Suicide prevention

Guidance for homelessness services

Let's end homelessness together

Homeless Link, 2-5 Minories, London, EC3N 1BJ | 020 7840 4430

www.homeless.org.uk | Twitter: @Homelesslink | Facebook: www.facebook.com/homelesslink

Suicide prevention

Guidance for homelessness services

Contents

Produced by
The Innovation and Good Practice Team

With thanks to
DCLG, Lisa Reed, St Mungo's, Angharad de Cates, Alys Cole-King

Published
October 2017

Introduction

Homelessness services play an important role in supporting people with their physical and mental safety and well-being. Experiences preceding a person's homelessness, as well as being currently homeless on the streets or in services, may increase the risk of suicidal thoughts or feelings, and the risk of suicide attempts. It is vital that organisations offer the right support, both to prevent suicide and to support staff who are working with homeless individuals.

This guidance has been produced in response to requests from Homeless Link's members for resources to help to support their work on suicide prevention. We have focused on how managers can incorporate suicide prevention into the planning and delivery of services, rather than creating a guide for working with individuals. The Resources section includes links to tools, information and training for teams to improve their support to individuals.

Policy context

There were 4,882 suicides[1] registered in England in 2014.[2] There are much larger numbers of suicide attempts and people experiencing suicidal thoughts or feelings. Suicidal thoughts or feelings can range from someone having thoughts that life is not worth living, through to clear intentions and plans to end their life.

While people from all sections of the population experience suicidal thoughts and feelings and die by suicide, people who are homeless or at risk of homelessness are at particular risk. This is because of the high prevalence of suicide risk factors in those who are homeless: high levels of mental ill health, previous episodes of self-harm, current poverty and debt, concurrent drug and alcohol issues, and physical and emotional isolation.

The commitment to developing local suicide prevention strategies is set out in the government's 2012 national strategy for England, 'Preventing suicide in England: a cross-government outcomes strategy to save lives'.[3] It is also a key recommendation in the Mental Health Taskforce's report to NHS England, 'The five year forward view for mental health'.[4] This document recognises the increased risk of suicide amongst people who are facing social issues including homelessness, unemployment, involvement in the criminal justice system, and exposure to violence and abuse.

The strategy recognises that a range of organisations need to play a role in preventing suicide, including Housing Associations and voluntary sector organisations. Most areas should have developed a local suicide action plan. Guidance can be found here:
www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

[1] In this guidance we use suicide to mean a deliberate act when someone intends to ends their own life.
[2] www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan
[3] www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[4] www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Developing an organisational approach to suicide prevention

Coordinating with local suicide prevention plans

All local areas should have developed a local suicide action plan as recommended by the 2012 strategy 'Preventing suicide in England: A cross government outcomes strategy to save lives'.[5] Accountability for the suicide prevention strategy and its associated action plan lies locally with the Health and Wellbeing Board.

Organisations are advised to contact local authorities where they provide services to enquire who is leading on their Suicide Prevention Plan, to find out what local networks and resources may be available. Guidance by Public Health England in 'Suicide prevention: developing a local action plan' sets out the importance of engaging the voluntary sector in suicide prevention partnerships.[6]

Developing a Suicide Prevention Protocol

Organisations can benefit from developing and implementing their own Suicide Prevention Protocol or reviewing an existing protocol. Public Health England's guidance suggests key areas that can be covered in such a protocol, but it is recommended that this is developed locally for the particular needs of your service. For example, some aspects will apply specifically to residential projects.

Aims and objectives

The aim of a Suicide Prevention Protocol is to provide guidance and direction to staff about the interventions and care required to increase the safety of service users who are at risk of experiencing suicidal thoughts/feelings.

