



SAMARITANS

Tomorrow is too late

Suicide prevention support for
people with no fixed address

March 2024





Contents

| | |
|---|-----------|
| Introduction | 3 |
| Our approach | 4 |
| What we did | 4 |
| Who we worked with | 5 |
| Attitudes towards people with no fixed address | 6 |
| Recommendation 1 | 8 |
| Recommendation 2 | 9 |
| Access to support | 10 |
| Recommendation 3 | 13 |
| Recommendation 4 | 14 |
| Support that meets people's needs | 15 |
| Recommendation 5 | 17 |
| Recommendation 6 | 18 |
| The role of community | 19 |
| Recommendation 7 | 20 |
| Contributors | 21 |
| References | 22 |

What is the Suicide Prevention Consortium?

The Suicide Prevention Consortium is made up of four organisations: Samaritans (lead), National Suicide Prevention Alliance, Support After Suicide Partnership and WithYou. As part of the Voluntary, Community & Social Enterprise (VCSE) Health and Wellbeing Alliance, it aims to bring the expertise of its member organisations and the voice of those with lived experience directly to policymakers, to improve suicide prevention in England.



In 2023, Samaritans responded to over

41,000
calls

for help that mentioned homelessness concerns.





Introduction

Suicide is complex and rarely caused by one thing. However, we do know that homelessness, housing insecurity and poor housing can increase suicide risk,¹ and that in 2021 13.4 per cent of the estimated deaths of homeless people (in England and Wales) were registered as suicide.² In 2023, Samaritans responded to over 41,000 calls for help that mentioned homelessness concerns. A total of 298,430 households in England needed support from councils in 2022-23 around statutory homelessness.³

In our previous work as the Suicide Prevention Consortium, we have heard that housing can impact people's suicide risk, especially when they are economically disadvantaged.⁴ There are many ways that homelessness, housing insecurity and poor housing quality can interplay with suicide risk and this happens on multiple levels.^{5,6} This can also include interaction with multiple risk factors for suicide. For example, in 2022-23, 20 per cent of people starting substance treatment had no home of their own and a further nine per cent said that they had a risk of homelessness in the coming eight weeks.⁷

This is why it is important for both policy and practice to take into consideration these factors in suicide prevention. NICE guidance provides important recommendations for improving access to and engagement with health and social care, and ensuring care is coordinated across different services for people experiencing homelessness.⁸

The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour is one model which proposes how a person might develop suicidal behaviour through many interacting feelings and cognitive factors, which can build on underlying vulnerabilities, such as early or traumatic life events.⁹ This model highlights the importance of feelings of

thwarted belongingness, burdensomeness, and having little or no social support in suicide risk.¹⁰ Existing research shows how financial hardship can contribute to feelings of entrapment and loss of control, other feelings that are explored in the IMV model.¹¹ The model also seeks to examine the factors that may move someone from suicidal thoughts to suicidal acts.

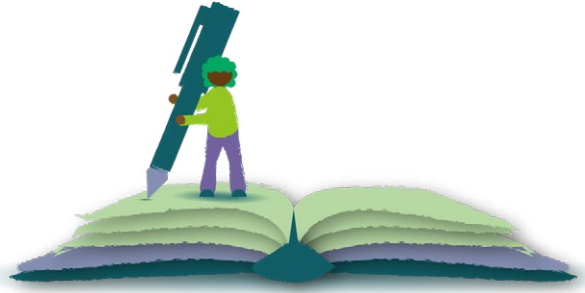
The latest Suicide Prevention Strategy for England¹² recognises that the wider determinants of health, including housing, are important to consider when addressing risk factors for suicide. One of the ambitions of the national five-year strategy is that systems and services are connected so that there is no wrong door for when people experiencing suicidal thoughts or feelings reach out.¹³ But what more can policymakers and service providers do to improve suicide prevention activity for people experiencing homelessness or housing insecurity? We worked with people with relevant lived experience to find out.

This report outlines our approach as well as key themes and recommendations for policy and practice.





➤ Our approach



What we did

First, we held workshops with people who have experience of living with no fixed address and have experience of one or more of the following:

- suicidal feelings
- attempted suicide
- self-harm
- being bereaved by suicide

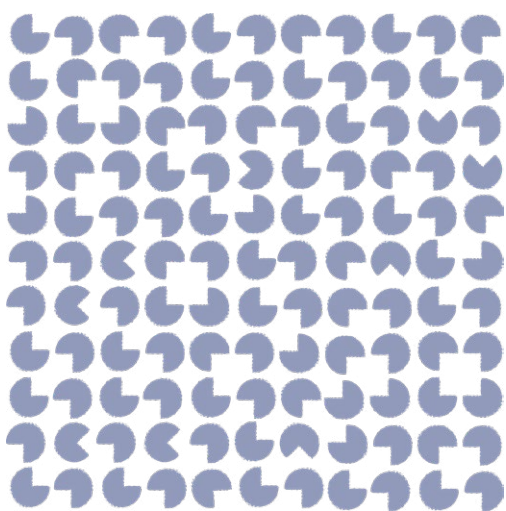
We explored three interconnected topics in these workshops.

