Lost your *happy* place?

A guide for the Western Australian youth sector in responding to young people who are homeless and at risk of suicide

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Youth Affairs Council of Western Australia

Abbreviations

ASIST: *Applied Suicide Intervention Skills Training*
CAP: *Community Action Plan*
CBT: *Cognitive Behavioural Therapy*
CRA: *Community Reinforcement Approach*
LGBTI: *Lesbian, Gay, Bisexual, Transgender and Intersex*
LGBTIQ: *Lesbian, Gay, Bisexual, Transgender, Intersex, Gender Questioning*
NAHA: *National Affordable Housing Agreement*
NPAH: *National Partnership Agreement on Homelessness*
NSPS: *National Suicide Prevention Strategy*
SEI: *Social Enterprise Intervention*
SPI: *Safety Planning Intervention*
STORM: *Skills-based Training on Risk Management*
The Strategy: *Western Australian Suicide Prevention Strategy 2009-2013*
WACHPR: *WA Centre for Health Promotion Research*
YACWA: *Youth Affairs Council of Western Australia*

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Acknowledgements

Executive summary

Throughout Australia, suicide remains the leading cause of death within the 15 to 24 year old age bracket. In Western Australia, 9595 people are homeless every night, 5% of which are young people aged 12 to 24.[1] These statistics reinforce feedback to the Youth Affairs Council of WA (YACWA) from the WA Youth Sector that homelessness and suicide are real and present issues impacting youth and community work practice across WA.

YACWA, through the commission of this report, aims to provide the Western Australian Youth Sector with a useful resource in supporting young people who are homeless, at risk of homelessness and who are also at risk of suicide. The report has been guided by a theory-led and evidence-based approach. This involved a comprehensive review of current research and literature and led by the perspectives from key practitioners and leaders from front-line youth focussed services across Perth. This process identified key local, national and international literature findings and evidence-based approaches to 'what is working' in suicide prevention and intervention. In addition, the report also provides comprehensive e-links to many relevant web-based resources with the aim to encourage integration by practitioners and agencies with the goal to further guide their thinking.

It is acknowledged that the task of bringing this material together in one document has been somewhat challenging. One of the main challenges is the absence of specific literature outlining ways of working with young homeless people who are at risk of suicide. What was apparent was that there was evidence that described ways of working with young homeless people and unconnected evidence of ways of working with people at risk of suicide. Synergies within the evidence base

have been aligned through the research process and reference group expertise, consequently, guiding the identification of best practice principles for working with young homeless people at risk of suicide.

The findings of this report and its recommendations need to be interpreted with reference to the individual young person's circumstance, as young homeless people do not represent a homogenous group. There will be unique differences based upon age, experience, sexuality, ethnicity, family supports, social supports, geographic location, substance use, mental health issues and a range of other dimensions. Likewise, Youth Service Providers in WA are also not a homogenous group and have unique strengths premised upon their areas of expertise.

The main findings from the literature review, guidance from the expert reference group and service provider interviews suggest that:

- Young people are over-represented in Australia's homelessness and suicide statistics;
- Young homeless people have many risk factors for suicide and fewer protective factors, placing them at high risk of suicide;
- There is a lack of current suicide prevention research amongst young homeless people;
- There are barriers to connecting young homeless people to mental health services;
- A range of theories and models underpin practice approaches in the sector with the majority adopting a client-centred and strengths-based approach;
- Addressing suicide from a recovery perspective provides insight into the young person's journey, promotes their independence and helps to build resilience;
- Suicide prevention training is one of the best strategies that Youth Service Providers can participate in to improve their response to suicide; and
- Responding to suicide is challenging. Hence, Youth Workers need to be supported to develop professionally through training, appropriate internal and/or external supervision and organisational supports so as to maintain their own resilience.

Based upon these findings, the following recommendations have been developed for Youth Service Providers working with young homeless people at risk of suicide. It is suggested that they be considered for integration into Youth Service Providers' own aims and operational thinking. Organisational and managerial leadership in driving these initiatives is integral in effective service integration.

Recommendation 1

All Youth Service Providers have current policies and procedures that provide clear direction to all staff working with young people at risk of suicide.

Recommendation 2

Procedures be developed, under Recommendation 1, incorporating a response protocol based on responding to young homeless person at risk of suicide through the following three steps:

1. *Recognise the warning signs*
2. *Ask 'the question' and listen*
3. *Connect to support*

Recommendation 3

Youth Service Providers have in place protocols whereby a safety plan is negotiated for young homeless people at risk of suicide. The development of this safety plan should be grounded in a client-centred, strengths-based approach and incorporate:

- *Internal coping strategies*
- *Social distractions*
- *Assistive social supports*
- *Accessing professional support for assistance*
- *Removing access to means of suicide*
- *Include and consider the views of the client*
- *A follow-up agreement*

Recommendation 4

Youth Service Providers ensure that support services for Youth Workers dealing with young people at risk of suicide are in place and consider:

- *Need for ongoing professional development, including suicide prevention training*
- *Need for supervision that is either provided internally and/or externally*
- *Support personal well-being after dealing with a crisis situation*

Recommendation 5

That Youth Service Providers across the youth, homelessness and mental health sectors work more collaboratively, allowing for stronger referral pathways as well as more efficient use of resources.

Recommendation 6

That further Western Australian research is required to better articulate the size of the problem, effectiveness of early intervention and prevention programs and to provide a more in-depth evidence base to guide best practice in the area.

A note on working with people from different cultural backgrounds

It is acknowledged that the recommendations described in this report may not be appropriate for use when working with all young people. Young Aboriginal people and people from Culturally and Linguistically Diverse (CaLD) backgrounds are over-represented within the homeless population. It is recommended that additional training is undertaken to be able to adapt these practice guidelines to meet the needs of these young people in a culturally appropriate manner.

To find out more, visit the training section of this website
www.yacwa.org.au/youthworkertoolkit/suicide-prevention

2.0 Background to the project

This project was developed by YACWA in response to the high rate of suicidal behaviours amongst homeless young people (aged 12 to 25 years) and qualitative data collected as part of a youth sector survey in 2012. YACWA's Homeless Youth Suicide Prevention Project is a Community Action Plan (CAP) under the WA Suicide Prevention Strategy (One Life). Key outcomes that YACWA has sought to achieve through this Homeless Youth Suicide Prevention Project are to identify best practice principles and useful sector focused resources and tools, through theory-driven and practice-led approach. The Western Australian Centre for Health Promotion Research (WACHPR) was commissioned by YACWA to identify best practice principles for Youth Service Providers responding to the needs of young homeless people at risk of suicide within the Perth metropolitan area.

This report includes the findings from a literature review and information gained through consultation with a number of Youth Service Providers located in the Perth metropolitan region. The outcomes of the consultations are described in Section 12, Supporting Youth Workers and Section 15, Service provider perspectives. The outcomes of this report will help identify best practice principles for Youth Service Providers who work with homeless young people at risk of suicide in WA.

As part of the literature review, a database search was undertaken for articles published between 2008 and 2013 relating to suicide, young homeless people and service delivery. Electronic databases were searched including Medline, Embase, PsycInfo, Informit, Proquest, Trove, Cochrane Library and Web of Knowledge. Literature was also obtained from government websites, Google scholar, clearing houses, relevant organisational websites and hand searching. Key words used included a combination of ('self-harm' OR suicide OR 'mental health'), '(youth homelessness' OR 'homeless young people' OR 'homeless youth'), (service delivery' OR 'intervention' OR 'service provision), (model OR theory OR frameworks OR 'recovery model') and ('Social Worker' or 'Youth Worker').

The findings of this report were constrained by the lack of reported research into suicide prevention in young homeless populations, both internationally and within the Australian context. The majority of evidence identified is from Australia, the United States and the United Kingdom. There are limitations resulting from a lack of generalisability of suicide prevention strategies for this demographic as identified in the literature. Homeless young people are a diverse group, and what has proven effective in one population group may not be effective in another. Studies have shown significant differences between young homeless people across countries [2] and therefore where available, Australian data has been focussed upon.

This report begins by setting the scene on homelessness and suicide amongst young people. It will then present a discussion on the literature relating to suicide prevention and service delivery. Findings from interviews with Perth based Youth Service Providers will be outlined, providing insight into the current responses to suicide prevention efforts with homeless young people within the Perth metropolitan area. Throughout the report, resources that support suicide prevention efforts will be incorporated. Lastly, recommendations will be presented, taking into account the findings from the literature review as well as current practices and initiatives within the sector.

3.0 *Setting the scene: Homelessness and young people*

Youth homelessness does not involve a particular type of young person but a process of events that happen in a young person's life.[3]

A person is defined as homeless when they do not have access to one or more of the elements that constitutes home. These elements include a sense of security, stability, privacy, safety and the ability to control living space.[4] The most recent data from the 2011 Census illustrated that there were 105,237 people experiencing homelessness across Australia, this is an increase of 15% from 2006.[5] Approximately 25% (26,238) of homeless people on Census night were between the ages of 12 and 24. In Western Australia, 9,595 people are homeless on a given night and 25% (2,280) of these people are between the ages of 12 and 24 (see Figure 1.0). Due to the nature of Census data collection methodology these figures are likely to be significantly underreported.[5]

Figure 1.0 *Number of homeless people in WA on Census night 2011 by age group*
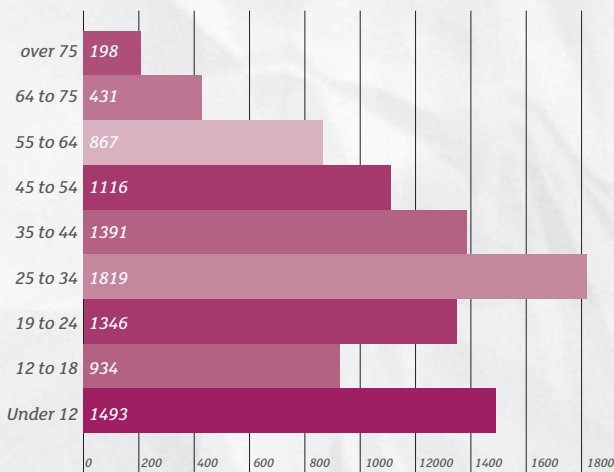
The main risk factors for homelessness are family conflict (including abuse and neglect), economic hardship, poor mental health and problems with substance misuse.[3] Certain groups of people are over-represented in the young homeless population including those who have been in state care facilities,[3] Aboriginal people,[3] refugees and recent arrivals to Australia.[6] It is thought that young people who are Lesbian, Gay, Bisexual, Transgender, Intersex, Gender Questioning (LGBTIQ) are also overrepresented in the homeless population as being LGBTIQ is recognised as a main pathway into homelessness, however homelessness data does not capture this information.[7]

Young homeless people experience higher levels of physical and mental illness and considerably higher levels of mortality than other young people.[8-10] Young people who are homeless are more likely to be victimised and experience violence,[3, 11] engage in harmful behaviours such as alcohol abuse, drug use and sexual risk taking.[3, 12] Homeless young people are often disengaged with usual social support structures such as schools, employment, family units, services and programs.[13-15]

4.0 *Setting the scene: Suicide and young people*

Box 1:
Definitions

Due to the complex nature of the behaviours surrounding suicide, there are a number of different terms used in the literature. For the purposes of this report, the terms used have been aligned with the Living Is For Everyone (LIFE) Framework[14] and with Suicide Prevention Australia.[16]

Suicidal ideation:
Thoughts of taking one's own life. Suicidal ideation varies in severity depending on intent and specificity of suicidal plans.

Suicidal behaviours:
Any actions or thoughts related to suicide. This includes self-harm with suicidal intent, suicidal ideation and suicide attempts.

Suicide:
Is the intentional act of taking one's own life.

Self-harming:
The non-fatal, intentional act of harming oneself without suicidal intent.

Suicide attempt:
The intentional act of trying to take one's own life.