The objectives of a protocol are:

- To promote good practice in suicide prevention across the organisation
- To be aware of the wider causes of suicidal thoughts and feelings, including mental ill health and, therefore, to provide a safe and welcoming environment for all service users
- To provide a framework to enable staff to feel empowered to talk to individuals about how they feeling and then develop an appropriate safety plan
- To provide guidance to staff on referrals for specialist assessment and intervention as part of the safety plan
- To ensure that all team members are proactively engaged in suicide prevention and, where appropriate, they record details of discussions, and serious incidents (such as self-harm or attempted suicide) to promote organisational learning.

The role of staff teams in preventing suicide

It may be helpful for a protocol to explicitly set out key roles in preventing suicide, for example:

Management are responsible for:

- Ensuring staff are aware of the contents of the organisational Suicide Prevention Protocol
- Ensuring suitable training is provided about how to structure discussions on mental health and self-harm, and produce a Safety Plan for all service users:

[5] www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[6] www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

  - All staff should listen compassionately to individuals, and have a low threshold to seek advice from managers or more experienced staff if concerns about mental health or self-harm are raised as part of routine discussions
  - Ideally, all staff should have face-to-face training (see 'Further resources' below)
  - As a minimum, all staff should undertake on-line training, such as free training from the Royal College of General Practitioners e-learning: www.rcgp.org.uk/learning/online-learning/ole/suicide-prevention.aspx
- Ensuring good quality supervision structures are in place, including clinical supervision where required
- Reviewing and auditing all incidents

Frontline staff are responsible for:

- Being aware of the Suicide Prevention Protocol
- Undertaking training in mental health and discussions about self-harm, ideally face-to-face (see 'Further resources' below)
- Engaging with supervision
- Having time and space for discussions with all new and existing service users and asking about mental health symptoms and thoughts of self-harm in a supportive manner
- Working with individuals to develop an individual-focused Safety Plan for every service user to be able to access when required
- Proactively escalating concerns about mental health and self-harm to senior staff/management, and to feel empowered to approach health services with appropriate supervision when required
- Contributing to a safe and welcoming environment where service users feel able to disclose suicidal thoughts and feel these are taken seriously

Having discussions with a service user about mental health and thoughts of self-harm

As part of the organisation's initial assessment process, and ongoing monitoring, there should be discussions with every service user about mental health and thoughts of self-harm or suicide, in collaboration with the service user. Staff should be supported in this with appropriate training and supervision. Some general guidance is given below, but note that this cannot replace dedicated training.

Where possible, staff should offer to have discussions with the service user at a time and place to suit them and where they will feel most comfortable. It is helpful to ensure that the atmosphere of the discussion is welcoming, unhurried and non-judgemental, and consider posture and eye-contact, to make the environment as comfortable as possible for the service user. Also, particularly with new service users, it is beneficial for staff to spend some time building rapport and getting to know the person as an individual before asking any difficult questions. During the discussion, it is helpful to show genuine warmth and interest in the person's wellbeing, as well as honesty. These strategies will enhance the quality of the discussion and resulting Safety Plan.

The discussion should take the format of an informal chat, rather than a list of 'tickbox' questions. However, in general, the following points can be helpful for staff to consider:

- Use language that is appropriate and similar to that used by the service user.

- Allow the service user enough time to respond to questions, and avoid any assumptions or interruptions.
- Frame questions as openly as possible, and avoid any implicit judgement or bias. For example, these could include “How are you feeling today?”, “What has happened to you?”.
- Gather specific details about the individual’s strengths and supports. To this end, asking “What is important to you?”, “What do you find comforting?”, “What should I know about you?” can be helpful.
- Acknowledge that some topics may be particularly sensitive and difficult, and allow service users more time to answer these questions. It may be beneficial to inform the service user of the benefits of gathering this information to aid formulation a plan so that they can move forward.