1. What good suicide prevention support looks like for a person with no fixed address.
2. What the barriers are for people with no fixed address getting good support around self-harm, suicidal behaviour or bereavement by suicide.
3. What needs to change to improve support around self-harm, suicidal behaviour or bereavement by suicide for people with no fixed address and what already works well.

As noted, we were open to exploring not only suicide prevention support but also hearing about support for the risk factors of self-harm and bereavement by suicide. The people that we worked with all experienced either suicidal feelings and/or had attempted suicide and focused predominantly on suicide prevention support, so this has become the focus of this report.

Next, we hosted a recommendation session with the same people where we reflected on the workshop discussions and agreed upon recommendations for change in policy and practice.

Finally, we discussed our recommendations with a number of homelessness charities in England to ensure our recommendations are relevant and meaningful for wider application in policy and practice.





Who we worked with

We worked with nine people with relevant lived experience to discuss this topic.

The people we worked with had a range of different experiences of suicidal feelings, attempting suicide, self-harm and being bereaved by suicide. Most of the group had experienced more than one of these.

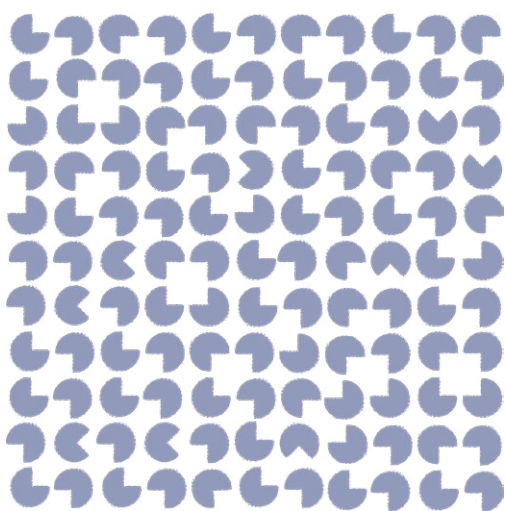
People can experience homelessness and housing insecurity in many different ways. For this work, we were looking at suicide prevention support for people with no fixed or permanent address. The experiences of the people we worked with included but were not limited to; living rough, use of emergency accommodation, living in temporary accommodation for the homeless, staying in a women's shelter, living in temporary accommodation for immigrants, experience of being released from institutions, relying on insecure accommodation such as using Airbnb, a tent or living in their car.

People had varied experiences of accessing support. Some people had tried to get support for suicide, self-harm or bereavement by suicide when they had no fixed address and they were able to access it.

One person tried but was denied or unable to access support for suicide, self-harm or bereavement by suicide. Some people did not try to access this kind of support at the time. It was unclear if this was because they didn't think they needed it, there were barriers to them trying or if they didn't think they would be able to access it.

The people we worked with were between the ages of 35 and 64 and included people of different genders, ethnicities, sexualities and religions, as well as some people who were disabled. These nine people were based in different areas in England.

It is important to highlight the diversity of experience and perspectives that we heard from for this project but to also acknowledge that nine people do not represent all experiences of people with these same identities or experiences. Additionally, we did not hear from a number of people with specific experiences which could be relevant. Notably, we did not work with young people or a wide range of ethnic groups or faith groups.





➤ Attitudes towards people with no fixed address



We heard experiences of people with no fixed address being treated poorly by healthcare and other professionals. People told us about feeling invisible, about being refused support, being made to feel unwelcome and being treated differently to other people because they were experiencing homelessness. What we heard corresponds with the existing evidence base.¹⁴

“ I’ve been sprayed with air freshener by a receptionist once. ”

People shared assumptions that had been made about them; that they smelled bad, that they were time-wasting, that they were an additional burden on services, that they must already have the help they need because they are in a women’s refuge.

“ Attitudes and the way that they look at people who are homeless needs to change drastically. ”

We heard from one person who had previously gone to a GP for a physical health issue and was treated so poorly that, when they were experiencing suicidal thoughts, they did not trust that a GP would be able to help them so didn’t seek help.

“ I went to hospital with severe abdominal pain, doubled up in pain, had to stand in the queue and was told ‘go and stand in the corner and when the normal people have been seen we’ll get to you’ and the only reason I actually got help is because I collapsed, in the corner. ”

We heard from people who have experience of homelessness who had advocated for one another in healthcare settings in response to the poor treatment.

“ A guy came in clearly street homeless, and I was at the reception and there was 3 of them behind the counter and a nurse and they said ‘Oh, let’s get him out as fast as we can. He’s going to stink the place’ [...] I actually demanded to see a manager and saw the line manager of the people working on reception and they all ended up apologising. ”

Judgemental and poor treatment of people with no fixed address spanned further than just experiences within healthcare services, but to other public services as well.