In 2011, suicide was the 15th leading cause of death in Australia, accounting for 2,273 deaths.[17] Overall deaths from suicide have been declining from 12.7 deaths per 100,000 in 2001 to 9.9 per 100,000 in 2011.[17] This decline has been attributed to suicide prevention initiatives in Australia that began in the mid 1990s.[14] Although suicide accounts for a relatively small percentage (1.5%) of overall deaths in the whole population, it was the leading cause of death among young people aged 15 to 24, accounting for 26% of all deaths in this age group.[18] This was followed by car related transport accidents, (14%), and events of undetermined intent, (5%).[18] Young males were 2.5 times more likely to die from suicide than females.[18] These recent figures should be interpreted with caution as they are likely to represent an underestimation due to challenges associated with reporting deaths as suicide. To classify a death as suicide, the coroner must be able to confirm suicidal intent; this can be difficult especially with deaths from drug overdoses and single vehicle car accidents.[18] Furthermore, deaths that have not yet been coded by the coroner at the time of reporting are classed as an event of undetermined intent.[19]

Currently, there are no reliable figures that illustrate the level of suicide amongst homeless young people in Australia. The report entitled Before it's too late: Report on the inquiry into early intervention programs aimed at reducing youth suicide highlighted the need for collecting more social and demographic data on suicide, the Australian Government indicated in its response that this is not likely to occur in the foreseeable future.[20] This makes it challenging to be able to determine the true extent of the problem within this group and to advocate from greater investment in prevention strategies.

Box 2:
A word on self-harm

Differentiating between self-harming behaviours with and without suicidal intent is challenging.[21] Recent studies suggest that the differences can be determined through intent, rate of reoccurrence and the degree of lethality, however, different types of self-harming behaviours can coexist in an individual.[15] While most acts of self-harm are generally not intended as an attempt to end one's life, a previous incident of deliberate self-harm is the strongest predictor of a completed suicide and the risk for accidental death can be high.[1, 22] Consequently, all self-harming behaviours should be taken seriously.

This report acknowledges the shared characteristics of self-harm and suicide, but understands that they are two very different issues that require separate responses from Youth Service Providers. This report does not attempt to address self-harm, other than to acknowledge the overlapping nature of suicide and self-harm.

5.0 Setting the scene: Homelessness and suicide policy

The Australian Government recognises the complex nature of suicide and has taken a broad approach to suicide prevention.[23] Suicide prevention is addressed in a number of policy areas outside of mental health including education, employment, community welfare, family and housing.[20]

Homelessness policy in Australia

The existing Australian government response to homelessness is informed by the White Paper on homelessness.[24] This White Paper entitled The Road Home: A National Approach to Reducing Homelessness set two ambitious goals to be achieved by 2020. These goals include halving overall homelessness and offering supported accommodation to all rough sleepers who need it.

To achieve these goals three key approaches were outlined;
- Turn off the tap: Develop evidence-based prevention and intervention strategies that reduce the burden of homelessness
- Improving and expanding services: Address both mainstream services and specialist services so that people experiencing homelessness can seamlessly receive the services they need
- Breaking the cycle: Some people cycle in and out of homelessness for extended periods of time. Services need to meet people's requirements in new and innovative ways in order to break the cycle of homelessness.

The strategic initiatives outlined in the White Paper are implemented through the National Affordable Housing Agreement (NAHA) and associated national partnership agreements. The NAHA came into effect in 2009, following the 2003 Commonwealth State Housing Agreement and is an agreement between the Commonwealth, the States and the Territories to ensure that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation.[25] The NAHA outlines expectations and roles of the Commonwealth, the States and the Territories to improve programs and services that address housing and homelessness and to address the issue of social inclusion.[25]

A range of National Partnership Agreements have been developed to support the NAHA including the $1.1 billion National Partnership Agreement on Homelessness (NPAH). This agreement was developed in 2009 to address the NAHA outcome that individuals who are experiencing, or are at risk of, homelessness have access to sustainable housing and to enhance social inclusion. This agreement expired on June 30, 2013 and a Transitional National Partnership Agreement on Homelessness has been agreed upon until June 30, 2014 while a new longer term response to homelessness is finalised.[26] The Transitional National Partnership Agreement on Homelessness will continue to work toward the goals outlined in the White Paper on homelessness.[26]

In Western Australia, The Department of Child Protection and Family Support is responsible for the coordination and implementation of the NPAH. As part of this, the Department of Child Protection and Family Support has engaged with government agencies and 71 not-for-profit organisations to deliver 20 programs across WA.[27] These programs target a range of population groups, including young people, and aim to reduce homelessness by focusing on early intervention and increasing integrated service delivery.

For a full overview on the progress of the NPAH in Western Australia and related programs see the Western Australian Auditor General's Report available at **audit.wa.gov.au/wp-content/uploads/2013/05/report2012_13.pdf**

Suicide prevention policy and frameworks in Australia and Western Australia

The National Suicide Prevention Strategy (NSPS) has been operational since 1999 and is funded by the National Action Plan on Mental Health.[23] The NSPS guides suicide prevention policy across Australia.[23] The NSPS focuses on the promotion, prevention and early intervention of suicide.[23] Living is for Everybody (LIFE) Framework is part of the NSPS and provides a strategic framework for suicide prevention in Australia and outlines the type of suicide prevention strategies that are required to reduce the incidence of suicide.[14] These prevention strategies exist on a continuum and range from whole population strategies such as education, to indicated interventions for vulnerable individuals, to ongoing treatment and support for those in recovery.[14]

For an overview of the Living is for Everybody (LIFE) Framework and the continuum of suicide prevention activities visit **www.livingisforeveryone.com.au/life-framework.html** and for more information on the NSPS visit **www.health.gov.au/internet/main/Publishing.nsf/Content/mental-nspss**

The Mental Health Commission provides governance and support in the delivery of mental health services and the promotion of mental wellbeing to organisations and government department across Western Australia, including to the Department of Health.[28] The Mental Health Commission is leading mental health reform and is overseeing the implementation of Mental Health 2020 Strategic Policy. To allow for greater integration of mental health and drug and alcohol prevention and treatment services the Drug and Alcohol Office will be merged with the Mental Health Commission in 2014.

The objectives of the Mental Health Commission are to provide:
- person-centred services that support recovery
- connected whole of government and community approaches
- a balanced investment in new priorities [28]

The Western Australian Suicide Prevention Strategy 2009-2013 (The Strategy) is aligned with the Living is for Everybody (LIFE) Framework.[14] It is funded by the Mental Health Commission and led by the Ministerial Council for Suicide Prevention. The Strategy provides a framework to direct suicide initiatives in Western Australia. The Strategy has six key action areas that are actioned through local Community Action Plans (CAPs). These CAPs will work towards decreasing both suicide and suicide attempts across the population.[29]

The six action areas are:
- Improve the evidence base and understanding suicide prevention
- Building individual resilience and the capacity for self-help
- Improving community strength, resilience and capacity in suicide prevention
- Taking a coordinated approach to suicide prevention
- Providing targeted suicide prevention activities
- Implementing standards and quality in suicide prevention

YACWA's Homeless Youth Suicide Prevention Project is a CAP that has focussed upon improving the evidence base and understanding suicide prevention, improving community strength, resilience and capacity in suicide prevention whilst taking a coordinated approach to suicide prevention. In addition to this, the following literature review and sector consultation seeks to identify best practice standards and quality in suicide prevention in relation to young people and the Youth Sector in WA.

6.0 Risk factors, protective factors and warning signs

Mental illness is a major risk factor for suicide and an episode of psychological distress is frequently the 'tipping point' to an act of suicide.[20]

The reasons why people become suicidal are unclear. There are particular risk and protective factors that may influence the likelihood of a person engaging in suicidal behaviour.[1] Common aspects can include the desire to escape pain or emotions associated with hopelessness and ambivalence.[30] Suicide often results from a combination of a number of risk factors that are complex and intertwined (see Figure 2.0).

Providing an overview of the unique risk and protective factors for suicide in homeless young people will assist in developing a thorough understanding and the subsequent development of suicide prevention initiatives within this group. However, risk factors should be interpreted with caution as they continually change and do not provide information about an individual or their definitive risk of suicide.[30] The evidence presented in Table 1.0 provides a brief overview of some of the individual, social and structural risk factors for suicide in homeless young people that have been identified in the literature. Table 1.0 illustrates that homeless young people experience many of the risk factors associated with suicide, which increases their vulnerability and highlights the importance of increasing suicide prevention efforts within this marginalised group.

Figure 2.0 Risk factors for suicide in young people who are homeless

Indiviudal
Mental illness, history of self-harm or suicide attempt, substance use, genetics, Aboriginal LGBTI*, CaLD**

Social
Homelessness, exposure to stressors, contagion, statutory care, history of family abuse or conflict

Structural
Unemployment, economic insecurity, poverty, lack of access to support services
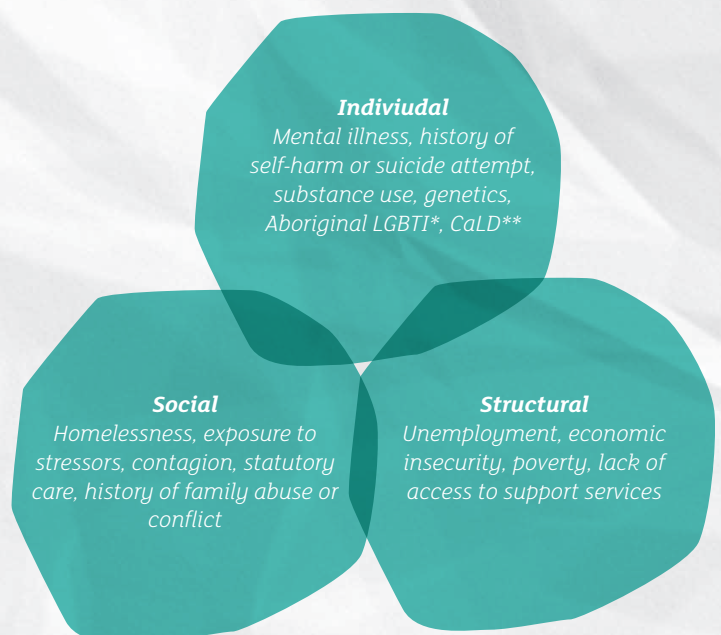
Table 1.0 *Risk factors for suicide in young people who are homeless*

Individual

Mental illness	The single largest risk factor for suicide is mental illness.[20] Young people who are homeless are far more likely to experience mental illnesses when compared to other young people.[9] A person's mental disorder can be made worse by homelessness and homelessness itself can be a cause of mental health disorders.[31]
History of self-harm or a suicide attempt	A previous incident of deliberate self-harm is one of the strongest risk factors for suicide.[22] In a study by Rossiter et al[31] it was found that 37% of young Australian homeless people had attempted suicide at some point and 36% had self-harmed within the previous three months.[31]
LGBTI (Lesbian, Gay, Bisexual, Transgender, or Intersex)	Young homeless people who identify as LGBTI are more likely to self-harm or attempt suicide than those who do not.[32, 33] Therefore, young homeless people who are LGBTI face a higher suicide risk burden than those who are not.[34]
Substance abuse/misuse	Suicide is more common in people who engage in drug and alcohol abuse.[35] A large proportion of young homeless Australians consume alcohol at risky levels, engage in injecting drug use and frequently use marijuana.[31] Over 50% of young homeless people feel dependant on the drugs or alcohol they use.[31]
Being Aboriginal	People who identify as Aboriginal are 10 times more likely to experience homelessness.[3] Young Aboriginal men are over three times more likely to commit suicide than non-Aboriginal men.[29]
Being from a non-English speaking background	People from non-English speaking or CaLD backgrounds, are close to six times more likely to experience homelessness than the general Australian population.[3] Furthermore, people who have migrated to Australia, particularly those from a non-English speaking background are at higher risk of suicide.[29]
Genetics	There is a strong link between genetic factors and suicide risk.[36, 37] Genetic factors can increase the likelihood of a person developing depression and how they respond to stress which impacts on suicide risk.[37]

Social

Homelessness	A person experiencing homelessness is at increased risk of suicide.[38, 39] Studies have shown that the risk of suicide in young homeless people is intensified due to the high stress environment in which they live.[9, 39]
Exposure to stressors	Homeless young people experience significantly higher levels of life stressors than other young people.[32] Common life stressors for homeless young people include abuse, criminal activity, substance abuse/misuse and engaging in survival sex.[32, 40]
Previously in care	Young people who have been in care such as foster care or the juvenile justice system, are significantly more likely to experience homelessness and to attempt suicide than other young people.[3, 40]
Abuse and conflict	Many young homeless people have experienced abuse and conflict, often within the family home. This contributes to both homelessness and suicide risk.[32, 41]
Contagion	Young people who lose a friend to suicide are at increased risk of attempting suicide, having suicidal thoughts and experiencing higher levels of depression.[42, 43]

Structural

Unemployment, economic insecurity or poverty	Many homeless young people in Australia lack a reliable source of income and experience poverty and barriers to gaining employment.[3, 11, 31] Suicide amongst young people is higher in low socio-economic areas.[44]
Lack of access to support services	Accessing support services is a fundamental aspect of suicide prevention efforts.[45] However, only 62% of young homeless people access mental health services when required.[31]

Suicide prevention and intervention efforts with young people who are experiencing homelessness should draw upon protective factors as well as an understanding of risk factors.[46] Protective factors reduce the likelihood of a person engaging in suicidal behaviours as they increase the person's capacity to manage life's challenges.[1] A number of studies have described drawing upon protective factors to enhance resiliency against suicide in homeless young people. A young person is resilient when they have the ability to cope successfully in the face of adversity.[47]

Resilience is dynamic and changes to reflect the context of the environment and the experiences of the individual.[48] Resilience includes factors such as self-esteem, coping, social connectedness and a sense of control.[8] Taking a strength-based approach to suicide prevention promotes the development of the factors associated with resilience. Table 2.0 outlines key factors that may demonstrate a protective effect against suicidal behaviours.