When discussing mental health with service users, staff should include questions referring to past or present suicidal thoughts and any previous self-harm. This is likely to be a sensitive topic, and therefore care must be taken, particularly if staff members have not attended training sessions and/or are inexperienced in this area. It is usually better to use open questions, and spend time listening to the service user exploring any detail in their own words. However, service users should be made aware that at times organisations may have a duty of care to share this information with other parties if necessary to maintain their safety. Helpful areas of discussion may include:

- Have they had any times when they thoughts of self-harm in the past? Did this ever lead onto undertaking self-harm at any point? Where there any triggers at this time?
- Are they having thoughts of self-harm or ending their life at the moment/recently? How often is this happening? How long do they last and how strong are they? Are there any specific triggers for these thoughts?
- If they are thinking about self-harm, do they have any thoughts about how they might do this? Do they feel that they might go ahead with this plan? What are the reminders for them of their reason for living (sometimes known as protective factors)? What makes them feel hopeful? This may include important people, places, animals, activities, or achievements in their life.

Latest evidence advocates avoiding formal risk assessment using specific tools. These tools in isolation are not accurate at predicting future self-harm on an individual level, and may falsely reassure or mislead those conducting them[7,8,9]. It is preferable to conduct a collaborative discussion, and from this co-produce a plan tailored to that individual that focusses on addressing current concerns and producing plans for future crises (the Safety Plan), and which can be reviewed regularly as part of routine discussions, particularly at change and transition points.

Safety Planning

All individuals should have a Safety Plan tailored to them following discussions during the initial assessment process, or at another relevant point. Safety Plans build on strengths and are a good way to involve service users in the prevention of suicide by having conversations about future harm, in advance of any crisis. Good

[7] Quinlivan, L., Cooper, J., Davies, L., Hawton, K., Gunnell, D., Kapur, N. (2016). Whichare the most useful scales for predicting repeat self-harm? A systematic reviewevaluating risk scales using measures of diagnostic accuracy. BMJ Open 6,e009297.

[8] Katz C., Randall J.R., Sareen J., Chateau D., Walld R., Leslie W.D., Wang J., Bolton J.M. (2017). Predicting suicide with the SAD PERSONS scale. Depress Anxiety. May 4. doi: 10.1002/da.22632. [Epub ahead of print]

[9] Bolton, J.M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *BMJ*, *351*(nov09 1), h4978–h4978. http://doi.org/10.1136/bmj.h4978

quality relationships are fundamental to the development of safety planning and therefore staff need to be given sufficient time to undertake this work.

Each individual Safety Plan should be developed in collaboration with the service user in order to draw on their own internal resources and external support when they experience suicidal thoughts and feelings. It is also important to engage other professionals supporting the service user, such as a Care Coordinator from the community mental health team (CMHT) or a key worker from drug and alcohol services. Where appropriate, and where consent is given, it can be helpful to engage with friends or family members.

The guidance sets out the key areas that need to be covered in the Safety Plan including:

- What helps the individual to manage suicidal thoughts or feelings in their experience? What coping strategies have been useful in the past/what support is needed?
- What is the best course of action for them in the event of a crisis? What will they want to do when they experience suicidal thoughts and feelings?
- Who the service user prefers to speak to when they have suicidal thoughts or feelings. This may include a friend or relative, a staff member in your project, another professional or a telephone helpline.
- Which other agencies they can contact or who they are happy to be contacted by staff on their behalf (such as support or advice lines, Mental Health Teams or Emergency Services).
- Depending on circumstances, service users may be able to identify a safe place they can go to.

A Safety Plan could include the following areas:

Connecting with People[10] **immediate Safety Plan**	
Reasons for living	
Safe environment	Remove means / identify distress triggers & rehearse safety responses
Calming / distracting activities	
General support	Include people's names and all their contact numbers
Suicide prevention support	
Emergency contacts	

Safety Plans should set clear actions and recommendations, and be as collaborative as possible. It is important to give service users a copy of their Safety Plan. This should include key names and phone numbers for helplines and professionals (contact details of supportive organisations can be found in 'Help and information for people who are feeling suicidal' below).

Safety Plans should be reviewed regularly, particularly if there is an increase in risk or an incident.