“ Policemen walked by and one of them came over with a huge piece of cardboard, a box that had been opened up, and laid it over the top of me. I thought what a kind thing to do, it's raining and he's put that over the top of me to keep me dry and as he walked away he said 'out of sight, out of mind.' ”

People also hear assumptions about people experiencing homelessness within their daily lives. When one person told their neighbour they did work with a homelessness charity they said:

“ I couldn't work with drugs and druggies and alkie. ”

This treatment has an impact on how people feel about themselves, leading to isolation, lack of self-worth and poor self-esteem, which people told us increased their suicide risk. This can then cause people to not trust the places that are supposed to help them, stopping them from seeking help when they need it.

“ The lack of education out there is difficult. ”

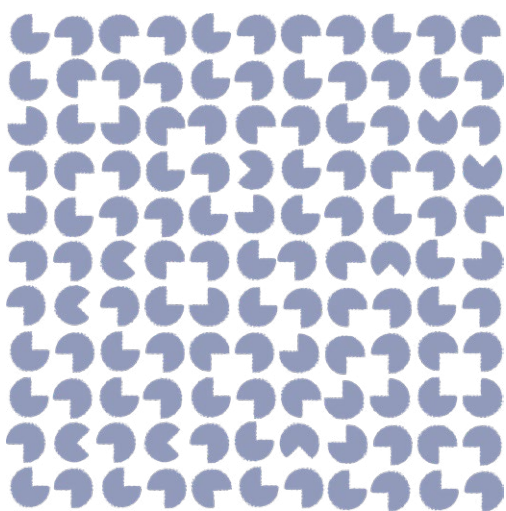
The way that people with no fixed address are treated is unacceptable. This is not down to one service or one person to change. Whole organisation and societal approaches are needed to address this. As one of the people we worked with said:

“ I also think that this is everybody's responsibility, it's not just one person's responsibility. ”

Services must treat people with respect, care and kindness in order to provide meaningful care for people with no fixed address, recognising that people's behaviour and engagement with services can be influenced by traumatic experiences and previous experiences of services. This is in line with NICE guidelines on improving access to engagement with health and social care for people experiencing homelessness.

“ They [all healthcare staff] need to learn more about empathy. ”

“ The attitude they [public services] should have is compassion, 'of course we will help'. ”





Recommendation 1

All public services and voluntary sector provision need to take a person-centred, trauma-informed approach to care for people with no fixed address. This must acknowledge that people will have different experiences and needs and that these identities and experiences will impact suicide risk and their healthcare needs differently.

“It’s not about what you think about them, it’s about what they think will help them.”

There is a need for mandatory training on the needs and experiences of people with no fixed address for staff and volunteers in all relevant services. This should include recognition of the barriers that people may have already overcome to access the service and the barriers they may face on being discharged from a service.

There are existing models of effective training provision in the voluntary sector for everyone working in a service that may come into contact with people experiencing homelessness, that takes a holistic approach to training all frontline staff.¹⁵

It is also important that training takes a whole-person approach that doesn’t simply reduce someone to their experience of having no fixed address.

“Are they fully trained on the challenges people are facing? Because sometimes if you don’t know something, you’re not even aware of it and you don’t acknowledge it.”





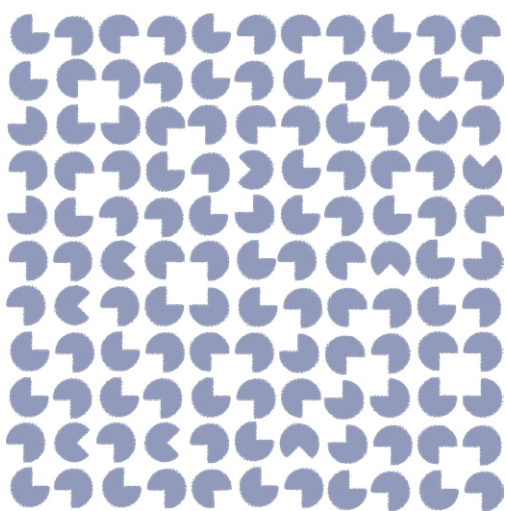
Recommendation 2

People with lived experience of having no fixed address should be involved with the design, development, delivery and evaluation of services to ensure that they are non-judgmental and supportive.

This involvement could be at different points in the ladder of engagement and many examples of great practice are already happening. For example, Groundswell, Homeless Link and Pathway worked with people with relevant lived experience to develop resources to ensure staff have the knowledge and skills to support people effectively around suicide within the homelessness sector.¹⁶ NICE guidance on integrated health and social care for people experiencing homelessness also recognises the value of co-designing and co-delivering services with people with lived experience of homelessness.¹⁷

“ I’ve actually joined the patient panel group for the GP surgery specifically to make sure that they treat the homeless better. ”

“ Those closest to the solutions are often furthest away from the power and the resources. ”





➤ Access to support



We heard that there is a lack of consistent access to good suicide prevention support for people who have no fixed address. This applied to support that could help specifically when they were actively planning to take their life or had attempted to take their own life eg, crisis support. People also told us about support that could have helped to reduce their suicidal thoughts and feelings which included reference to housing, mental healthcare and physical healthcare.