Table 2.0 Individual protective factors

Individual protective factors

Resilience	A young person who demonstrates resilience is less likely to engage in suicidal behaviours.[8] Despite poor mental health status and exposure to trauma, homeless young people exhibit moderate levels of resilience.[46] Resilience levels decrease the longer a young person is homeless.[8]
Social support and connectedness	Homeless young people are often stigmatised by society, peers and services and disconnected from family.[31, 49] Conversely, they may also have a strong group of peers.[50] While these groups of peers may consist of other homeless young people in complex life circumstances, they can also act as a valuable source of social support and connectedness.[49]
Sense of control	Homeless young people who have a sense of control over their life circumstances often demonstrate a strong commitment to making positive changes in their life.[51]
Self-esteem	Self-esteem is a factor of resilience that has shown to be a protective factor against loneliness, fearful attachment and suicide ideation.[52] Young people with moderate to high levels of self-esteem are less likely to engage in suicidal behaviours.[38, 46]
Positive coping strategies	Positive coping styles such as believing in the existence of a better future have been linked to decreased suicidally.[47] Maladaptive coping mechanisms such as social isolation, are associated with increased self-harming behaviours and loneliness.[48, 53]

When a young person is contemplating suicide, there are often noticeable changes in their behaviour that indicate they are at risk. These changes are called warning signs. Warning signs are different from risk factors as they relate to what is happening for that young person in the present moment.[54] Warning signs are more effective than risk factors at identifying those at risk of suicide.[30] This is because they are visible signs that indicate a person may be at risk of suicide within the short term, whereas risk factors are useful at indicating those at risk in the longer term.[30] For more information on warning signs refer to Section 13 of this report.

To understand more about risk and protective factors in the general population read the factsheet developed as part of the National Suicide Prevention Strategy **www.livingisforeveryone.com. au/Individual-fact-sheets.html**

7.0 *Suicide prevention*

Despite considerable research into suicide prevention, the evidence base does little to identify a clear and definitive approach to preventing suicide amongst homelessness population.[55] While it is clear that more evidence demonstrating the effectiveness of particular approaches in reducing suicide is needed, many studies have been unable to demonstrate such effects.[56] It has been suggested that research efforts should focus on the reduction of risk factors associated with suicide. This is because there is a growing evidence base for suicide prevention efforts that focus upon the reduction of suicide risk factors such as treatment uptake, depression and self-harming behaviours.[56] A number of strategies, described below, have demonstrated effectiveness in reducing suicide in the broader population.

Education

General awareness raising public health campaigns advocating for suicide prevention have shown moderate effectiveness on improving attitudes towards suicide. However, limited evidence exists to suggest that they can elicit a reduction in suicidal behaviours.[57, 58] Targeted suicide intervention training such as gatekeeper and Applied Suicide Intervention Skills training (ASIST), described in detail in Section 10, have demonstrated contextual positive outcomes.[55]

Screening

Screening individuals for risk of suicide or depression and directing them to appropriate treatment services has been shown to result in increases in treatment for depression as well as decreases in suicide rates.[57, 59] Debate exists upon how to accurately identify individuals at risk of suicide. Current evidence suggests a movement away from standardised risk assessment tools that characterise people as low, medium or high risk, to an approach that involves gathering a comprehensive picture of the unique individual and tailoring an approach that meets their needs.[60]

Reduce access to means

Reducing access to lethal means such as guns and poisons has shown to reduce suicide rates.[39, 57] This approach does not always see a reduction in overall suicide as a substitution of a method may occur. Nevertheless, reducing access to means has been shown to be one of the most effective suicide prevention strategies available.[57]

Clinical interventions

Clinical interventions including Cognitive Behavioural Therapy (CBT) and medications such as anti-depressants have demonstrated promise in eliciting reductions in suicide.[57, 61, 62] However, clear links between other clinical interventions and suicide reductions have not been established.[30, 61, 63] Providing information on clinical interventions is outside the scope of this report. To find out more about the evidence for clinical interventions for suicide and mental health disorders visit **www.griffith.edu.au/health/australian-institute-suicide-research-prevention**, **http://www.headspace.org.au/what-works/evidence-maps**, **http://www.thelancet.com/series/suicide**, **http://www.livingisforeveryone.com.au/Research-**

and-evidence-in-suicide-prevention.html or **https://www.sane.org/information/research**

Follow-up care

Increasing support provided by health services to at risk groups, in particular through the provision of follow-up care is thought to decrease suicide re-attempts and encourage treatment compliance.[39, 57, 64, 65] Follow-up contact should be provided on a long term basis and at regular intervals.[66] Service providers should provide follow-up contact in a positive, empathetic and personal way.[66]

Crisis lines

Crisis lines have demonstrated effectiveness in reducing suicide rates and suicide related feelings in callers.[66] Suicide specific training can improve call centre operators response to people at risk of suicide resulting in reductions in feelings of depression and suicide ideation.[67]

For a list of crisis lines suitable for young people visit **www.yacwa.org.au/youthworkertoolkit/suicide-prevention** and search emergency services. YACWA's Pling app is available for Apple and Android devices.

School based interventions

School based suicide prevention efforts have shown to increase suicide related knowledge and diversionary skills.[55] However, evidence of the efficacy in reducing suicide rates varies between studies.[55, 66] Interventions that trained school staff in suicide prevention demonstrated the greatest impact on suicide rates in this age group.[66]

For more information on suicide prevention in schools visit **http://www.mindmatters.edu.au**

http://www.beyondblue.org.au/resources/schools-and-universities/secondary-schools-and-tertiary or **http://www.headspace.org.au/what-works/school-support**

Responsible coverage of suicide in the media

Evidence shows that media reporting of a suicide can lead to increased suicide rates.[68] Changes towards responsible reporting of suicide in the media have seen a reduction in suicide related behaviours.[68]

For more information on appropriate ways of communicating and reporting in relation to suicide visit **http://www.mindframe-media.info**

8.0 Improving the mental health of young homeless people

Specific intervention studies that focused on suicide prevention in young homeless people were lacking in the literature. However, seven intervention studies were identified that had mental health related outcomes and will be discussed in this section. A summary of these studies is provided in Appendix A. Four of these studies were specifically mental health focused.[70-73] The remaining three had both a mental health and substance misuse focus.[74-76] Due to the small sample sizes and heterogeneity between these interventions, it is concluded that there is no compelling evidence linking specific strategies to positive outcomes in the mental health of homeless young people. However, what these studies do demonstrate is that the mental health of homeless young people can be improved through targeted interventions.

Two studies utilised a Community Reinforcement Approach (CRA) with the aim of decreasing alcohol and drug use and improving mental health outcomes in homeless young people.[74, 75] The CRA is primarily employed with problem users of alcohol and other drugs and is based on the understanding that aspects of a person's environment can influence behaviour. CRA works with an individual to substitute aspects of the environment that have supported the use of alcohol and or other drugs with aspects that support recovery. The positive impact of CRA therapy on both substance use and mental health that were reported in these studies, suggest that CRA may be effective in supporting homeless young people with co-occurring substance use and mental health issues. These findings are supported by Barker et al[77] who concluded that integrating the treatment of co-occurring alcohol and other drugs with mental health issues is more effective than treating each in isolation.

Alternatively, other intervention studies that had been explored identified Cognitive Behaviour Therapy (CBT) as an effective option in treating several suicide risk factors.[72, 73] This skills based treatment centres on restructuring thinking patterns that are linked to thoughts and beliefs that are maladaptive.[78] Hyun et al[72]

reported that depression decreased and self-efficacy increased significantly through CBT. In addition to this, Taylor et al[73] reported that a range of mental health issues improved including depressed mood and levels of aggression with the integration of CBT. Interestingly, CBT also significantly decreased self-harming behaviours. These reductions in self-harming behaviours through CBT interventions have not been replicated in other interventions aimed at young people.[78] However, CBT has been shown to be effective in treating depression and generalised anxiety in young people, two key risk factors for suicide.[78]

McCay et al[70] and Stewart et al[76] suggested that intervention studies utilising social support may be of benefit to suicide interventions.[70, 76] Stewart et al[76] developed a network of peers and professionals for young homeless people to interact with. This resulted in improvements being exhibited in emotional and mental well-being, decreased loneliness, support-seeking and coping.[76] McCay et al[70] developed relationship-based group sessions to increase social support as well as a range of other emotional factors including positive self-concept, resilience and self-determination, which consequently reported increased levels of social connectedness and decreased hopelessness. The study undertaken by McCay et al[70] however, suggests no statistically significant difference was reported in resilience, self-esteem or mental health symptoms.

Another model identified during the literature review is that of a Social Enterprise Intervention (SEI) model which was implemented by Ferguson and Xie.[71] SEI aims to improve the mental health status and a variety of other outcomes for young homeless people through supporting engagement with vocational programs that provided mentoring, employment training, clinical services referral and harm reduction strategies. Ferguson and Xie[71] reported decreased depressive symptoms and increased life satisfaction, family contact and peer support as a result of utilising this model.

9.0 *Taking a recovery orientated approach*

The recovery orientated approach to mental health is a shift away from the view of treating illness, toward promoting individual strengths and well-being.[79] The recovery orientated approach has been informed through the lived experiences of people that demonstrate the ability of people who experience mental illness to rebuild their lives.[80] Although the recovery orientated approach is widely endorsed in the literature, many mental health services are yet to genuinely adopt a recovery oriented approach.[80]

There are key differences between the traditional approach to mental illness and a recovery-oriented approach. The most significant is that recovery acknowledges that symptom improvement is important, but the central focus is on creating a life with meaning and purpose as defined by the individual.[79] As the process of recovery lies with the individual, the role of service providers is to offer support to the person as they move towards recovery.[81]

Currently in Australia, the majority of Youth Workers take a strengths-based approach and centre their work around the individual young person's needs.[82] This commitment to client-centred care is reflected in YACWA's & The Western Australian Association of Youth Workers' (WAAYW), Youth Work Code of Ethics which encourages Youth Workers to operate on the assumption that young people are competent in assessing and acting on their interests.[83] This approach reflects aspects of recovery.

