ *ibid*

⁵ Office National Statistics (2000) quoted by Mind

http://www.mind.org.uk/help/research_and_policy/statistics_1_how_common_is_mental_distress

⁶ Homeless Link (2010) 'The Health and Wellbeing of People Who Are Homeless: Evidence from a National Audit – Interim Report' http://www.homeless.org.uk/sites/default/files/Interim%20report_HomelessHealthAudit0910.pdf

⁷ Salvation Army (2009) 'The Seeds of Exclusion 2009'

[http://www.salvationarmy.org.uk/uki/www_uki.nsf/0/58A56A802FEAE3EC802575E5004A2FED/\\$file/The%20Seeds%20of%20Exclusion%202009.pdf](http://www.salvationarmy.org.uk/uki/www_uki.nsf/0/58A56A802FEAE3EC802575E5004A2FED/$file/The%20Seeds%20of%20Exclusion%202009.pdf)

⁸ Eynan et al (2002) 'The Association between homelessness and suicidal ideation and behaviours: Results of a cross sectional survey' <http://hrc.relyonmedia.com/ResourceFiles/THEASS~1.pdf>

⁹ Salvation Army (2009) 'The Seeds of Exclusion 2009'

[http://www.salvationarmy.org.uk/uki/www_uki.nsf/0/58A56A802FEAE3EC802575E5004A2FED/\\$file/The%20Seeds%20of%20Exclusion%202009.pdf](http://www.salvationarmy.org.uk/uki/www_uki.nsf/0/58A56A802FEAE3EC802575E5004A2FED/$file/The%20Seeds%20of%20Exclusion%202009.pdf)

¹⁰ McDonagh, T (2011) 'Tackling Homelessness and Exclusion: Understanding Complex Lives'

http://www.homeless.org.uk/sites/default/files/Tackling_homelessness_and_exclusion_understanding_complex_lives.pdf

¹¹ Scottish Government (2008) 'Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review' <http://www.scotland.gov.uk/Resource/Doc/251539/0073687.pdf>

¹² Salvation Army (2009) 'The Seeds of Exclusion 2009'

[http://www.salvationarmy.org.uk/uki/www_uki.nsf/0/58A56A802FEAE3EC802575E5004A2FED/\\$file/The%20Seeds%20of%20Exclusion%202009.pdf](http://www.salvationarmy.org.uk/uki/www_uki.nsf/0/58A56A802FEAE3EC802575E5004A2FED/$file/The%20Seeds%20of%20Exclusion%202009.pdf)

national audit ¹³	Would like more mental health support	35%
	Not registered with a GP	15%
	Self-Harm	14%

There is also evidence that the experience of homelessness itself increases risk of suicide. An American study found that 73% of those who had experienced homelessness for a period longer than 6 months had considered suicide, compared with 55% of those who were homelessness less than 6 months¹⁴.

Given the level of risk experienced by this group suicide prevention work focused on homeless people has the potential to substantially reduce the nation's overall suicide rate. The next section proposes tailored prevention techniques for this group.

4. In your view, are there additional measures or approaches to reduce suicide in the identified groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

We would like to emphasise the importance of three additional measures for preventing suicide: improve access to mental health services for homeless people; provision of suitable mental health training for homelessness staff; and increased provision of psychologically informed environments by homelessness services.

IMPROVING ACCESS TO MENTAL HEALTH SERVICES

Homeless people persistently experience poor health and inequalities in access to health care. Due to the complexity of the health needs with which many present, homeless people can be marginalised from mainstream services which leads to poorer health outcomes¹⁵. An essential element of suicide prevention for people experiencing homelessness is to ensure that this group can access timely and appropriate health interventions.

Homeless Link has developed the following proposals to ensure that the mental health needs of this excluded group are at the forefront of local health strategies:

- All newly commissioned community mental health services should have a responsibility to pro-actively work in homelessness services and draw up a clearly defined service level agreement between mental health and homelessness services in order for this to be effectively monitored; and
- All commissioners should take steps to identify the mental health needs of homeless people in their area and incorporate these into their commissioning plans.

We would welcome the opportunity to work with the DH further to ensure homeless people can access appropriate services to prevent risks associated with suicide.

TRAINING

92% homelessness service providers provide mental health support to their clients, however, only 8% of services receive funding from a health source¹⁶. Furthermore

¹³ Homeless Link (2010) 'The Health and Wellbeing of People Who Are Homeless: Evidence from a National Audit – Interim Report' http://www.homeless.org.uk/sites/default/files/Interim%20report_HomelessHealthAudit0910.pdf

¹⁴ Eynan et al (2002) 'The Association between homelessness and suicidal ideation and behaviours: Results of a cross sectional survey' <http://hrc.relyonmedia.com/ResourceFiles/THEASS-1.pdf>

¹⁵ Homeless Link (2011) 'Liberating the NHS: An Information Revolution'

http://homeless.org.uk/sites/default/files/Information%20Revolution%20Homeless%20Link_Jan11.pdf

¹⁶ Homeless Link (2011) 'Survey of Needs and Provision 2011' <http://homeless.org.uk/snap-2011>

findings from one of Homeless Link's Health Needs pilots in the West Midlands found that 65% clients went to housing staff for help around their health¹⁷. Up to 60% of homeless people experience complex trauma and personality disorder and this morbidity substantially increases the likelihood of suicide¹⁸. It is important that homelessness services providers are able to respond to their clients' complex mental health needs.