[10] www.connectingwithpeople.org/StayingSafe

Working with other agencies

A Suicide Prevention Protocol needs to recommend the circumstances in which contact should be made with appropriate health services.

If teams have concerns about the mental health of an individual, they should have a low threshold for making a referral for assessment by Mental Health Services. An individual may already be known to local services and have access to a Care Coordinator (a health professional responsible for co-ordinating mental health care for that individual). If so, any concerns can usually be addressed directly to this person or a duty member of the same team. New referrals may need to go through a GP or a single access point depending on the local process.[11]

Wherever possible, referrals should take place with explicit consent, but the Protocol should set out the circumstances and procedure for overriding consent when there is potentially a significant risk of harm.

Where someone with a history of suicidal thoughts is being discharged from in-patient psychiatric settings, it may be helpful for staff members to attend ward rounds or discharge meetings to help prepare for discharge to the community. Following discharge, the in-patient team will normally organise appropriate follow-up from Mental Health Services in the community. This may include support by a local Home Treatment Team or Crisis Team for a period of time after discharge, who have greater resources to manage higher risk patients in the community or those where medication observation is required. Alternatively, mental health care may be transferred to a Community Mental Health Team (CMHT) for appropriate longer term follow-up, either as a new referral or to a team who may already know the patient. Both types of community teams are keen to receive involvement from homelessness teams.

How to respond to an assessment of immediate suicidal intent

The Suicide Prevention Protocol should set out procedures for when initial discussions indicate that staff are concerned about an individual's level of mental health distress or crisis. This may include having frequent or constant suicidal thoughts, having a specific plan and intention to act, and being unable to identify protective factors. An individual's Safety Plan should set out the steps to be taken in a crisis.

If staff feel that someone is at immediate risk of harm:

- Contact the GP Practice or the Community Mental Health Team, who will usually have a duty worker. This may result in service users being advised to attend the Accident & Emergency department at hospital for psychiatric assessment or it might trigger a Crisis Response or Home Treatment Team visit. Discuss this onward referral with the client, gain consent where possible and follow procedures for overriding consent when there is significant risk of harm.
- In the event of immediate risk of suicide, workers need to know that they must call the Emergency Services. An ambulance can take someone to hospital for assessment or the police might use their legal powers granted under the 1983 Mental Health Act to escort the service user to a place of safety with a view to being assessed.
- Any incidents, including your intervention, should be documented in the service user notes and shared with other relevant staff and partner agencies in accordance with your organisation's confidentiality and safeguarding policies.

[11] Navigating Mental Health Services guidance: www.homeless.org.uk/working-with-mental-health-services

Regular observation or monitoring to reduce the risk of suicide

In some services, particularly relating to projects set up to support people with enduring mental health issues, there may be joint protocols developed with Community Mental Health Teams to take practical steps to monitor or observe people who are currently in crisis.

Depending on the staffing level and nature of the project, this may include observing or monitoring a person at regular intervals. A Suicide Prevention Protocol should cover the circumstances when this is appropriate, i.e. it must only be undertaken for time-limited periods and be in collaboration with the service user as part of the agreed Safety Plan. Observation should be treated as a tool for engagement and be as non-intrusive as possible. Service users may prefer to 'check in' at set times than for staff to go to them. Adequate staffing needs to be provided in order for this intervention to be consistent and effective.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) undertook research into suicide when people were under observation,[12] which set out practice findings that may be of relevance for some services:
http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

Removing the potential means of suicide

Assessments of people at risk of suicide should ideally involve liaising with partner agencies should record any previous suicide attempts and the means that were used.

The most common method of suicide in the UK is hanging.[13] Some institutions, such as psychiatric hospitals, have altered the design of rooms to decrease the opportunities for death by suicide using this method, removing 'ligature points' such as curtain rails, hooks and door handles.