While recovery from a mental illness perspective is discussed frequently in the literature, there is a lack of evidence on recovery from the perspective of a suicidal young person or a person experiencing homelessness. One article was identified which developed a recovery model through exploring the experiences of a group of young people aged between 18 to 25 years with a history of repeated suicide attempts.[84]

Bergmans et al's[84] recovery model describes the transition away from suicidal behaviours and is based upon a journey that incorporates three key phases (see Figure 3.0). The first phase is living to die, where death is seen as desirable for a number of reasons including to provide relief from a painful existence, as a cry for help or as a way to fulfil a promise to one's self. The second is ambivalence and turning points. Ambivalence begins when a young person moves away from living to die and towards being uncertain about both living and dying. What helped young people through these periods of uncertainty were turning points that brought about an increase in self-awareness. Turning points are drawn from individual experience, indicating that what elicits a change in behaviour is unique to each person. The third is pockets of recovery, where drawing on personal strengths unique to each individual supported the road to choosing life, and hence, the road to recovery. This process is undertaken through small steps. It is important to note that the young people in this study progressed through these stages in a non-linear fashion, cycling back in and out depending on life circumstances. It is to be acknowledged that this is part of the recovery process and is not to be interpreted as moving backwards.[84]

Figure 3.0 *Three phases of recovery for young people with repeated suicide attempts*

Living to die ⋯ **Ambivalence and turning points** ⋯ **Pockets of recovery**

Source: Adapted from Bergmans et al[84]

The following are factors of relevance for Youth Service Providers working with suicidal young people as identified by Bergmans et al's[84] study:

Helpful staff: Young people who experienced suicidal thoughts or behaviours identified professionals as being helpful if they were open and honest, able to listen, understanding and consistent.[84] This links back to the principles of practice for working with young homeless people outlined in Table 3.0.

Talk openly about suicide and validate emotions: The evidence explored[84] emphasised the importance of talking openly about suicide, as it is the most important aspect of the young person's life at that point in time. Service providers need to validate

the young person's emotions including the young person's experiences with death and their fear of the future.[84] Understanding ambivalence: The evidence reviewed explained that service providers must understand ambivalence as an opportunity for increased self-awareness and as an essential step in the road towards recovery. Service providers should allow for discussion around the individuals connection with death and for the reasons for living thus assisting them to move toward choosing life.[84]

Self-care: The evidence reviewed highlighted the difficult and stressful task that service providers have in dealing with young people at risk of suicide and recommended that access to appropriate support and guidance is essential.[84]

Box 5:
Peer support and recovery

Peer support is based on mutuality and a shared journey of discovery within which people help and support each other as equals, share their personal stories, teach, learn and grow together. This is a relationship that empowers each to grow within and beyond what has happened and to find a new sense of self, meaning, value and purpose in life.[85]

Peer based initiatives including peer support enhance young people's skills, self-efficacy and confidence.[86] Providing a young person with the skills to support their peers, not only enhances their self-esteem, but also the self-esteem of the young person they are supporting.[86] Programs that address peer support in young homeless people have not been well researched and there does not appear to be any literature describing the impact of peer support on suicidal behaviours. Young people experiencing mental health issues however prefer to utilise informal supports such a family and peers over professional supports[87] and that being connected to positive and supportive peers promotes healthy development.[88] It makes sense that promoting and fostering positive connections between young homeless people and peer supports would elicit a beneficial effect on mental health outcomes and potentially suicidal behaviours.

Peer support has an important role to play in supporting people through recovery. A fundamental aspect of the recovery process is establishing connections with others and many individuals describe the important role that connecting with others played in their personal recovery.[89] The key principles of peer support from a recovery perspective as described by Ashcraft and Johnson[90] are below:

- **Mutuality:** *Giving and receiving help and support with respect based on a shared experience.*
- **Empathy:** *Understanding through the personal experience of having "been there."*
- **Engagement:** *Sharing personal recovery experiences. "If she/he can do it, so can I."*
- **Wellness:** *Focusing on each person's strengths and wellness.*
- **Friendship:** *Promoting recovery through relationship and friendship.*

Internationally, there is a movement to promote recovery in mental health services through utilising peer support workers in service delivery.[91] These peer support workers would be people who have personally experienced mental health problems. Their peer support role would facilitate their personal recovery and enable them to share their lived experience to support the recovery of others.[91]

*To learn more about peer support and mental health visit **www.together-uk.org/about-us/peer-support***

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*To support a young person on the road to recovery, it is important to understand how identity and meaning is constructed for each individual. The document Identity and meaning in the lives of vulnerable young people provides further insight into factors that support positive identity and meaning. To read it visit **www.acu.edu.au/about_acu/faculties,_ institutes_and_centres/centres/ institute_of_child_protection_studies/ our_work/practice_series***

*To understand how to support recovery from a service provider perspective see https:// www.sane.org/suicide-prevention-and-recovery-guide, **www.mhrecovery.com**, **www.mentalhealthrecovery.com/ recovery-resources/documents/100_ ways_to_support_recovery1.pdf**, **www.centreformentalhealth.org.uk/ recovery/recovery_into_practice.aspx**, or **www.gpnsw.com.au/__data/assets/ pdf_file/0016/3625/110712_res_Glover-careplan_process.pdf***

10.0 *Suicide prevention training*

People who work with individuals at risk of suicide must have appropriate training to be able to respond effectively in a crisis to ensure the best possible outcome for the suicidal person.[83]

Suicide prevention training for professionals and community members is a fundamental aspect of suicide prevention efforts. Gatekeeper training is a widely used type of suicide prevention training and teaches those who may come into contact with individuals at risk of suicide to be able to identify the warning signs, assess the level of risk, manage the circumstances appropriately and refer on for treatment.[55] Gatekeeper training is effective at increasing suicide related knowledge and skills, including how to undertake appropriate referrals.[92, 93] It has proven effective in reducing suicide and suicide related

behaviours within certain settings including medical clinics, crisis call centres and in the US Air Force.[55, 67] It is important to note that these settings tend to be structured and are very different to the environment of service provision for young homeless people, which is often described as fragmented.[77] Challenges for gatekeeper training are that it is dependent on access to support services which are not always available and that people identified as at risk of suicide may choose not to take up referral suggestions.[55]

Box 6:
A word on self-harm

Preparing:
Participants are provided an overview of the course and learning expectations.

Connecting:
Participants discuss attitudes related to suicide and the impact they may have on responding to suicide.

Understanding:
Gain the knowledge and skills required to help a person at risk of suicide though the identifying risk factors and creating a plan to assist.

Assisting:
Participants work through a model for effective suicide prevention. Role playing and/or simulation is undertaken to support the learning process.

Networking:
Information on resources within the community are provided and instructions on how to connect to these resources.

Source: Isaac et al[55]

Applied Suicide Intervention Skills (ASIST) training is the most widely used gatekeeper training.[94] ASIST training is different from many other gatekeeper training programs in that it advocates for a framework that focuses upon connecting with the young person, understanding their circumstance and assisting them to a safer sense of being. ASIST emphasises the importance of empathetic listening and the development of a collaborative safety plan. The purpose of the intervention is to find ways to keep the person safe and to reconnect the person with a form of support that is suitable to them. This may be informal supports such as a friend or family member or formal supports such as a mental health service provider.

The ASIST Suicide Intervention Model has three core aspects of providing care to a person at risk of suicide.[67] These are;

1. ***Connect:*** *The gatekeeper responds to the person's 'invitations'. The term 'invitations' is interchangeable with the term 'warning signs', which are signs that the person may be considering suicide. The gatekeeper will respond to the warning signs and ask about suicide. For more information on warning signs refer to Box 3 in Section 6.0.*

2. ***Understand:*** *The gatekeeper will employ listening skills to explore the person's reasons for dying and reasons for living.*

3. ***Assisting:*** *At this point a 'safeplan' will be established. This stage will assist the person with connecting to available supports. Follow-up is also an important aspect to ensure that both the gatekeeper and person at risk of suicide have fulfilled their commitments to the 'safeplan'.*

ASIST training has been shown to improve suicide related attitudes and knowledge.[67, 94] One promising study on a crisis hotline had compared ASIST trained counsellors with non-ASIST trained counsellors and concluded that people who rang the crisis line and spoke with an ASIST trained counsellor seemed less suicidal and depressive and demonstrated greater feelings of hope.[67] Furthermore, the ASIST trained counsellors had longer call times and increased disclosure from callers indicating an increased connection between caller and counsellor. Exploring reasons for living was linked with more positive caller outcomes and this approach interconnects with CBT in that it encourages people to think of reasons to live as a method of overcoming stressful states of being.[95] Although the findings of this study are encouraging, results may not be applicable across different settings.

The ASIST approach aligns with the understanding that many people who have suicidal urges, including young homeless people, often choose not to access mental health services.[31, 96] Young homeless people are often very independent as they have had negative experiences with relying on people in the past.[97] A result of this independence may be that they try to manage suicidal thoughts or behaviours themselves. This highlights the pivotal role that Youth Workers have in identifying young people at risk of suicide and referring them to appropriate and timely support.

There are a number of suicide prevention training opportunities available in Western Australia. Each of these programs vary depending on approach, duration, delivery style, cultural approach and the experience of the trainer.[55] For a list of suicide prevention training currently available in Western Australia please see **www.yacwa.org.au/youthworkertoolkit/suicide-prevention**.

Box 7:
Skills-based Training on Risk Management (STORM)

STORM is a suicide prevention training package that focuses on building risk assessment and risk management skills for those directly working with those at risk of suicide.[98] It is similar to ASIST in that it is skills based, utilises role play and has been shown to be effective in increasing suicide related skills and knowledge.[99] While ASIST training is widely disseminated in Australia and has a greater evidence base, STORM training may also be beneficial to Youth Service Providers as it offers a specific module which respond specifically to suicide in children and young adults.

For an overview of ASIST and STORM read The use and impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation available at **www.scotland.gov.uk/Publications/2008/05/19160110/00**

11.0 Meeting the service needs of young homeless people

Young people need to know that there is at least one player in the game that they can rely on to uphold their interests.[83]

Creating lasting positive relationships between Youth Service Providers and young homeless people at risk of suicide is a major factor in suicide prevention efforts. Young people who are homeless are a particularly difficult group to engage with. This is due to a myriad of reasons including unpredictable living arrangements and the absence of trust in both people and services.[77, 100] To be able to successfully engage this group it is important that services employ approaches that encourage and support positive and lasting relationships.

Table 3.0 outlines key principles of practice to consider when working with young homeless people. These principles were identified in a review by Barker et al[77]. It is important to note that the evidence base for these factors is often from studies on young people, not specifically homeless young people.

Table 3.0 *Principles of practice for working with young homeless people*

Strategy	Background
Positive relationships	Developing and maintaining respect, a sense of connection and trust between service staff and young people is seen as essential from the perspective of both young people and service providers.[46, 47, 101, 102] Services where staff were caring, friendly and supported young people to think positively and develop their skill base were perceived as attractive by young people.[101, 102]
Collaboration	Young homeless people have needs that extend over a number of areas including housing, welfare, employment and mental health. When service delivery is fragmented and geographically dispersed this can be frustrating for young people as they experience service access difficulties and are often required to repeat their story.[102] A lack of collaboration results in inefficiency in the form of duplication and misunderstandings surrounding accountability and responsibility.[30]
Strengths-based	Young homeless people demonstrate strength through the personal skills required to survive on a daily basis.[50] Taking a strengths-based approach requires service providers to recognise and support a young person's individual strengths as well as the strengths located within their environment.[77] A strengths-based approach facilitates the development of resilience within a young person and allows them to take control of their lives.[77] When interventions aimed at young people have taken a strengths-based approach it has had a positive impact on outcomes.[103]
Participation and inclusion	It is important to acknowledge a young person's autonomy and address the issues that they perceive as important.[77, 103] To encourage participation and positive outcomes, services can provide young people with opportunities that are relevant and meaningful and are delivered in a way that is acceptable.[77]
Individually responsive and flexible	Services that are flexible and individually responsive reflect the diverse needs and backgrounds of homeless young people.[77] Flexibility can be achieved through the provision of outreach services,[104] flexible opening hours,[46] meeting times that suit the young person[105] and through individual case management.[77]
Capacity building	Capacity building can be addressed from both an individual and community perspective. Capacity building in individuals reflects the need to foster the development of personal skills and attributes such as resilience.[77] From a community perspective, capacity building can reflect the need to build up the capabilities of the service provider workforce to better meet the needs of young people.[77]
Continuity of care	Often young homeless people are involved with services for many years and engage with multiple services throughout this time.[77] Providing continuity of care ensures that they do not slip through the gaps when transitioning between services.[77] This means addressing longer term care, treatment and support where required.[30, 77]
Sustainable	The provision of long term support is an important aspect of care for young vulnerable people due to the complex and often long-term nature of their service needs.[106] Barker et al[77] identified a number of factors that can increase the sustainability of a service. These include; • Development of community based services • Development partnerships and methods of service coordination between services • Inclusion of young people in decision making processes • Work force development • Evaluation of effectiveness of services

