How to get emergency mental health support in a crisis

Supporting people experiencing homelessness with suicidal ideation

In partnership with:

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A client has come to you with suicidal thoughts.

Where it has been possible, you have explored their risk of suicidality using gentle but direct questions, for example:

- *'What kinds of thoughts have you been having?'*
- *'How long have you been having these thoughts? When did they first start?'*
- *'How often are these thoughts happening?'*
- *'Do you have a specific plan?'*
- *'How likely do you think it is that you would act on this?'*

Answers to these questions have been combined with any information you have on their impulsivity, and past mental health and behaviour.

As a result, you think that their risk of attempting suicide is high, and you feel you need the support of health services immediately.

This leaflet focuses on what you can do next to get support from mental health professionals.

First, you should inform the client that you are concerned about their wellbeing and would like to see some specialist support.

Obviously, if someone is in immediate physical danger (e.g. they say they have taken an overdose, or they are threatening to seriously hurt themselves) call the police / ambulance service on 999.

Otherwise:

1. Contact existing services already in contact with the client

If a client is already linked into mental health services, they may have a Care Coordinator or a duty number which you can contact in office hours. If it is out of office hours, they should have been given a phone line to call in a crisis. If you have people linked into mental health services always ask for / find out the mental health service and crisis numbers to keep on record.

If they are not already linked in with mental health services, during office hours you could also contact the client's GP. You may be told there are no appointments, but if you explain the issue is suicidal ideation, they should engage with you on how to get a health response.

2. Contact specialist / crisis services in your area

If a client is not already linked into any services locally, it may be difficult to get a first line mental health response directly from mental health services, but it may not. There are different approaches to first line mental health provision in different areas.

You can use the NHS search facility 'Where to get urgent help for mental health':https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

This facility requires your current postcode to direct you to the local service.

To find other local service provisions you could try a Google search: 'Mental health emergency – your borough / City / area'. This is likely to reveal other first line mental health support lines in your area if they are open access.

In some areas, there are mental health 'crisis cafes', sanctuaries or houses. These are safe spaces with access to non-clinical mental health support and are an alternative to attending A&E. Some operate 24/7, whilst others are after office hours only. They will have different ways to access them, so it is important to find out if there is one local to your service and how it can be accessed (obviously this is better done in advance). People who are already known to services can also access these.

Otherwise, you could also try phoning your local hospital with an A&E, and asking to speak to their on call Psychiatric Liaison team. They may be prepared to speak to you directly, but again, local policies vary.

Top tip: If you are in an area that has a specialist mental health team, it may be possible for you to develop specific pathways for your staff to get expert support and advice for all your homelessness clients. You may want to talk to them about this.

3. NHS 111

NHS 111 is there to deal with mental health emergencies as well as physical health emergencies and should be the next first step if the first two options are not available.

4. Going to A&E

Finally, it may be that you will be left with no alternative, and you will need to send a client to A&E for assessment. This is likely to be quite hard for the client to deal with.

In this case:

1. **Accompany the client, whenever this is possible. It can be hard for any of us to deal with the challenges that attending an Accident and Emergency department may present.**

If this is not possible:

2. Send the client with a detailed letter that gives practitioners all the key information they need. You will probably also want to do this if a person accompanying a client does not know the client well.
3. Prepare the client regarding the specific challenges present in A&E, for example waiting times, stresses and triggers that may present whilst waiting, and zero tolerance policies.
4. Prepare the client for what they can expect in the assessment.
5. Ensure that the client has a way to contact you, and ask them to call you if they are thinking of self-discharging.

What to write in a letter

The amount you write in a letter will obviously depend on the urgency of a person's transfer to A&E, but the more information you can give, the more you will assist your client.

What to include if you can:

- Name(s) of the key workers to contact at the hostel / service.
- Address and contact details of the hostel or support organisation. Give several numbers if the service is difficult to get through to.
- Nature of the hostel and the level of support available there. Mental health professionals make incorrect assumptions about what can reasonably be expected in terms of support.
- Next of Kin details if they are available, and appropriate to give.
- GP details. Although most hospitals will be able to identify in A&E whether someone is registered with a GP, this is not true in all hospitals.
- A description of the behaviours that are causing concern, and in particular anything that is new, and worrying for you and your service.
- Medication list with doses / timings if possible (including Methadone / Subutex), including any evidence you have. For example, if you have a MARS (Medical Administration Record Sheet) you could photocopy this, or photocopy any other records you have.
- Any communication challenges you think the person has with suggested responses. For example, if the person has language or literacy issues, learning difficulties, neurodiversity or cognition challenges, say this, and suggest what helps them to understand.
- Any reasons why you think the person will self-discharge (if this is likely to be an issue) and things that might help. For example, if someone will need to go outside to smoke, but will most likely come back, say this.
- Likely withdrawal time for alcohol and/or drugs and suggested responses.
- Details of any addictions / mental health teams the client is involved with and brief details of their perspective of this support if this is known.
- Details of any other recent attendances / contacts with health services that are known about, particularly if they have been at other services, other than the one you are sending the client to.
- What you think should happen.

A draft letter can be found at the end of this document.

Always keep a copy of the letter. If clients get admitted letters such as these often get lost in transfer yet they will be equally valuable to the admitting teams.