Poisoning is the second most common method for suicide: opiates are the most commonly used drug in fatal overdose but other drugs used include anti-depressants, anti-psychotics and paracetamol. A protocol may include working with a service user to check for supplies of these drugs and holding them where there is immediate risk or working with GPs and pharmacists to arrange for shorter term supplies.[14]

Working with people who may self-harm regularly

Homelessness organisations may be working with people who self-harm or express suicidal intent or attempt suicide regularly. This can be very distressing for staff and can result in staff frustration or burn-out. It is important that staff are trained in understanding the context surrounding these behaviours, such as having an awareness of mental health, personality disorder and complex trauma. Managers need to support teams to provide a compassionate response, utilising their local Community Mental Health Team[15] and, where possible, having access to clinical supervision.[16] Clinical supervision is particularly important to prevent burn-out for individual staff members.

---

12 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). In-patient Suicide Under Observation. Manchester: University of Manchester 2015
http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/ipobsreport.pdf

13 Office of National Statistics (2015). *Suicides in the United Kingdom 3013: Registrations.* Statistical Bulletin
http://www.ons.gov.uk/ons/dcp171778_395145.pdf

14 Managing Medication: www.homeless.org.uk/our-work/resources/managing-medication

15 Working with statutory mental health services: www.homeless.org.uk/working-with-mental-health-services

16 Reflective Practice: www.homeless.org.uk/trauma-informed-care-and-psychologically-informed-environments

The principles of developing a Psychologically Informed Environment (PIE) in homelessness services are particularly relevant to supporting people who display regular suicidal intent. Teams who adopt a trauma-informed approach may also feel better equipped to cope with complex needs. More information about both approaches can be found here:
www.homeless.org.uk/trauma-informed-care-and-psychologically-informed-environments

Whilst not all self-harm is intended to cause death, each incident needs to be taken seriously. People who have attempted suicide or self-harmed may need to be offered treatment for the physical consequences of self-harm as well being referred for mental health assessment or support. It is important to remember that the risk of eventual suicide is increased for those with any previous self-harm episodes, regardless of the previously stated intent of the episodes[17].

Mental health charity Mind has produced resources for people who self-harm and those who support them:
www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/about-self-harm/#.WNvqx6K1vIU

NICE has provided guidelines on 'Self-harm in over-8s: short-term management and prevention of recurrence' which sets out what to expect for service users when they access health services:
www.nice.org.uk/guidance/cg16/chapter/1-Guidance#support-and-advice-for-people-who-repeatedly-self-harm

Responding after a suicide

The death of a service user is a traumatic event, both for other people using the service and for the staff team. When the death is by suicide, people across the service may experience feelings of guilt, as well as concern about whether staff could have intervened to prevent the death, which may lead to anger from staff and service users. It is essential that there are clear procedures around communication, support, and review for managers to apply during this difficult time.

Suicides and serious suicide attempts are normally reviewed using an organisation's Serious Incidents or equivalent policy, which should include procedures for informing and involving staff and other relevant partners. Either the organisation or another body should undertake a post-incident review, which includes clarification if any lessons can be learned from the incident and recommendations for actions with an appropriate timetable and designation of accountable leads.

Supporting people following a suicide or serious attempt

Staff members and other service users affected by a suicide or serious attempt should be given timely, appropriate and effective support and supervision. For staff this may include taking compassionate leave or access to therapeutic support. Service users should be given as much information as possible (individually and/or in a house meeting) and referred to therapeutic support. It is important to recognise that the incidence of suicide may trigger suicidal feelings in others and therefore this should be discussed and, where appropriate, Safety Planning for other service users should be provided.

[17] Carroll, R., Metcalfe, C., Gunnell, D. (2014). Hospital management of self-harm patients and risk of repetition: systematic review and meta-analysis. J Affect Disord 168, 476-483

Homeless Link

Public Health England and The National Suicide Prevention Alliance have produced 'Help is at Hand', a booklet for people bereaved by suicide which addresses the range of emotions people may experience, as well providing advice on practical matters. Download it here:
www.nspa.org.uk/home/our-work/joint-work/

Support after Suicide is a partnership of organisations that provide bereavement support in the UK and there are a range of useful factsheets and links:
http://supportaftersuicide.org.uk/#start

Practical steps to respond to a death or serious incident

A death or other serious incident should be reported to Emergency Services immediately.