For a guide on principles of practice for working with homeless young people read Research to Practice Series Issue 1: Interventions and practice principles for supporting young people who are homeless
www.acu.edu.au/about_acu/faculties,_institutes_and_centres/centres /institute_of_child_protection_studies/our_work/practice_series

12.0 *Supporting youth workers*

> *Youth workers need to prioritise the practice of self-care; of looking after the self as a means to assure longevity of career and continued high quality service provision to young people.[83]*

The second most common reason that young people require support from Youth Workers is because of mental health issues, including suicidal behaviours.[82] Often, Youth Workers are the first point of contact for a suicidal young person and their response can help ensure they receive appropriate support and care.[16] Given the challenging and stressful nature of working with young people who are at risk of suicide as well as the fact the Youth Workers dedicate a significant amount of time to this aspect of care, it is important that Youth Workers are well trained and supported in order to be able to respond appropriately. The youth work sector experience a number of challenges. These include a high staff turnover, a large proportion of workers with less than two years of experience, a shrinking workforce, reduced access to training and education and a shortage of career pathways, and inability to retain qualified and experienced staff.[82] In addition to this, Youth Workers often feel undervalued and unsupported.[82]

These challenges are likely to impact on the ability of the sector to respond to suicide, in particular the lack of experience and need for training, and highlight the need for services to have support systems in place that address these issues. A number of studies have described strategies that can be used to better support Youth Workers. These include suicide specific strategies such as organisational policies and procedures outlining how to respond to suicide, access to suicide specific training as well as general support strategies such as opportunities for reflective practice, supervision and self-care.[16, 61] This section describes the existing literature on ways of supporting Youth Workers who work with suicidal people and reports on the findings from the interviews with Youth Service Providers to describe what is currently happening in the sector.

a) Policy and procedures

Youth Workers operate under a variety of different frameworks. These include legal frameworks including the Privacy Act, structural frameworks such as their own organisation's policy and procedures and the ethical frameworks as outlined in the Youth Work Code of Ethics.[83] Youth Workers also draw on their own personal ethics to guide their practice.[83] Youth Workers are required to fulfil their obligations under each framework whilst meeting the needs of young people.

Organisational policies and procedures provide guidance for Youth Workers responding to a suicide crisis or emergency situation. There are specific aspects that should be incorporated into organisational policies and procedures that outline how to respond to suicide. These include outlining who is responsible for decision making, what factors will underpin the decisions made, ways to communicate what approaches have been used to provide care for the young person and strategies for follow-up care.[107] Policies and procedures may also address how to respond after a suicide or suicide attempt has occurred. This will help to identify how staff can be best supported, as well as

the young person and anyone else affected. Headspace has developed a Suicide Postvention Toolkit for secondary schools that outlines how to respond after a suicide has occurred. While it was developed for use within a school setting, it has relevance for Youth Service Providers working with homeless young people and is available on request from **www.headspace.org.au/what-works/school-support/resources**.

Organisational policies and procedures need to be flexible enough to meet the diverse needs of young people, but this should not prevent them from being specific and easily understood.[107] Additionally, organisational policies and procedures should be reflected in practice. If there are barriers to implementation such as lack of time, poor communication or a lack of staff training, then, where possible these will need to be addressed.[107]

What is happening in the sector?

Most of the Youth Service Providers interviewed had organisational policies and procedures that described in broad terms how to respond to a suicidal person. The larger Youth Service Providers tended to have more in-depth policies and procedures when compared to the smaller services. Only a few services had procedures that described in detail specific aspects of responding to suicide such as creating a safety plan or how to assess the level of suicide risk. Very few services provided information to staff on how to respond after a suicide or suicide attempt had occurred. Services that did not have policies and procedures often explained that instead they relied on staff to draw on their own skills and training. Another common practice was to contact a senior staff member in a crisis situation who could provide support as well as advice on how to respond. One service cited a lack of resources as a barrier to implementing suicide specific policies and procedures.

b) Access to training

Providing suicide specific training to those who work directly with suicidal people has been shown to reduce suicidal behaviours in certain population groups.[55] Youth Workers have a duty under the Youth Worker Code of Ethics, to maintain a level of knowledge that ensures they are competent to meet their obligations. This includes keeping informed on current approaches to best practice in youth work.[83]

What is happening in the sector?

Most Perth based services working with homeless young people encourage Youth Workers to complete suicide prevention training. However, suicide specific training was not compulsory at any of the services interviewed and as a result, often not all service staff had undertaken training. The training that was most commonly completed was ASIST, Youth Mental Health First Aid and Gatekeeper Training. A few Youth Service Providers had staff with specialist skills or representatives from YouthLink to provide specific training to address some of the complex issues around suicide.

For more information on suicide specific training available in Western Australia visit the training section of this website **www.yacwa.org.au/youthworkertoolkit/suicide-prevention**

c) *Reflective practice*

Reflective practice provides an opportunity for professionals to critically review their approach, identify areas for improvement and ways to achieve this.[108] Reflection enables Youth Workers to continue to refine and develop their practice with each experience. Without reflective practice, professionals may become rigid in their approach, thus limiting their ability to meet the needs of clients.[108] Reflective practice can increase a Youth Workers self-awareness of how they practice and encourage them to seek out opportunities for professional development.

What is happening in the sector?

In Perth, Youth Service Providers generally incorporate reflective practice into supervision or de-briefing sessions. One service provider encouraged Youth Workers to undertake reflective practice through personal journal writing which could then be shared in supervision sessions.

For an easy to use personal reflective practice tool see **www.yacwa.org.au/youthworkertoolkit/suicide-prevention**

d) *Self-care*

Working with a suicidal person can be emotionally draining and unsupported workers risk becoming disconnected and experiencing burnout.[109] Effective self-care can protect against these factors.[16, 109] The Youth Work Code of Ethics encourages Youth Workers to engage in self-care to ensure personal health, career longevity and quality care for young people.[83]
There are a number of ways that Youth Workers can engage in self-care and include both personal and professional strategies. Personal strategies may include taking time out to relax with friends, catching up on sleep or exercising. Professional strategies may include participating in peer de-briefing or contacting a professional help line. In Western Australia there are number of sources of professional help for Youth Workers. This includes the Suicide Call Back Service which is a free service that can provide information, advice and support to professionals who work with suicidal people. Another option that may be available is an Employee Assistance Program (EAP). EAP is a professional fee-for-service program that provides support to employees in relation to their psychological well-being.[110] Organisations must pay for employees to have access to EAP and therefore, it is not available to all Youth Workers. It should be noted that EAP does not provide support for professional development and should not be used as a replacement for supervision.

What is happening in the sector?

The majority of services interviewed provide their employees with access to EAP. Few services knew about the professional support offered by the Suicide Call Back Service, which is useful to Youth Workers following a crisis situation as it can provide emotional support as well as professional guidance on responding to suicide. Peer and team de-briefing was a common strategy and was usually undertaken as part of team meetings or following a crisis situation. Youth Service Providers have an open door policy where management is available for de-briefing and support at any time.

For self-care tips visit**www.yacwa.org.au/youthworkertoolkit/suicide-prevention** to ten self-care tips document

e) *Access to supervision*

Within the context of youth work, supervision is a meeting between a Youth Worker and another person or persons who has a higher level of skill, knowledge or experience.[111] This person takes the role of the supervisor, enabling the Youth Worker to reflect on their professional practice so that they can learn and develop professionally and contribute to advancing the profession.[112] External supervision occurs when a person, who operates externally to the Youth Workers place of employment and is generally paid for their time and undertakes supervision in a confidential environment.[111] External supervision is different from internal supervision, where the supervision session is undertaken by a senior staff member within the Youth Workers place of employment.[111] In a report undertaken by the Australian Youth Affairs Coalition,[82] Youth Workers reported that internal supervision often focuses on performance evaluation or administrative support as opposed to professional development and emotional support. Youth Workers interviewed preferred if supervision encompasses support and learning, is free of charge, easy to access and offered outside of their place of employment.[82, 113]

What is happening in the sector?

The majority of Youth Service Providers that were interviewed offered Youth Workers access to regular internal supervision; only one service provider offered access to regular external supervision. Youth Service Providers acknowledged the importance of external supervision and stated that cost was a barrier. To increase the effectiveness of internal supervision a number of Youth Service Providers stated that they made sure performance evaluation was undertaken separately to supervision.

To learn more read Professional Supervision **www.yapa.org.au/youthwork/facts/supervision.pdf**

13.0 *Responding to a young homeless person at risk of suicide*

This section describes best practice guidelines for Youth Service Providers responding to a homeless young person at risk of suicide. The concepts and principles that underpin these have been drawn from the Suicide Prevention Intervention,[114] the ASIST model as described by Rodgers,[35] the findings of Bergmans et al[84] and those outlined by the World Health Organisation.[115]

These guidelines have been developed to be as inclusive and as flexible as possible. Young homeless people are a diverse group and so are the services that support them. Therefore, when utilising these guidelines consideration needs to be given on how to adapt them to meet the individual needs of the young person as well as how to adapt them to work within the setting that the support service operate within. These guidelines are intended to provide additional information and support to Youth Workers and Youth Service Providers. They are not designed to replace formal suicide prevention training, professional training, organisational policy or medical advice. The decision on how to respond to a young homeless person at risk of suicide ultimately depends on the service provider.

Box 8:
Determining suicide risk

In order to determine how to respond to a young person at risk of suicide, Youth Service Providers must first assess the level of suicide risk.[60, 116] Given the lack of evidence surrounding the most accurate way of determining suicide risk and the consequences of assessing risk incorrectly, extreme care must be taken. The decision about the level of suicide risk and the best way to respond, lies with the service provider. Strategies to determine risk include:[8]

- talking with the young person to ascertain the degree of suicidal intent,
- utilising formal risk assessment tools,
- seeking advice from a senior staff member or
- contacting a help line such as the Mental Health Emergency Response Line on **1300 555 788**, or if the young person is under 16 years old, the Acute Response Team on **1800 048 636**.

There are a number of factors that may indicate a high level of suicide risk, including;
- talking or writing about death, dying or suicide
- threatening suicide
- having a plan
- having, or seeking, means for suicide
- impulsive, aggressive or anti-social behaviour and/or impaired decision making.[14, 30, 117]

Table 4.0 describes the **three key steps** to responding to a person at risk of suicide. These are

1. **Recognise the warning signs**
2. **Ask 'the question' and listen**
3. **Connect to support**

For a brief information sheet that outlines these three key steps visit insert link to Ask and Listen, Connect document

If the young person is at imminent risk of suicide or they are behaving in an aggressive or threatening way, then emergency services should be contacted immediately on Triple Zero 000.