What to say about waiting times

Accident and Emergency waiting times vary depending on the severity of a person's presenting complaint, the number of patients in the department, and the number of relevant staff available, for example staff with mental health training. Waiting times are also unpredictable and can change at very short notice. Clients need to be prepared for this. It can be easy to feel you are being side-lined or discriminated against when waiting, but this is not generally true. At the time of writing the average waiting time for a person to be seen is over three hours.

Difficulties associated with A&E waiting rooms and how to help

Experts by Experience tell us that difficulties associated with waiting in A&Es often result in them self-discharging. Common problems and mitigations are outlined here:

- **Fear** – clients can be very anxious about engaging with healthcare, and worry about the worst case scenario. It is important to let clients know that it is highly unlikely that they will be held against their will (sectioned) if they are going to A&E in a voluntary capacity, and it is quite likely that they will not be admitted to the hospital. Community support may well be recommended. This may help them to feel less fearful.
- **Embarrassment** – in particular, feeling that others are looking at and judging them on account of their appearance / cleanliness can be stressful. If possible, ensure that clients go with sensible / adequate clothing.
- **Alcohol or drug withdrawal OR merely the anticipation of withdrawal symptoms** – people who have experienced physical symptoms of withdrawal will often become anxious if they think they may go into withdrawal. This is an area where your skilled advocacy can make a real difference, either face to face or in a letter.
- **Pain** – there is evidence that pain is a key cause of distress in many homeless clients. Indeed, many clients use alcohol and drugs to mask pain. Being forced to sit down in one place can mean that someone focuses on their pain. If this is likely to be the case, this may again be an area where skilled advocacy will also make a difference.
- **Concerns about property that has been left somewhere** – ensure that if a client is leaving possessions at their hostel, or with you, that they know they are secure.
- **Concerns about a significant other or a dog** – often people experiencing homelessness are in contact with others who are more unwell than them, who they worry about. Clients with pets such as dogs also often believe they have nowhere they can leave them safely, and the pets themselves may not want to be left. If these issues are relevant, you may need to work with the client to develop a clear plan to work around these concerns, and reassure them.

- **Hunger** – if someone is attending for mental health problems, you could ask whether the person wants to take something to eat and drink, or eat something first.
- **Wanting to smoke** – if a client will need to smoke, recommend that they tell A&E staff when they do this, so that staff know they are not leaving.
- **Language and literacy issues** – clients often feel that their reason for attending has not been understood, particularly if they don't speak English as a first language. Other worries include being asked to fill in forms, and not feeling able to admit having literacy issues. Encourage clients to proactively voice their communication difficulties and to ask for support. Sending them with a letter will help.

Zero tolerance policies

A&E services find it hard to be 'trauma informed', and there are many things that may be triggering. These environments are busy, bright, noisy, fast and confrontational, and can generate feelings of disempowerment. In combination with the stressors above, and also due to specific psychological challenges, for example around impulse control, A&E visits can cause clients to lose their temper or even just be quick to raise their voices. They may also use colourful language.

It is important to warn clients that that the NHS has a 'zero-tolerance' policy towards all violence and aggression. This policy is not only for the protection of all NHS staff, but also for the protection of other patients, their families, visitors, etc. What constitutes aggression is open to interpretation, but raised voices and colourful language may result in being removed from a department very quickly. This may feel unfair but will be non-negotiable. Clients need to be aware and prepared to try to voice their frustrations in a calm manner.

What to expect in the assessment

Finally, it will be useful to prepare the client for the kind of questions they will get asked. You will likely have already asked the person about their current mood / state of mind, suicidal thoughts, and about intent or specific plans they have or haven't made, before deciding to send them for emergency assessment. Tell them that you will be sharing this information, to get them assessed by the right person.

However, it is important to tell the client that they will be asked these things again, and they may be asked about other things which may seem less relevant, for example their history of diagnosis and treatment, their support networks, sleep patterns, eating patterns, alcohol and substance misuse, patterns of mood and behaviour over a period of time, culture, beliefs etc.

This is because professionals need this information to make the best judgement about the kind of interventions and treatments that might help a person stay safe. Indeed, it might be useful to say that they are likely to be asked the same questions

repeatedly. This will be because lots of clinical opinions may be required to decide on some courses of action or treatment. This can be very challenging when someone is feeling suicidal, but knowing this will happen can help clients to deal with this.

More information

For more information on how to support people with suicidal ideation, please see the suite of resources available on the Homeless Link website hosted at:

https://homeless.org.uk/knowledge-hub/suicide-prevention-and-postvention

or contact:

info@pathway.org.uk

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Draft letter

Team address
Team contact details
Date

Dear Doctor,

I am referring the following client for mental health assessment:

Name
Date of birth

The reason for referral is:

1. **Description of the behaviours that are causing concern**
2. **Recent attendances /contacts with health services and outcomes**
3. **What you think might need to happen**

I am referring on behalf of the following organisation that supports this client:

1. **Address, phone and email contact details of the hostel or support organisation**
2. **Nature of hostel and the level of support**

The name of the client's keyworker is:

Name(s) of the key worker(s)

Relevant further details for the client are:

1. **Communication challenges**
2. **Next of Kin details**
3. **GP details**
4. **Medication list with doses / timings**
5. **Alcohol / substance misuse issues**
6. **Addictions / mental health teams involved**
7. **Likelihood of self-discharge and mitigations**

Yours faithfully,

Etc etc.