People shared that there are practical and emotional barriers that prevent people who had no fixed address accessing help for their experiences related to suicidal behaviour and bereavement by suicide. One person shared:

“Often the only support out there is support from the other people who are homeless.”

Emotional barriers included feeling overwhelmed, isolated and undeserving, being unsure about safety and lack of trust in certain services. People told us that these feelings had prevented them from help-seeking around suicidal thoughts and so are important to consider when designing accessible support.

“When I had nowhere to stay, I stayed with my brother for a week, and I stayed with a friend for a week, but you feel that you’re a burden and you feel worthless and that’s why my suicide tendencies were sky-high because of that feeling of worthlessness [...] it’s more of the kind of emotional barriers for me, I didn’t feel that I deserved any help.”

Some people told us that these feelings of being a burden contributed to their thoughts about ending their life. This further emphasises the importance of understanding and addressing the needs of people experiencing homelessness and housing insecurity. These feelings were frequently referred to by the people we worked with.

When people do present at services, they must be offered the mental health, wellbeing and crisis support they need there and then. Unfortunately, we heard that even when someone was able to overcome the emotional barriers to seek help, they were met with obstacles from services. One person told us about a friend they were supporting who was rough sleeping and experiencing suicidal thoughts:

“He went into the local hospital, went to the A&E. And they told him they couldn’t really help him today. If he came back tomorrow, they’d be able to have somebody there to talk to him. He didn’t make it through the night.”





Barriers to receiving help took many different forms. Some people were refused services due to availability or not meeting eligibility criteria. Some people didn't know how to access support; we heard that support is not being offered in the geographical locations where people are experiencing homelessness or housing insecurity.

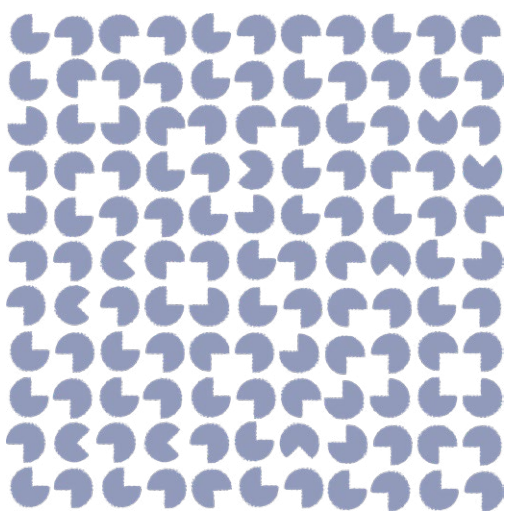
Support is also not being offered in an accessible way. For example, some people experience language barriers to accessing suicide prevention support such as helplines and crisis services. A key issue around accessibility in respect to not having a fixed address was raised regarding having to book and get to appointments. Without access to a phone or the internet, booking an appointment in the first place is difficult and without a means of travel, getting to the appointment or picking up medication is another issue. One person described how difficult it can be to access support when it is appointment only:

“ I didn't have a watch, I didn't have a smartphone, I didn't know what day it was then, so how was I going to work out 3 weeks' time on a Tuesday at 2pm? ”

We also heard about long waiting lists to access mental health care and specialist mental health services that were listed as being available through the NHS not being available in practice. We also heard about the impact of waiting lists for other types of health needs such as gender identity care and the impact not accessing this in a timely manner can have on someone's experiences related to suicide.

“ Another issue is waiting lists for counselling and gender transition [...] and trans people are a very high-risk group regarding these issues [suicide risk and homelessness]. ”

Research tells us that the risk of suicide and self-harm is higher for trans people than cisgender people,¹⁸ and 25 per cent of trans people have experienced homelessness at some point.¹⁹ People we worked with felt that these experiences should be considered in tandem to ensure that people can access the support and care they need to reduce suicide risk.





People also provided examples of good practice when it comes to service access. This included the importance of direct outreach to people experiencing homelessness and housing insecurity, to let them know what support was available and how to access it. The services that were able to provide the support that was needed were reliable and well known in the community and offered holistic support in many different ways to meet the needs of different people.