Table 4.0 Responding to a young homeless person at risk of suicide

Response	Description
Recognise the warning signs	Warning signs are changes in behaviours that indicate a person may be at risk of suicide in the near future.[30] Recognising warning signs is key to identifying a person at risk of suicide. Young people who are experiencing homelessness are at greater risk of suicide; therefore, if they display warnings signs they should be taken very seriously. Warning signs may include; ● Increases in suicidal thoughts ● Creating suicide plans ● Attempting to access lethal means ● Expressing feelings of hopelessness ● Dramatic mood changes without external reason ● Engaging in high risk behaviours ● Withdrawing from social networks and or support services ● Changes in substance use ● Giving away possessions or saying goodbye ● Increases in self-harming behaviour ● Expressing feelings that life is not worth living ● Preoccupation with suicide, death or dying ● Threatening suicide or self-harm ● Reduced care in appearance and hygiene This list is not exhaustive and many of these warning signs can be seen in people who are not suicidal but may be experiencing a period of stress. Warning signs should be interpreted within the context of what the known usual behaviour is for the young person. For example, if a young person is often depressed, a sudden unexplained elevated mood may be interpreted as a warning sign.
Ask 'the question' and listen	If a service provider recognises warning signs in a young person they should ask them directly if they are thinking about suicide. Asking about suicide is essential to determine the level of suicide risk. Asking about suicide should be done in an empathetic way and wherever possible, within a safe and secure environment. Before asking about suicide, consideration will need to be given to the fact that it may bring up a lot of thoughts and feelings that the young person wants to share. Therefore, time will need to be allocated to listen and respond in a way that ensures the best possible outcome for the young person. Talking with a young person who is suicidal is challenging. The most important aspect is to listen non judgmentally, validate feelings and demonstrate empathy.[118] This will help to establish a sense of trust and enable the young person to talk openly about their suicidal thoughts and feelings.[102] The young person should be encouraged to talk about their reasons for dying as well as reasons for living. Feelings of ambivalence surrounding death may be used to motivate the young person to engage with mental health services and reduce suicidal urges.[61] At this point the young person's level of suicide risk should be determined in order to decide on the most appropriate course of action. Refer to Box 8 in Section 13 on ways to determine the level of suicide risk.

Table 4.0 *Responding to a young homeless person at risk of suicide*

Response	Description
Connect to support	Although not all suicidal young people have a mental health disorder, mental health services are generally the best equipped services to meet the young person's needs.[119] Therefore, wherever possible the young person should be promptly connected with a mental health service.
	Deciding on which mental health service to contact will depend on the individual circumstances and the young person should be included throughout the entire decision making process.[102] There are two main mental health call centres available in the Perth metropolitan area that can provide expert advice on the most appropriate way to connect a young person to mental health services. For support with people over 16 years old, contact the Mental Health Emergency Response Line on 1300 555 788 or if the person is under 16 years old, contact the Acute Response Team on 1800 048 636.
	If the young person refuses to engage with mental health services and it has been established that professional mental health support is necessary, then mental health services will need to be contacted on their behalf. Be clear to the young person about the reasons for doing this. Explain that you are unable to provide sufficient support on your own. Remind them that their wellbeing is your priority and connecting them with professional support it is the best way to keep them safe. Normalise the idea of help seeking as much as possible.
	Referring to a mental health service is not always the best option. Mental health services may not be accessible or the young person may be at low risk of suicide. Instead it may be useful to develop a safety plan with the young person that outlines alternatives including strategies to connect to appropriate social supports. Refer to Section 14.0 that describes how to develop a safety plan.

14.0 **Developing a safety plan**

It is not always possible for Youth Service Providers to connect a young person to mental health services. The reasons for this include the person refusing to engage with services, inequitable access (including opening hours), long waitlists, specific admission criteria and cost.[80] Stanely and Brown[114] developed an approach called the Safety Planning Intervention (SPI), which is a brief intervention that aims to reduce suicidal urges. The SPI addresses the fact that many suicidal people experience delays in accessing mental health services or choose not to attend follow-up appointments with mental health services. Therefore, the initial contact between a service provider and a young suicidal person is an opportunity to provide a brief intervention that may assist in reducing suicidal feelings and behaviours.[114] This approach is particularly relevant for homeless young people who are often disengaged from mainstream services.

A safety plan is an agreement between the service provider and young person that outlines actions the young person can take when feeling suicidal. Safety plans are client-centred, the role of the service provider is to support the young person to identify their personal strengths. It is envisioned that the process the youth worker explores with a young person to understand and acknowledge their strengths will then be drawn upon by the young person at times when they're considering suicide. Developing a safety plan is also recommended when immediate access to mental health services is not possible, or if the young person is at low risk of suicide (Refer to Box 8, in Section 13 that describes strategies to assess suicide risk). The SPI is a safety plan which has been identified as best practice by the Suicide Prevention Resource Centre.[120]

The aspects that should be included in a safety plan are;

1. **Internal coping strategies**
2. **Social distractions**
3. **Social supports for assistance**
4. **Professional support for assistance**
5. **Remove access to means of suicide**
6. **Follow-up agreement**

These six aspects are described in Table 5.0 and are underpinned by the Suicide Planning Intervention, as well as what has been identified as best practice when working with homeless young people. For a safety plan template visit **www.yacwa.org.au/youthworkertoolkit/suicide-prevention**

Table 5.0 *Creating an individual safety plan for at risk youth*

Step	Description
Internal coping strategies	The assistance of others, to manage suicidal thoughts and feelings.[114] Using internal coping strategies can increase a person's sense of self-efficacy and belief that they can overcome suicidal urges.[114] Internal coping strategies may include having a shower, going for a walk, listening to music, surfing the net, reading, writing or drawing. Coping strategies are unique to each person and therefore, will need to be identified by the young person. The young person may need to be encouraged to identify coping strategies that work for them. Youth Service Providers can prompt the young person by describing strengths they see in the young person such as I have noticed that you are quite creative and spend a lot of time drawing. How do you feel when you are drawing? Not all coping strategies will be effective all of the time; therefore, a number of coping strategies should be identified. Educational and self-help materials can enable a young person to help themselves when they are feeling suicidal. For some useful tools to help young people, including information on coping strategies visit Insert link to tools to help young people
Social distractions	Social distractions can be useful when internal coping strategies are not effective at reducing suicidal ideation. Social distractions may include interacting with friends and family or visiting a place where people socialise such as a local park or drop in centre. The young person will need to determine who these people are and which social environments they like to spend time in. If the young person chooses to socialise with another person such as a friend or family member, they do not necessarily need to disclose that they are feeling suicidal.[114] The purpose of socialising is about creating a sense of belonging and to facilitate a reduction in suicidal urges.[114] Young people should be discouraged from using social distractions where it is likely that drugs and alcohol will be available.
Social supports for assistance	If a young person feels that the coping strategies and social distractions are not effective in reducing suicidal thoughts, they may wish to contact someone such as a family member, partner or friend to let them know that they are feeling suicidal. This is different from using social distractions, as in this instance the young person discloses that they are feeling suicidal and need support.[114] For a young person who is experiencing homelessness, identifying suitable social supports may be challenging, as they are often disconnected from family, peer networks and from social structures such as schools.[101] Furthermore, someone that the young person enjoys spending time with may not always be the ideal person to support them through a suicidal crisis. Therefore, Youth Service Providers should work collaboratively with the young person to determine who would be best to contact and there should be a discussion around some of the positive and negative aspects of disclosing suicidal feelings to each potential support person identified.[114] Sometimes, the young person may not be able to identify an appropriate person and in this instance, professional supports should be used.
Professional support for assistance	Together, the service provider and young person should make a list of mental health services that the young person can contact. This may include crisis call lines, online support or mental health professionals. The service provider should discuss what the young person expects from these services and address any barriers that may prevent them from seeking professional support. For information on professional support services that are available for young people in Perth visit (insert website link to support sevices for young people).

Table 5.0 *Creating an individual safety plan for at risk youth*

Step	Description
Remove access to means of suicide	A vital step in safety planning is to determine if the young person has access to means of suicide and then either remove or restricting access.[107] Common means to suicide are alcohol and other drugs, medications, weapons, sharp objects and access to a car. Removing access to means is important as there is generally only a short period of time in which a person is likely to act on suicidal thoughts. Therefore, by removing or restricting access to means makes it less likely that the person will be able to act on suicidal thoughts.[107] At this point, the service provider should discuss with the young person that if possible they should not use alcohol or other drugs and if they choose to, they should do so in a safe way as it may affect their mental wellbeing and impair their judgement.
Follow-up agreement	It is recommended that Youth Service Providers follow-up with young people after the initial intervention as it is understood to decrease future suicide attempts and encourage compliance with treatment.[39, 57, 64, 65] Follow-up care can help to ensure that the young person is fulfilling their commitments to the safety plan and that where required, have engaged with mental health services. The type of follow-up care provided will depend on the young person's needs, organisational policies and procedures and should align with the principles of confidentiality and duty of care as outlined in the Youth Worker Code of Ethics.[83]

Box 9:
Looking behind what is really going on

When creating a safety plan, there may be an opportunity to look at other needs that the young person may have. What these needs look like will vary greatly between individuals and may include access to education support, credit for public transport or a place to have a shower and chill out. While the young person is still in a vulnerable state, care should be taken not to explore problems that may cause additional stress.

After a critical incident has occurred organisational requirements for reporting will need to be completed. In addition a de-briefing session should be held between staff involved in the critical incident and service management. This de-briefing session may include a review of what happened, what was done well, what could be improved for next time as well as to address any further personal or professional support that staff involved in the critical incident may require.

Despite Youth Service Providers' best efforts some young people will either attempt or complete suicide. This is a traumatic experience for Youth Service Providers and those close to the young person. There are a number of considerations that should be addressed to reduce the impact of suicide on those affected as well as the potential for contagion. Support for staff is important and strategies to best support Youth Workers are described in Section 12 of this report. A Suicide Postvention Toolkit for secondary schools that outlines how to respond after a suicide has occurred has been recently developed in WA. While developed for use within a school setting, this toolkit has relevance for Youth Service Providers working with young people at risk of homelessness and is available on request from **www.headspace.org.au/what-works/school-support/resources**

15.0 *Service provider perspectives*

During the consultation process Youth Service Providers were asked to describe any factors that they believed supported or inhibited their ability to respond to young homeless people at risk of suicide. Youth Service Providers were from outreach and accommodation services and responses differed between these two types of services as a result of the structure and services provided by each.

When Youth Service Providers were asked what the main challenges were to providing care to young homeless people who were at risk of suicide, the most common response was access to mental health services. The types of access issues experienced varied between services and included:

- Challenges that were the result of many mental health and support services not being available after hours i.e. nights or weekends
- Extended waitlists
- Young people refusing to access services
- Young people not meeting admission criteria
- Lack of mental health professionals working at accommodation services

Young people may not meet the admission criteria for mental health services, this may be because they were assessed as not being at risk of suicide, despite having disclosed suicidal urges to Youth Service Providers, or because, they were experiencing behavioural issues not attributed to mental ill health. One service provider explained that if a young person has behavioural issues they may be struggling just as much as a young person with mental health issues but do not receive the same level of care. When an accommodation service provider is unable to promptly connect a young person to mental health services or other appropriate supports, this generally results in the young person being returned to their care. This is often not the best environment for the young person due to a lack of expertise of staff and insufficient time to address the young person's complex needs. A number of accommodation service providers explained that having a mental health professional work alongside services for young homeless people would help to overcome access barriers.

Access to accommodation services was described as a key issue by both accommodation and outreach service providers. Accommodation services regularly turned away young people, with one service explaining that in the first six months of 2013, they had declined close to 260 requests for accommodation. It is difficult for accommodation service providers to accommodate more than one person who is suicidal or who engages in self-harming behaviours because of issues with contagion. Accommodation services must consider the needs of existing residents and if they already have a young person who is self-harming or suicidal then the addition of another young person experiencing the same issues may exacerbate the situation, placing additional strain on a service staff and residents. Further to this issue, there seemed to be little existing expertise in the area of how to address contagion within accommodation service setting. As a result a number of services have adapted different, and at times, conflicting approaches.

Identified enablers that contributed to good service provision for young people at risk of suicide included relationship building.

The ability of service staff to develop positive relationships that encourage open communication was the most common factor that enhanced a service provider's ability to support young homeless people at risk of suicide. Outreach services often describe their ability to build relationships with disengaged young people and connect them to support as a key strength. Youth Service Providers described that the ability of staff to look behind what is really going on in their lives often helped to address the causal factors impacting a young person's behaviour and suicidality. The majority of services agreed that taking a client-centred, strengths-based approach fostered positive outcomes for the young people.

A number of Youth Service Providers described partnerships that they had developed with other services as enhancing their response to young homeless people who are suicidal. One service provider highlighted the important role that Headspace had played in encouraging services in the area to collaborate and the positive impact this had on service delivery. A few services held regular meetings with other services in the area to discuss current issues and to develop effective strategies to overcome them. Some Youth Service Providers felt that collaborating with other services enhanced the level of care provided to the young person through co-case managing as well as facilitating strong connections to referral services.