Organisations should support staff around practical arrangements, for example allocating time or management support:

- The police may need to ask service users or staff questions to explore the circumstances around the incident, including the events leading up to an incident. The police may take away any items that could be connected with a death. Staff should record the name and contact details of attending officers.
- Staff should work with the police to agree who is next of kin and who should be contacted.
- In England and Wales, sudden and unexplained deaths are reported to the coroner. The coroner may decide to investigate, in which case the death cannot be registered until this is completed. More information about the Coroners process is provided at www.gov.uk/after-a-death

Help and information for people who are feeling suicidal

Part of an organisational approach to preventing suicide is ensuring that people are able to seek support when they need it. This includes ensuring that staff are supported and trained to respond appropriately and compassionately when people express suicidal thoughts and feelings. It is important that service users know where they can access support in the event of a crisis, both during office hours and during weekends and evenings.

The following helplines and information can be shared in common areas or provided in welcome packs. Local branches of organisations, such as Samaritans and Mind, may be able to provide posters and cards. Some of the resources below can be printed off and given to service users.

Local Community Mental Health Teams may have Crisis lines or Single Points of Access numbers that can be shared with service users.

People can also call 111 for the **NHS** non-emergency number. In an emergency people should call 999.

Samaritans provide confidential, non-judgemental emotional support, 24 hours a day, 7 days a week, for people who are experiencing feelings of distress or despair, including those which could lead to suicide. Call: 116 123. Email: jo@samaritans.org. Many branches offer the opportunity for someone to speak to a volunteer face-to-face: www.samaritans.org/branches

Connecting with People resources

Staying safe if you're not sure life's worth living

Interactive online resource for anyone struggling to offer hope, compassion and practical ideas and suggestions on how to find a way forward. It includes a page specifically designed for children and young people, with advice on which adults should be approached for support, in order of safety. It also includes information on how to make a safety plan. http://www.connectingwithpeople.org/StayingSafe

U Can Cope film and self-help leaflets

Together with Samaritans, the Royal College of Psychiatrists and Southwick Media, Connecting with People have produced a short film and useful resources for people who are struggling to cope: www.connectingwithpeople.org/ucancope.This 22-minute film shares inspirational stories, focusing on three people for whom life had become unbearable but who found a way through with support.

#DearDistressed Project

#DearDistressed is a suicide prevention campaign that sends messages of hope and recovery to anyone who is thinking that life may not be worth living. It uses personal and heartfelt letters written by people with lived experience of suicidal thoughts and who are now in an emotionally-safer place, to show anyone in deep despair that it is possible to recover, with the right support. www.connectingwithpeople.org/deardistressed

The campaign has two main objectives:

1) To send a clear message to anyone emotionally struggling that *"suicidal thoughts are a sign to change something in your life, not to end your life, and that it IS possible to recover, with the right support."*
2) To send a clear message to everyone that "*anyone can find themselves thinking that life isn't worth living and it's essential to seek support."*

Mind has a range of resources that explain what suicidal feelings are, including possible causes and how people can learn to cope:
www.mind.org.uk/information-support/types-of-mental-health-problems/suicidal-feelings/about-suicidal-feelings/#.WNwBm6K1vIU

HOPELineUK is a specialist telephone service staffed by trained professionals who give non-judgemental support, practical advice and information to:

- Children, teenagers and young people up to the age of 35 who are worried about how they are feeling
- Anyone who is concerned about a young person

Call: 0800 068 41 41. Email: pat@papyrus-uk.org. SMS: 07786 209697

CALM, the Campaign Against Living Miserably, is a charity focused on reducing suicide in men aged under 35. CALM has a unique approach to engaging young men, using a distinctly non-medical inclusive approach in the way that it promotes its helpline and website: www.thecalmzone.net