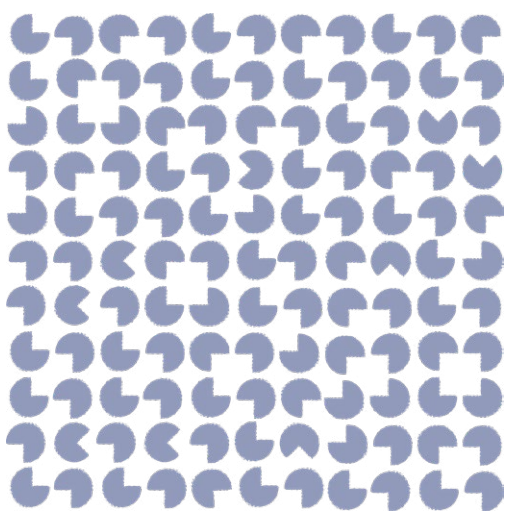
“ Different things work for different people. ”

We heard that there are often short-term projects that aim to address access needs but by the time they begin to be well known and trusted, they close or change due to funding or other external factors. One person explained that offers of short-term support can have a detrimental impact on how someone sees themselves. It can reduce their self-worth, feeling that they are not worthy of long-term support and time, and in turn, they said that this can increase suicide risk.

We know that people who experience homelessness are high-intensity users of A&E.²⁰ People we worked with told us that often accident and emergency services were the only place that they could go, but often described this as the last option, with a desire for community-based options available and accessible to them.

“ The main point that people might be offered support in terms of if you’re feeling suicidal is going to A&E and that can be quite an unpleasant experience. ”

“ No one went to the hospital unless it was a dire emergency and they thought they were dying. ”





Recommendation 3

There is a need to ensure that existing crisis provision, particularly A&E services, meets the needs of people with no fixed address seeking crisis support. This should be complemented by hubs based in communities that connect people with no fixed address to the mental health support they need earlier, helping to prevent suicide.

These hubs should be well known to people experiencing homelessness and their networks. They should be reliable, safe and trustworthy with open access, developed alongside people with lived experience of homelessness and housing insecurity. These hubs should provide immediate practical support and advice, as well as acting as a conduit to multidisciplinary support.

They should offer outreach services and be connected in the community so that people can more easily seek support and be met where they are. Consideration for the accessibility of the hub must be a key component, for example, if the hub is in a rural area, then transport needs must be met and translation services should be available for those who need them.

“ Having in our communities a hub, that’s dependable, that’s very well known within the community. That people can go to that’s safe. ”

The refreshed Joint Strategic Needs Assessments (JSNA) by Integrated Care Boards (ICB) offer a unique opportunity to identify existing hubs in local areas and identify gaps in provision. They would be best placed to support the development of this programme, including the crucial element of ensuring that these hubs are well known and accessible across healthcare services, housing systems and in the community to people experiencing homelessness and housing insecurity. This is in line with the national framework for NHS action on inclusion health that specifically identifies the needs of people who experience homelessness as requiring “explicit and tangible focus in system efforts to reduce healthcare inequalities”.²¹

NICE guidance on integrated health and social care for people experiencing homelessness also emphasises the importance of outreach, low threshold services, drop-in support and single spaces to access multiple services.²²



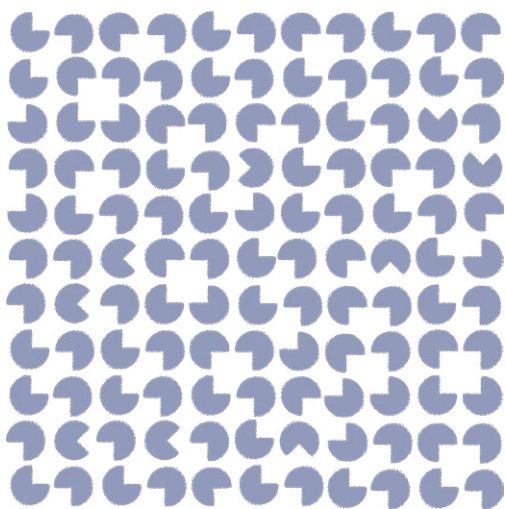


Recommendation 4

Where waiting lists persist across mental health and other health care provision, consideration should be given to the specific communication needs of those with no fixed address on waiting lists. For example, a person may not have access to the internet or a fixed postal address.

“ Really long waiting lists are hard for most people who have a consistent place to live, let alone if you don't. ”

While people are waiting for support, they should be given information in their preferred format on how to access immediate help if they experience suicidal thoughts, are actively planning to take their life, if they have taken steps to take their own life, are self-harming or become bereaved by suicide.





Support that meets people's needs



The needs of people with no fixed address are personal and complex. It is important to consider several factors when looking to provide good suicide prevention support. Suicide prevention support is about both offering help for suicidal thoughts specifically, such as during a crisis, as well as providing help that can reduce suicidal thoughts and feelings.

Numerous different types of support were shared with us as being important for suicide prevention for people with no fixed address. We also know that many of these support needs are directly linked to risk factors for suicide or at-risk groups. These included, but were not limited to, support with:

- bereavement
- domestic abuse
- drug and alcohol use
- gender identity care
- housing
- mental health
- peer support
- practical issues, ie, sleeping bag, food, a place to shower, a cup of tea.