16.0 *Conclusion*

> A key strength described by Youth Service Providers was the ability of staff to develop positive relationships with young people that are built on trust and open communication.
>
> The majority of Youth Service Providers acknowledged that their approach was client-centred and strengths-based.

This report forms part of YACWA's Homeless Youth Suicide Prevention Project. This project is a Community Action Plan that aims to develop specific intervention strategies for vulnerable groups, increase awareness of risk factors, encourage collaboration and enhance access to support services.[29] This report was undertaken to develop best practice principles and bring together existing resources to support Youth Workers responding to young homeless people at risk of suicide. The findings of this report were constrained by the lack of reported research into suicide prevention specifically within young homeless populations, both internationally and within the Australian context. The majority of available evidence identified is from Australia, the United States and the United Kingdom. There are limitations resulting from a lack of generalisability of suicide prevention strategies for this demographic as identified in the literature. Homeless young people are a diverse group, and what has proven effective in one population group may not be effective in another. Currently, there are no reliable figures on the incidence of suicide amongst homeless young people in Australia. This is a key barrier to determining the true extent of the problem. Consequently, this report has aligned the risk factors for suicide to what is known about young homeless people, making apparent the reality that young homeless people are far more likely to experience many of the risk factors for suicide than other young people, making them a vulnerable group.

A suicide attempt may be a sign of the early stages of a mental illness, and promptly connecting the person to appropriate support services may reduce the development of a mental illness.[119] A number of factors such as waitlists, admission criteria and young people refusing support has meant that it is not always possible to promptly connect a young suicidal person to mental health services. Therefore, prevention strategies need to include a focus on improving access to mental health services. Having mental health professionals working within or alongside services that provide support to young homeless people may be one strategy to overcome access issues. Another strategy is encouraging greater collaboration between services, especially those working in the same geographical area. Services that work in partnership are able to provide more sustainable outcomes for young people through addressing multiple needs in a coordinated way, creating stronger referral pathways and use limited resources more efficiently.

Youth Workers are often the first point of contact for a suicidal person and play a fundamental role in connecting them to an appropriate mental health services. Given that it is not always possible to connect young people to mental health services, the initial point of contact between a young person and a Youth Worker may be the best, if not the only, opportunity to provide support. It is recommended that Youth Workers are able to utilise brief interventions, such as the safety plan described, as a strategy to help keep a young person safe until they can be connected to appropriate support.

A key strength described by Youth Service Providers was the ability of staff to develop positive relationships with young people that are built on trust and open communication. The majority of Youth Service Providers acknowledged that their approach was client-centred and strengths-based. These factors reflect best practice when working with young homeless people and should also be reflected when responding to suicide. When working long-term with a young suicidal person it is useful to be able to understand and address suicide from a recovery perspective as it provides insight into the young person's journey and how to encourage hope as well as individual responsibility.

Given the crucial role that Youth Workers play in identifying young people at risk of suicide, they need to have access to suicide specific training, such as ASIST training, to provide them with the skills and confidence to effectively respond to a young person at risk of suicide. Youth Workers can benefit from suicide intervention training that is more specific to the needs of young homeless people, given their complex needs. It is recommended that Youth Service Providers support Youth Workers to undertake ongoing professional development, and where available, suicide prevention or mental health training that is specific to the needs of young homeless people.

Working with a young person who is suicidal is likely to be challenging and Youth Workers need to be properly supported in order to respond effectively. The support offered to Youth Workers should include access to supervision and de-briefing, personal counselling and opportunities for self-care. It is recommended that where possible Youth Workers are provided with support through their place of work. It is acknowledged that the youth work sector operates with limited resources; therefore, it is inevitable that not all of these options will be available to all Youth Workers. Where supports are not available, a Youth Worker may wish to utilise the online tools provided throughout this report that promote self-care strategies, personal reflection and peer de-briefing.

Looking to the future, there are many changes taking place in both the homelessness sector and the mental health sector. Thoughts are shifting toward greater collaboration between services and working from a recovery-focussed perspective. How these changes impact the community in the long term is yet to be seen. YACWA and their member organisations are an integral part of a broader network that provides valuable support to vulnerable young Western Australians. Recognition for this work via adequate resourcing is integral to creating better outcomes. Equally important is a commitment to consistent reflection on youth work practice through evidence-based, theory-led and practice-driven approaches with the aim of the young person's recovery.

Such a commitment will continue to ensure that young people who are homeless and the sector that supports them are resilient in finding 'their happier place' within our State.

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Appendix A: Summary of intervention studies in homeless youth with mental health outcomes

Author	Country	Target Group	Outcomes/measurement
Ferguson and Xie [71]	**California**, USA	Agency based homeless youth aged 18 to 24 years	**Outcomes**: mental and physical health status, high-risk behaviours including survival sex and substance use, peer and family social support, service utilisation, homelessness history, trauma history, residential status, and family and social history. **Measurements**: baseline and 9 months
Hyun et al. [72]	**Seoul**, South Korea	Adolescents (Age NA)	**Outcomes**: self-esteem, depression, and self-efficacy **Measurements**: baseline and eight weeks
McCay et al. [70]	**Toronto**, Canada	Community agency based street youth aged 16 to 24 years	**Outcomes**: hopelessness, depression, mental health, resilience, self-esteem **Measurements**: baseline and six weeks
Slesnick et al [74]	**New Mexico**, USA	Street living youth aged 14 to 22 years	**Outcomes**: substance use, delinquency, coping, depressive symptoms, health risks. **Measurements**: saseline, three months and six months
Slesnick et al [75]	**New Mexico**, USA	Youth accessing a drop in centre aged 14 to 24 years	**Outcomes**: substance abuse, mental health, housing, education, employment, and medical service access **Measurements**: baseline, six months, and 12 months
Stewart [76]	**Edmonton**, Canada.	Youth aged 16 to 24 years	**Measurements**: social network, support satisfaction, loneliness and isolation, support-seeking, coping, self-efficacy, mental health and health-related behaviours. **Measurements**: baseline, ten weeks and twenty weeks
Taylor et al [73]	**NA**, United Kingdom	Youth accessing shelters aged 16 to 25 years	**Outcomes**: aggressive behaviour, self-injury, alcohol or drug user, cognitive problems, physical illness, hallucinations/delusion, depressed mood, other mental problems, relationships, daily living activities, living conditions, occupation/activities

Treatment Groups	Intervention	Findings
Control (n=12) Intervention (n=16)	A pilot study to determine the feasibility of the Social Enterprise Intervention (SEI) for homeless youth. SEI participants received 7 months of vocational and small business training and service referrals.	Homeless youth who received SEI experienced increased life satisfaction, family contact, peer support, and decreased depressive symptoms. No statistically significant changes in other outcomes.
Intervention (n=14) Control (n= 13)	The intervention group received eight weekly cognitive behavioural group therapy sessions.	The intervention group reported depression decreased significantly and self-efficacy increased significantly. No significant change in self-esteem.
Intervention (n=15) Control (n= 18)	Six relationship-based group workshops focusing on social support, social networks, positive self-concept and resilience, emotional understanding and self-determination and choice.	Intervention group experienced higher levels of social connectedness, decreased hopelessness. No difference on resilience and self-esteem. Improvements in mental health symptoms in intervention group were not statistically significant.
Control (n=84) Intervention (n=96)	The intervention group received an average of seven Community Reinforcement Approach sessions.	Depressive symptoms and substance use decreased and social stability increased significantly in the group the received a Community Reinforcement Approach. Both groups improved in other behaviours such as internalizing and externalising problems and coping.
No control	Youth were assigned a case manager (average sessions attended n= 8) and participated in Community Reinforcement Approach therapy sessions (average sessions attended n= 5)	Statistically significant improvements were found in substance abuse, mental health and days spent housed. Decreased alcohol and drug use was associated with an increase in housing. No changes in overall housing, education, employment, and medical service access.
No control Intervention (n=56)	Pilot study. Participants attended four support groups, optional one-on-one support, group recreational activities, and meals. Support was provided by professionals and peer mentors.	Participants reported improvements in mental health, health behaviours, coping skills and self-efficacy. Decreases were seen in loneliness and use of drugs and alcohol.
No control Intervention (n=150)	Young people were referred to specialist mental health centres to participate in sessions with mental health professionals. Sessions included counselling skills, cognitive-behavioural therapy, substance use interventions and psycho-education. Mean number of sessions (n=5.5)	Self-harm significantly decreased. Significant improvements were seen in depressed mood, other mental problems, aggressive behaviour, cognitive problems, relationships, daily living activities, living conditions and occupation/activities

Appendix B: Suicide and mental health training in Western Australia

Organisations that run programs for professionals working with young people with mental health problems

Organisation	Country	Website
Drug and Alcohol Office	Drug and Alcohol Office provides range of knowledge and skills-based training for those working with people with both co-occurring alcohol and other drug issues and mental health issues. All Training@DAO calendar events are free of charge.	http://www.dao.health.wa.gov.au/Educationandtraining/TrainingDAOCalendar.aspx
Youth Focus	Youth Focus training can assist professionals in responding to young people with mental health issues. Youth Focus provides training on request from workplace. While Youth Focus has a number of core programs, they specialise in the development and delivery of tailored programs that deal with specific issues identified in the workplace.	http://youthfocus.com.au/training-education-programs/community-2/
YouthLink	YouthLink offers a variety of training that is suitable for Youth Workers. Training sessions including working with young people with complex needs, suicide prevention, mental health and cultural training. Additionally, individual agencies may request education and training workshops tailored to their specific requirements.	http://youthlink.perthwa.net/training.html

Suicide and mental health training

Training	Detail	Website
Aboriginal & Torres Strait Islander Course	**Organisation:** Mental Health First Aid **Length:** 14 hours (6 modules) This course aims to provide people the skills to support an Aboriginal or Torres Strait Islander adult who is experiencing a mental health problem or crisis.	https://www.mhfa.com.au/cms/
Applied Suicide Intervention Skills Training (ASIST)	**Organisation:** YACWA **Length:** Two days ASIST is a two day interactive workshop that aims to provide a person with the skills to respond appropriately to someone at risk of suicide.	http://www.yacwa.org.au
ASIST T4T	**Organisation:** Living Works **Length:** 5 days ASIST T4T is a five day train the trainer program that prepares individuals to be able to prepare and present the ASIST workshop.	http://www.livingworks.net/programs/asist-t4t/
First Aid Course in Suicide Prevention	**Organisation:** The Salvation Army **Length:** 1 hour (Online) This one hour online training enables participants to identify warning signs of a suicide crisis and how to questions, persuade and refer someone to help. This is known as the QPR (Question, Persuade and Respond) approach. This course is free of charge	http://suicideprevention.salvos.org.au/training/qpr-suicide-prevention
Grieving Aboriginal Way	**Organisation:** Anglicare WA **Length:** 1 day This training addresses the impact of suicide related grief and loss from an Aboriginal perspective.	http://www.anglicarewa.org.au/training-courses/training-services/professional-development/default.aspx