SANE runs a national, out-of-hours mental health helpline offering specialist emotional support and information to anyone affected by mental illness, including family, friends and carers.
SANEline: 0300 304 7000 (4.30pm – 10.30pm daily)

Maytree is a sanctuary for people in suicidal crisis. Their helpline is open 24hrs a day. www.maytree.org.uk/
Call: 020 7263 7070. Email: maytree@maytree.org.uk

Training for staff and volunteers

There are a number of organisations providing training on all aspects of suicide, with many catering for differing levels, from basic suicide awareness through to detailed interventions.

Please note that this list is offered as an overview of what is available – providers are not endorsed by Homeless Link. Readers should carry out their own research before booking a course.

- **Connecting with People** offers training in suicide and self-harm mitigation that has been informed by evidence-based principles. It aims to increase empathy, reduce stigma and enhance participants' ability to compassionately respond to someone who has suicidal thoughts or following self-harm: www.connectingwithpeople.org

- **Samaritans** offer training for anyone whose role may bring them into direct contact with people who have suicidal feelings. www.samaritans.org/for-business/workplace-training

- **Storm** are a not-for-profit social business committed to enhancing knowledge and skills in suicide prevention and self-harm mitigation: www.stormskillstraining.co.uk/dev/index.php

- **PAPYRUS** specialise in delivering community-based education based on their experience of working with young people and caregivers: www.papyrus-uk.org/training

- **Royal College of GPs (RCGP)** offer free suicide prevention e-learning: www.rcgp.org.uk/learning/online-learning/ole/suicide-prevention.aspx

- **Applied Suicide Intervention Skills Training (ASIST)** is an in-depth, two-day course to build skills to provide suicide first aid interventions. A number of organisations are accredited to deliver this training in the UK, and can be found via an internet search.

Further resources and information for services

- The Alliance of Suicide Prevention Charities (TASC) is an alliance of the leading charities dealing with suicide prevention and mental health issues. The TASC website is an educational and resource hub: http://tasc-uk.org/

- Manchester University's Centre for Mental Health and Safety have produced a range of relevant research findings and guidance: www.medicine.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/saferservices

- Safer Services: A Toolkit for Specialist Mental Health Services and Primary Care is designed for specialist mental health services. It sets out the key elements of safer care in mental health services and in the wider health system: https://apps.mhs.manchester.ac.uk/surveys/TakeSurvey.aspx?SurveyID=l2LI4p8K

- *Connecting with People self-care resources*
  Self-care is an effective approach to living a more balanced life and refers to an ongoing commitment to doing the things we enjoy, looking after ourselves and identifying the activities and helpful behaviours that will protect our mental health during particularly stressful periods. Connecting with People's self-care resources have been developed to help facilitate this process and include three print-friendly worksheets: www.connectingwithpeople.org/content/mhaw17

- Public Health England have produced 'Local suicide prevention planning – a practice resource'. This practice resource is to support local authority public health teams to work with clinical commissioning groups (CCGs), Health and Wellbeing Boards, the voluntary sector and wider networks of partners to develop or update local suicide prevention plans: www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

- The Zero Suicide approach is a US model based on the concept that suicides in health and behavioural care settings are not inevitable. It sets an aspiration and a bold goal of zero suicides within those settings rather than planning for incremental progress. It emphasises bold leadership, training and a data-focused quality improvement approach to inform system changes. It has been adopted in different ways in three areas in England: East of England, Merseyside, and South West England.
  See www.zerosuicide.com for more information.

- The National Institute for Clinical Excellence (NICE) are due to publish guidance on 'Preventing suicide in community and custodial settings' in September 2018 which is likely to be directly relevant to homelessness organisations: www.nice.org.uk/guidance/indevelopment/gid-phg95

- Crisis produced a research briefing in 2011 'Homelessness: A silent killer' on mortality amongst homeless people: www.crisis.org.uk/research.php?fullitem=337

Appendix: Research into homelessness and suicide

Suicide rates mirror wider inequalities within society and there are certain risk factors that can increase the likelihood of suicidal thoughts and feelings.