There were a number of principles that people with lived experience raised with us as important when looking to provide a service that meets people's needs.

“ For me, it comes down to just one word and that is safety. ”

Safety was a crucial feature of any help that someone sought. This can be provided through physically offering a safe and comfortable environment and offering emotional safety. For example, within

support services, building trust, being transparent and clarity of boundaries was key. One person summed up why the safety of the setting was so important to them.

“ Do you have enough time to go into details and going into that root cause, which that person is thinking, I think that needs a proper setting. As a suicide, it all comes from a lot of issues, it's not just one thing. ”

We heard about the need for services to be proactively welcoming. Given the emotional and practical barriers that many need to overcome to seek support at a service, whether that is a GP or housing-specific service, the positive impact that a warm and proactive welcome has for people cannot be overstated. All staff, from reception to clinical supervisors, have a role in providing a welcoming front-door to the service. This will reduce barriers to support that can reduce suicide risk.

There is a need to recognise the impact and power that having people with relevant lived experience involved in all aspects of a service from strategic decision making to service delivery can have on the mental health and wellbeing outcomes of the people accessing help. People strongly felt that services who had people with relevant lived experience working in them had better outcomes.





“ They [people with no fixed address] are more likely to get the help because there’s somebody there with the lived experience whether it be in a hospital setting, a GP surgery, or even outreach. ”

There is a need to personalise help being provided, whatever type of support this is. Personalisation includes giving people time and space to share their experiences and information that is relevant to their care. Given the nature of homelessness and housing insecurity, there are many factors that can be at play. Providing someone with multiple opportunities to explore different experiences and things that have happened will be beneficial to providing relevant support.

“ We’re talking about homelessness, they [people experiencing homelessness] are already struggling a lot in very different areas of life. ”

It is important to listen to and acknowledge a person’s whole experience. People told us that this was really validating to have their experiences acknowledged.

“ Giving them that opportunity and recognising them is important as well. ”

One person explained that some services don’t offer enough time for them to cover what they need.

“ It’s very little sessions you get and just as you get started then these sessions come to an end. ”

They highlighted that different people will need different amounts of time to explore different issues and experiences.

Inclusive services are vital to providing support that meets the needs of people with different identities and experiences. People shared that having their minoritised experiences acknowledged and understood helped to keep them safe from acting on their suicidal thoughts. Real emphasis was placed on cultural and religious sensitivity by the people we worked with.

“ Are they [the health workforce] coming with their own lenses to the situation or they are flexible to put another frame of reference and see through things. ”

People also shared with us that they felt that decisions were made on care and housing based on the perceived priority of need, but this didn’t take into account things they considered important to their vulnerability such as their mental health, gender or refugee status.

“ There needs to be a lot more scope of priority need not just physical conditions and age. ”





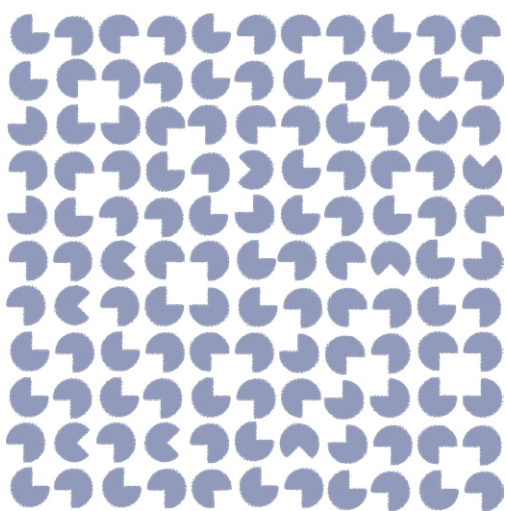
Recommendation 5

There should be no barriers or exclusion for people seeking support with suicidality wherever they seek help, in line with the Suicide Prevention Strategy's commitment to a 'no wrong door' approach.

Care and support around housing and health should be joined up to allow people to access the support they need wherever they present, the first time they present.

These systems of care and support must be equipped to confidently work with people who experience suicidal ideation and have the policies and processes in place to enable them to reduce barriers to support.

“ Help in every avenue, so if it's mental health, addiction, homelessness, you know, if you've got that map of their support, they've got more chance to succeed. ”



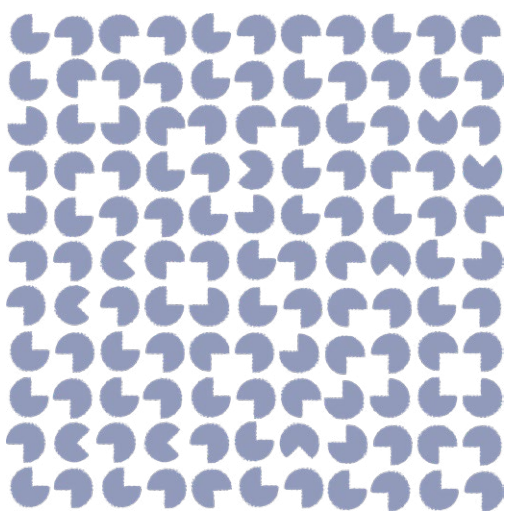


Recommendation 6

The government should ensure that all different types of support that help to prevent suicide are fully funded and resourced. Without funding, services will struggle to deliver the levels of help and support needed to meet the needs of people and achieve the ambition of seeing fewer people die by suicide. This includes both statutory provided services and the VCSE sector which provides vital suicide prevention support for people with no fixed address such as peer advocacy and facilitating community support groups.