LifeForce suicide prevention workshop	**Organisation:** *LifeForce* **Length:** *1 day* *LifeForce suicide prevention workshop is a one day workshop that will enable participants to identify warning signs and determine suicide risk.*	*http://www.wesleymission.org.au/Centres/lifeforce/programs.asp*
One Life Gatekeeper Train the Trainer	**Organisation:** *Centrecare Corporate* **Length:** *3 days* *This train the trainer program aims to provide participants with the necessary skills and knowledge to be able to prepare and present the One Life Gatekeeper Training workshop. Prior completion of the One Life Gatekeeper Training workshop is required.*	*http://www.centrecarecorporate.com.au/content/10-gatekeeper*
One Life Gatekeeper Training	**Organisation:** *Centrecare Corporate* **Length:** *2 days* *This 2 day workshop aims to improve participant's skills and knowledge in their ability to work with suicidal people and assist in referral pathway advice. Training provided can also be personalised to reflect organisational needs.*	*http://www.centrecarecorporate.com.au/content/10-gatekeeper*
Opening Closets Mental Health Training	**Organisation:** *Gay and Lesbian Community Services* **Length:** *3.5 hours* *This training aids to assist in improving access to mental health services by raising awareness and developing individual's capability to respond appropriately to Lesbians, Gay, Bisexual, Transgender and Intersex (LGBTI) people.*	*http://glcs.org.au/training-services/glcs-opening-closets-mental-health-training/*
SafeTALK	**Organisation:** *Living Works* **Length:** *3.5 hours* *This half-day seminar aims to raise awareness within the community of the warning signs of suicide, how to talk to people who are considering suicide and connecting them with help.*	*http://www.livingworks.net/programs/safetalk/*
Standard Mental Health First Aid training	**Organisation:** *Mental Health First Aid* **Length:** *12 hours (4 modules x 3 hour)* *This course aims to provide people with the skills to provide a person who is experiencing a mental health problem or crisis with appropriate care until professional help can be delivered or until the situation resolves. This course has been adapted for a number of specific groups including Youth Workers.*	*https://www.mhfa.com.au/cms/*
SuicideCare	**Organisation:** *Living Works* **Length:** *1 day* *SuicideCare is a full day workshop that provides clinical staff with the ability to assist people at risk of suicide on a long term basis. Participants must have completed ASIST training to be eligible.*	*http://www.livingworks.net/programs/suicidecare/*
SuicideTALK	**Organisation:** *Living Works* **Length:** *90 minute to half day session* *SuicideTALK is a brief seminar aimed at the wider community to raise awareness, reduce stigma and support life to open discussion about suicide.*	*http://www.livingworks.net/programs/suicidetalk/*
Youth Mental Health First Aid course	**Organisation:** *Mental Health First Aid* **Length:** *14 hours* *This course aims to teach participants the skills to assist adolescents who are developing a mental health problem or crisis. This enables participants to learn about adolescent development and the signs and symptoms of mental health problems, in addition to where and how to get effective help.*	*https://www.mhfa.com.au/cms/*

🔴 recognise 🔴 ask 🔴 connect

This brief information sheet provides guidance for Youth Workers on how to recognise and respond to the warning signs for suicide in young people who are experiencing homelessness. It is not designed to replace formal suicide prevention training, professional training or organisational policy.

If at any time, the young person is at imminent risk of suicide or are behaving in an aggressive or threatening way, then emergency services should be contacted immediately on Triple Zero 000.

1. **Recognise** the warning signs

When a young person is contemplating suicide, there are often noticeable changes in their behaviour that indicate they may be at risk of suicide in the near future. These changes are called warning signs. Being able to recognise warning signs is key to preventing suicide. As young people who are experiencing homelessness are at greater risk of suicide, when they display warnings signs they should be taken very seriously.

Warning signs may include;
*Increases in the frequency of suicidal thoughts
Creating plans to kill oneself
Attempting to access to lethal means
Expressing feelings of hopelessness, being trapped or that life is not worth living
Dramatic mood changes without external reason
Engaging in high risk behaviours
Withdrawing from social networks and or support services
Changes in patterns in alcohol and other drugs use
Giving away possessions or saying goodbye
Increases in self-harming behaviour
Creating safeguards to avoid discovery
Preoccupation with suicide, death or dying
Threatening suicide or self-harm
Reduced care in appearance and hygiene*

This list is not exhaustive and many of these warning signs can be seen in people who are not suicidal but may be experiencing a period of stress. Warning signs should be interpreted within the context of what the known usual behaviour is for the young person. For example, if a young person is often depressed, a sudden unexplained elevated mood may be interpreted as a warning sign.

2. **Ask** the question and listen

If you suspect that a young person is contemplating suicide, it is important to ask them directly if they are thinking about killing themselves. Asking about suicide is essential to determine the young person's risk of suicide. It will not put thoughts of suicide into their mind. Asking about suicide should be done in an empathetic way and where possible, within a safe and secure environment.

Ask in a way that feels natural for you. You may wish to say "Have you been thinking about killing yourself?" or "Are you considering taking your life?"

Talking with a young person who is suicidal is challenging. Be aware that asking about suicide may open up a lot of feelings that the young person wants to share and you will need to be prepared to listen and respond in a way that ensures the best possible outcome for the young person. Encourage the young person to do most of the talking. Allow them to talk about their reasons for wanting to die and their reasons for wanting to live. Do not try to solve their problems, instead listen, validate feelings and demonstrate empathy.

If you feel that you are unable to assist the young person, refer them to a co-worker who is qualified to help.

3. **Connect** to support

Depending on the needs of the person you will need to connect them to appropriate supports.

Connecting the young person to mental health services

There are two main mental health call centres that can provide expert and accurate advice on how to respond to person at risk of suicide. Both of these services will be able to provide support and guidance on the most appropriate course of action to ensure the best outcome for the young person.

If the person is aged under 16 years old call the Acute Response Team (ART). **1800 048 636** (Available 8am and 10pm), after 10pm call Princess Margaret Hospital directly on **08 9340 8222** and ask to speak to the Psychiatric Liaison Nurse.

If the person is over 16 years old call the Mental Health Emergency Response Line (MHERL) **1300 555 788** (24 hours).

Referring to a mental health service is not always the best option, as they may not be accessible or the young person may be at low risk of suicide. Instead it may be useful to develop a safe plan with the young person that outlines alternatives including strategies to connect to appropriate social supports.

What if they refuse to engage with mental health services?

If the young person refuses to engage with mental health services and the immediate risk of suicide is high, you will need to call emergency services on their behalf. Be clear to the young person about your reasons for doing this. Let them know that their wellbeing is your priority and it is the best way to keep them safe.

What if immediate access to mental health services is not possible?

Often there are waitlists for mental health services, especially if the person is at low risk of suicide. In this instance it may be helpful to develop a safety plan with the young person.

What if I am unsure about my actions or am feeling overwhelmed?

Responding to a person at risk of suicide is difficult. At times you may be unsure if you responded appropriately or you may feel overwhelmed. If you are feeling this way it is important to speak to someone about your feelings. There are a number of options available. You may wish to speak to your manager or you can call the Suicide Call Back Service on 1300 659 467. They can provide confidential feedback on your response as well as provide support for your personal wellbeing.

Remember to understand the limits of your role. Even with the best care some people will still suicide.

Acknowledgements

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Suicide Call Back Service. 2013. Suicide warning signs. www.suicidecallbackservice.org.au

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Disclaimer

This factsheet has been developed for service providers who work with young people who are experiencing homelessness. It provides guidance on how to recognise and respond to a person at risk of suicide. This guide should be used in conjunction with formal suicide prevention training and organisational policy and procedures. The Youth Affairs Council has made every effort to ensure the accuracy of the information provided. The Youth Affairs Council takes no responsibility for any loss, or misuse of the information contained herewith.

Appendix D: **Personal Safety Plan for Young Person**

This is an agreement developed by _____ *(insert name) in partnership with* _____

(staff member) from _____ *(agency) that describes actions that can be taken when feeling suicidal.*

My coping strategies (E.g. read, take a shower)

1. ....

2. ....

3. ....

Things I can do to distract myself (E.g. visit a friend, go to the park)

1. ....

2. ....

3. ....

People I can talk to

Name: .... *Phone Number:* ....

Name: .... *Phone Number:* ....

Services I can talk to

Name: .... *Phone Number:* ....

Name: .... *Phone Number:* ....

Follow-up agreement

To make sure that I am okay

1. I will contact .... *(insert name)*

When: .... *How:* ....

2. .... *(insert name) will contact me*

When: .... *How:* ....

In an emergency I can contact
Emergency services: 000
Mental Health Emergency Response Line (MHERL) (For over 16's): 1300 555 788
Acute Response Team (ART) (For under 16's): 1800 048 636 (8am to 10pm),
after hours call 08 9340 8222 and ask to speak to the Psychiatric Liaison Nurse.
Poisons Information Centre: 13 11 26
Lifeline: 13 11 26
Kids Help Line: 13 11 14
Suicide Call Back Service: 1300 659 467
The Samaritans 24/7 Youth Line: 1800 198 313

Other: ....

Appendix E: *DIY Reflective Practice Tool*

Undertaking reflective practice increases your self awareness about how you work and supports you to develop professionally. This tool has been developed to guide your personal reflective practice and can also be used as a peer debrief tool.

What happened?
Describe in detail the event. Consider it from your perspective and from the perspective of others.

....

....

....

....

What were you thinking and feeling?
Consider how you felt before, during and after the event. Why does this event stick in your mind?

....

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What was good and bad about the experience?
Evaluate the situation and consider what went well and what needs to change.

....

....

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....

What else could you have done?
What could you have done differently? What can you do now to be able to do things differently in the future?

....

....

....

....

If it happened again what would you do?
Imagine you are in the same situation again, would you act differently or would you act the same?

....

....

....

....

Adapted from: Jasper, M. 2003. Beginning Reflective Practice – Foundations in Nursing T2nd Health Care Nelson Thornes. Cheltenham

Appendix F: Ten self-care tips for Youth Workers

1. Look around and figure out what is going on.
The first step towards taking better care of yourself is knowing where your problem areas are. Identify specifically what it is that is adding to your stress levels. Ask yourself what you can change and what you would like to change the most. Perhaps share this with a friend and discuss strategies to minimise the stressors in your life.

2. Unwind every day
Daily rituals can be a great way to de-stress. Can you find ways to take small short breaks at work? This could be as simple as grabbing a coffee with a work friend or finding a quite spot for ten minutes to unwind. Small everyday changes can make a big difference.

3. Ask for help
If you are feeling overwhelmed with your work load, are there things that others could help you with? Do you have difficultly letting go and letting others do it their own way? Don't expect other people to be able to read your mind. For things to change for the better you need to ask for support and consider new ways of doing things.

4. Create a transition ritual
It can be difficult switching from work to non-work or home mode. Having a transition ritual is a useful way to help you to mindfully put your work away when you arrive home. Some transition rituals include listening to your favourite music on your commute home, changing into comfortable clothes or going for a walk.

Being accessible 24/7 is one of the quickest ways to burnout. You need to create boundaries between your personal life and work and clients need to be aware of where these are.

5. Learn to say no (or yes) more often
Youth Work attracts people who are naturally giving. Being the person that all of your friends and family depend on can be very draining to deal with on top of other commitments. Being able to say no or at least not saying yes straight away is an important skill that stops you from taking on too much. Practice this and using statements like "I need to think about taking this on. Let me get back to you" if you do not want to say outright first up. If you feel you are not good at setting limits perhaps this is something that you need to explore. Can you think of areas in your life where you could say no more often?

On the other hand, you may have stopped saying yes, because you have been feeling drained. This may mean that you are missing out on new opportunities. Take some time to consider if you would be better off saying yes or no more often.

6. Minimise your trauma exposure.
When you work with young people who have experienced trauma it is important that you protect yourself from other external sources of trauma where possible. Consider where you absorb trauma from. Do you see it on the news or on other television shows? Do you listen to it on the radio? Do people close to you work with people who have experienced trauma and do you debrief with each other about your experiences?

There is a lot of additional trauma that you may be exposed to outside of your work that you do not necessarily need to absorb. Consider ways that you can reduce your exposure.

7. Understand more about burnout and ways to recognise and prevent it
Some common signs of burnout include; withdrawing from work or personal relationships, constantly feeling exhausted or experiencing a loss of motivation.

Workplace supervision or debrief sessions may provide an opportunity to talk about burnout and to identify burnout prevention strategies that can be implemented within your workplace.

8. Organise a support group
Not all workplaces have opportunities for formal supervision and support. Consider organising a small group of people to get together on a regular basis to debrief and offer each other support and guidance.

9. Commit to regular professional development.
Attending regular professional development helps with building skills and makes you feel as though you are on top of your game. There are also many other benefits including connecting with others in your field, learning new skills and hearing of new resources and tools.

10. Exercise
You have heard it 1000 times, physical activity is one of the best ways to reduce stress. Find something you enjoy and that is easy to do as you are more likely to do it regularly. It doesn't have to be high powered running or gym work. Brisk walking is a great start – you don't need special gear and you can do it anywhere. You might also want to try something new like start rock climbing or bush walking. Can you park further away from work and walk the rest of the way? The idea is to start small, enjoy it and turn it into a habit.

Adapted from: Mathieu. 2007. Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-Care Tips for Helpers.