For many homeless people services providers may be the only contact that could provide some sort of mental health intervention. It is important that we make the most of this opportunity. To do this we need to increase the level of mental health training provided to key workers and support provided to them by health professionals. We would like to see an increase in joint working and/or some sort of shadowing or skills exchange programme between the two sectors. The effect of joint work and/or mental health training can be seen in the cases studies presented in the response to question 13.

PSYCHOLOGICALLY INFORMED ENVIRONMENTS (PIEs)

Some homeless people find hostels and day centres an uncomfortable or chaotic environment. PIEs have significant potential to provide an empowering and calming environment where people can feel emotionally as well as physically safe, and can gain an understanding of their behaviour and an ability to take responsibility for themselves.

Psychologically aware housing services are an effective technique for addressing the mental health needs of this hard to reach group. However, they should be used as a compliment to clinical services not an alternative. Health commissioners should be involved to ensure that people with complex trauma, and those with dual diagnoses, have accessible and appropriate clinical services. More information on PIE's can be seen in the St Mungo's 'Life Works' case study included in our response to question 13 below.

AREA FOR ACTION 6: SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

11. Is there additional information available that could be collected at a national and local level to support the suicide prevention strategy?

Obtaining and using good quality information is vital to help facilitate better access to appropriate health services, to measure where services are failing these individuals, to spot trends and target services more effectively.

Many of the routine needs assessments do not include information about the health needs of excluded groups, or more hidden populations who are not registered with mainstream services. To ensure services can be responsive to the needs of all patients in a community, new commissioning structures must identify, include and act upon information about needs of homeless people who can be less visible but often have the most severe and costly health needs in our communities. To do this, we ask for a specific requirement in Joint Strategic Needs Assessments to include data about excluded groups' health needs and determinants of health, which could be identified by an inequalities assessment of the local population. Homeless Link's Audit tool is a practical way for commissioners and their partners to gather this

¹⁷ Homeless Link (2011) 'Liberating the NHS: An Information Revolution'

http://homeless.org.uk/sites/default/files/Information%20Revolution%20Homeless%20Link_Jan11.pdf

¹⁸ Homeless Link (2011) 'Understanding mental health, well-being and homelessness'

information¹⁹ and we would like to see such methods systematically used to gather this data.

MAKING IT HAPPEN LOCALLY AND NATIONALLY

13. Are there examples of local good practice that could be disseminated to other areas?

The above sections illustrate the importance of minimising the volume of suicide risk factors experienced by people who are homeless. The case studies below demonstrate how homelessness service providers can effectively develop services that address complex support needs through joint working.

COMMUNITY OF PRACTICE (WEST CUMBRIA)

The Cornes team established a 'community of practice' (COP) as a means of improving joint working around the issue of multiple exclusion homelessness. This brought together different practitioners: a social worker, a probation officer, a housing support worker, an advice worker, a mental health worker, a drugs worker and a researcher from this project. Members bring practice challenges and anonymised 'cases' to each session and seek support and help from the community. While still in the early stages of development, the COP has been described by its members as a 'lighthouse' for practice values and principles and a means of achieving real changes in approaches to joint working that are of direct benefit to people who use services²⁰.

JASON LEE HOUSE (JLH)

Jason Lee House is an 18 bed project providing temporary and, in some cases, longer term accommodation for multiply excluded homeless people exhibiting needs relating to mental ill health, drugs and alcohol use. As part of their commitment to improving the mental health and wellbeing of their clients they have undertaken a joint working initiative with the Samaritans who provide an onsite confidential drop-in. Clients can use this provision to access support for the sorts of intense distress that can lead to suicide.

THE WELCOME PROJECT REDBRIDGE

This project operates a drop-in centre for rough sleepers. It has received some funding from Department of Health to provide open access psychological support and talking therapies for those who identify abuse in childhood. They have developed a quick access referral route via an onsite nurse, who can spot early warning signs and signpost effectively.

ST MUNGO'S LIFE WORKS PSYCHOTHERAPY SERVICE

Life Works provided individual medium term psychodynamic psychotherapy to people who experience homelessness and complex needs. Life works offered longer term talking therapies beyond the scope of short term CBT and has had excellent results for people with a history of complex trauma. St Mungo's are collating the learning gained from Life Works and emerging good practice elsewhere in the field to develop 'psychologically informed approaches' across seven pilot projects. This is to compliment statutory provision, not replace it, and encompasses access to

¹⁹ Homeless Link www.homeless.org.uk/health-needs-audit

²⁰ McDonagh, T (2011) 'Tackling Homelessness and Exclusion: Understanding Complex Lives' http://www.homeless.org.uk/sites/default/files/Tackling_homelessness_and_exclusion_understanding_complex_lives.pdf

psychotherapy for clients, clinical supervision, reflective practice and training for staff and development of client co-production.

15. What issues should the Department of Health be considering as we develop any potential indicators in the Public Health Outcomes Framework relevant to suicide prevention?

We believe that all services should be working towards the prevention agenda. It is imperative that there are no geographic or demographic gaps in prevention activity. With this in mind we must ensure that responsibility and accountability for prevention work is a shared outcome across the NHS and public health. The national focus of Public Health England has the potential to ensure suicide prevention does not become another domain where homeless people experience health inequalities.

The experience of homelessness and the characteristics of people experiencing homelessness increases risk of suicide. It is important that we continue to take action to reduce the risks of homelessness alongside any targeted health prevention activities to reduce incidence of suicide. Continued commitment at a national and local level is critical to achieve this.

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