There is uncertainty over the future of ringfenced local suicide prevention funding which plays a vital role. Social prescribing budgets can also support relevant interventions.

“ People make a service, if they are trained properly, they are certified, they’re going to cost money and then they’re going to bring an effective and efficient service, that is why the funding is very, very important. ”





➤ The role of community

We heard that community can have a crucial role to play in suicide prevention support for people with no fixed address. Many people highlighted the role of community and friendship in reducing their suicide risk.

Safety and trust were really important features of community support, including peer support, when it comes to preventing suicide. One person explained that they had found some community spaces difficult to be in and explained what safe community support meant to them.

“ A structured format of community, that is chaperoned to make sure there isn't exploitation or bullying or anything like that. ”

Peer support was emphasised as highly valuable for people with no fixed address when it came to good suicide prevention. Having someone who can relate and understand your experiences helped some people address their emotional barriers to help-seeking. This also needs to be safe and fully resourced to have the levels of desired impact.

Community groups were also important in reducing suicide risk. Community groups geared towards specific experiences were particularly valued by the group, including queer spaces and bereavement support.

“ As long as you've got community and a connection with others facing the same unique challenge as you are, you can work together to find the solution. But when you're on your own in complete isolation, that's where the suicide thoughts are. ”

Community spaces specifically for people experiencing homelessness or housing insecurity are also crucial. People told us that these spaces allowed them to build up routines and experience social connections and activities that they otherwise don't have access to. This was empowering and helped reduce isolation and other factors related to suicide risk. The group gave examples of community spaces that can provide this preventative support, such as community football clubs and soup kitchens.

“ It should be about prevention. Not wait until it's too late. ”



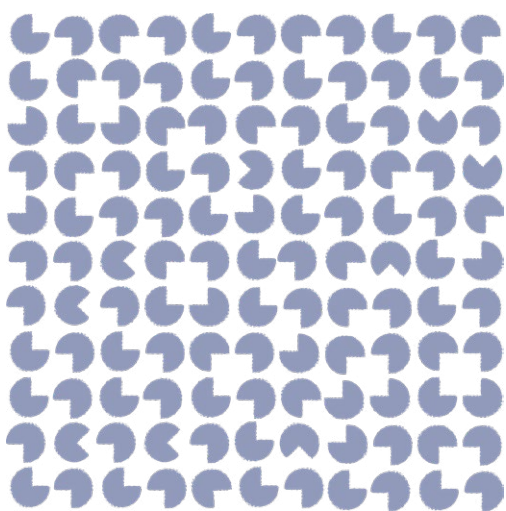


Recommendation 7

There is a need to fund quality peer support for people with no fixed address to help specifically with suicidal thoughts in every area of England. The charity Groundswell already has a brilliant model of Homeless Health Peer Advocacy (HHPA). Their research shows that this model of support led to a 42 per cent reduction in unplanned care activity costs, leading to an indicative saving of £2.43 for every £1 spent for the NHS.²³

“ More support groups in the community, things like that, because there’s a lot of people affected by it [suicide], either directly or indirectly. ”

“ We deserve consistent support that’s going to be there over years, not just funded for a couple of months or a couple of years. ”





Contributors

The Suicide Prevention Consortium (Samaritans, National Suicide Prevention Alliance, Support After Suicide Partnership and WithYou) couldn't have done this report without the people with lived experience who shared their time, experiences and perspectives with us and the person who gave us our title quote, thank you. And a special thanks to the organisations and individuals that helped develop this project and support it.

- Groundswell
- Homeless Link
- The Outside Project
- Pathway
- Christopher Frederick
- Sahar Khan