75% of deaths by suicide in the UK are in men.[18] The highest suicide rate in England is among men aged 45-49.[19]

Vulnerable people in institutional settings, such as prisons or psychiatric hospitals, are at increased risk of feeling suicidal. The environment itself can contribute, for example if there is a fear of violence or bullying, lack of structure or boredom. Between 2008-2012, 7% of mental health services' patients who died by suicide were in unstable housing, i.e. homeless or living in bed and breakfast or a hostel.[20]

Mental ill health, particularly depression, is strongly associated with suicide attempts and deaths by suicide.[21] People who access homelessness services have higher rates of mental ill health than the general population.[22] The Multiple Exclusion Homelessness Study found evidence of the frequent incidence of self-harm and suicide attempts amongst homeless people, particularly where mental health issues were present.[23]

Research in 2006 into suicides amongst homeless people found that half of people were in in-patient mental health services at the time of death. The study also found a clear link with drug and alcohol issues.[24] The research found evidence of recent disengagement with services and a lack of follow-up. Studies therefore show the value of assertive mental health treatment, integrated with housing support, that recognises that substance misuse is often co-occurring.[25]

Studies of deaths by suicide have found that the strongest predictor of suicide is previous episodes of self-harm and suicide attempts. A majority of people in mental health services who died by suicide had a history of self-harm.[26] Homeless people have a higher prevalence of both.[27]

However, not all individuals identified as high risk go on to attempt suicide, and a single formal assessment of risk factors is insufficient in isolation. Therefore, it is important that organisations support staff to be able to take the time to develop good relationships with service users in order to enable them to recognise the sometimes subtle signs that someone is experiencing suicidal thoughts or feelings, and provide assistance.

---

18 Office of National Statistics (2015). *Suicides in the United Kingdom 3013: Registrations.* Statistical Bulletin

19 World Health Organisation. Towards Evidence-based suicide prevention programmes. Geneva: WHO; 2010

20 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Annual Report 2015: England, Northern Ireland, Scotland and Wales. Manchester: University of Manchester; 2015

21 Hawton, K., Houston, K., Haw, C., Townsend, E. & Harriss, L. (2003). Comorbidity of Axis I and Axis II Disorders in Patients who attempted Suicide. *The American Journal of Psychiatry, 160 (8),* 1494-1500

22 Hwang, S. W., & Burns, T. (2014). Health interventions for people who are homeless. Lancet (London, England), 384(9953)

23 Fitzpatrick, S., Bramley, G., & Johnsen, S. (2013). Pathways into multiple exclusion homelessness in seven UK cities. *Urban Studies, 50*(1), 148-168.

24 Bickley, H., Kapur, N., Hunt, I. M., Robinson, J., Meehan, J., Parsons, R., Appleby, L. (2006). Suicide in the homeless within 12 months of contact with mental health services. Social Psychiatry and Psychiatric Epidemiology, 41(9), 686-691

25 Hwang & Burns (2014). Health interventions for people who are homeless. Lancet (London, England), 384(9953)

26 http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf

27 Haw, C., Hawton, K., & Casey, D. (2006). Deliberate self-harm patients of no fixed abode: A study of characteristics and subsequent deaths in patients presenting to a general hospital. *Social Psychiatry and Psychiatric Epidemiology, 41*(11), 918-925

What we do

Homeless Link is the national membership charity for organisations working directly with people who become homeless in England. We work to make services better and campaign for policy change that will help end homelessness.

Let's end homelessness together

Homeless Link
2-5 Minories
London EC3N 1BJ

020 7840 4430

www.homeless.org.uk

Twitter: @Homelesslink
Facebook: www.facebook.com/homelesslink