This work has been funded through the VCSE Health and Wellbeing Alliance, jointly managed and funded by Department of Health and Social Care, NHS England and UK Health Security Agency. For more information, please visit:

england.nhs.uk/hwalliance

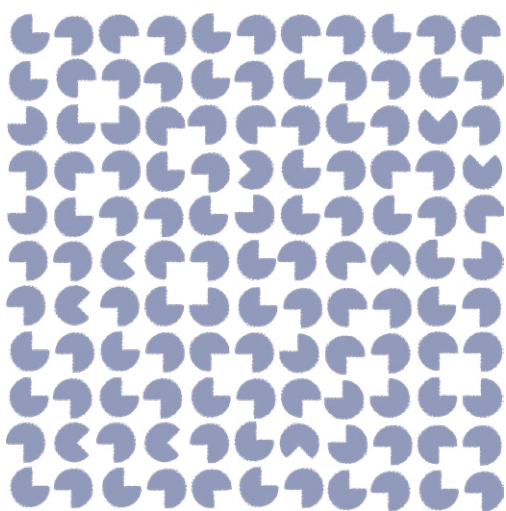
For more information Please contact the Policy, Public Affairs and Campaigns Team at Samaritans by emailing

campaigning@samaritans.org

**Contact a Samaritan.
If you need someone
to talk to, we listen.
We won't judge or
tell you what to do.**

**Call us any time, day or night,
for free on 116 123 or visit
samaritans.org for other
ways to get in touch.**

**Whatever you're facing,
a Samaritan will face it
with you.**

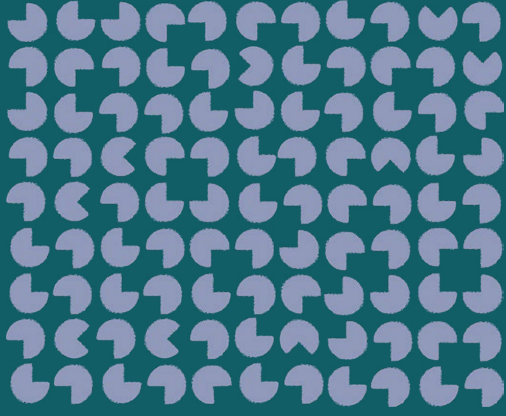




References

1. Brackertz. "The role of housing insecurity and homelessness in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours: a review of the evidence." (2020).
2. There were an estimated 99 suicide deaths, accounting for 13.4% of deaths. Office for National Statistics (ONS). "Deaths of homeless people in England and Wales: 2021 registrations" (2022).
3. Department for Levelling Up, Housing and Communities (DLUHC). "Statutory homelessness in England: 2022-23" (2023).
4. Suicide Prevention Consortium. "Insights from experience: economic disadvantage, suicide and self-harm" (2023).
5. Nilsson, S.F., Nordentoft, M. & Hjorthøj, C. "Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: a Systematic Review and Meta-analysis." (2019).
6. Bernadette Peltier, et al. "A Longitudinal Study of Suicidality in a Homeless Population Sample" (2021).
7. Office for Health Improvement & Disparities (OHID). 'Adult substance misuse treatment statistics 2022 to 2023: report' (2023).
8. NICE. 'Integrated health and social care for people experiencing homelessness' (2022)
9. O'Connor, R. C., & Kirtley, O. J. "Integrated Motivational Volitional (IMV) Model of Suicidal Behaviour." (2018).
10. O'Connor, R. C., & Kirtley, O. J. "Integrated Motivational Volitional (IMV) Model of Suicidal Behaviour." (2018).
11. Samaritans. "To thrive, not just survive: The case for joined up money and mental health support" (2023).
12. Department for Health and Social Care (DHSC). "Suicide prevention in England: 5-year cross-sector strategy" (2023).
13. Department for Health and Social Care (DHSC). "Suicide prevention in England: 5-year cross-sector strategy" (2023).
14. Healthwatch. "What homeless people told us about their experience of health and care services". (2023)
15. For example, as of January 2024 Homeless Link offer training on 'Homelessness: an introduction' as well as 'Suicide: prevention, intervention and post-incident protocols'.
16. Groundswell, Homeless Link and Pathway. 'Resources for organisations developing suicide prevention policies and procedures' (2023).
17. NICE. 'Integrated health and social care for people experiencing homelessness' (2022)
18. Bailey, L. et al. 'Suicide Risk in the UK Trans Population and the Role of Gender Transition in Decreasing Suicidal Ideation and Suicide Attempt', Mental Health Review Journal, 19(4), 209–20 (2014).
19. Stonewall. "LGBT in Britain: Trans Report." (2018).
20. Moss et al. "Comparative 4-year risk and type of hospital admission among homeless and housed emergency department attendees: longitudinal study of hospital records in England 2013–2018" (2021).
21. NHSE 'A national framework for NHS – action on inclusion health' (2023).
22. NICE. 'Integrated health and social care for people experiencing homelessness' (2022)
23. Groundswell. 'Saving lives, saving money: How homeless health peer advocacy reduces health inequalities' (2015).





SAMARITANS

Samaritans Registered Office

The Upper Mill, Kingston Road, Ewell, Surrey KT17 2AF
T 020 8394 8300 F 020 8394 8301

samaritans.org

Founded in 1953 by Prebendary Dr Chad Varah CH CBE.

Samaritans is a charity registered in England & Wales (219432) and in Scotland (SC040604),
and a company limited by guarantee registered in England & Wales (757372).

Cover photo: ©Chris O'Donovan Photography/Samaritans.

