Opening the Door to Hope 2

An evaluation of suicide prevention in homeless services

Dublin Simon Community

Sure Steps Counselling

2020

Acknowledgements

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Foreword

This report is set against the background of the *Opening the Door to Hope* report launched by Sure Steps Counselling in June 2018. Little did we all know then, that since that time the world would be in the grip of a pandemic, impacting on the physical, mental and social health of society.

Since June 2018, Sure Steps Counselling with the support of our partners in National Office For Suicide Prevention, extended our suicide prevention service to provide much-needed support seven days a week, 365 days a year to clients across a wide range of homeless services, mainly in the greater Dublin area. The extended service went live in September 2018 and since that time has demonstrated an increasing need for mental health support to one of the most at-risk groups in society. When Covid-19 forced a national lockdown in March 2020, Sure Steps Counselling established a Freephone support line, and continued supports through phone and video until we in June 2020 could again meet with clients face to face.

This report provides an independent evaluation of our suicide prevention service over an 18 month period. It also analysis the clinical data from interventions utilising the Collaborative Approach Managing Suicidality (CAMS) within homeless services and a comparative analysis of data with a community mental health service, and finally the report contains a published report on counsellors' experience of utilising CAMS in the homeless sector.

Once again it is with tremendous pride that we present this comprehensive report. While we all face into an uncertain future, we remain hopeful and focused, that we in collaboration with our partners will continue to adapt to meet the needs of our clients for whom we exist to serve, providing the best possible evidence-based interventions.

Derek Depmsey
Sure Steps Counselling Manager

Opening the Door to Hope 2

As we continue to navigate this global crisis of human health, holding on to hope has never been more important. This virus has waged war on our communities, our families and our hospitals. This prolonged period of fear, worry and isolation has led to the rise of important discussions about our mental health and a greater willingness to talk openly about how we are coping under these extremely challenging conditions.

Across our services, we have responded to the pandemic in real-time. We identified the unique vulnerability of our clients as Covid-19 crept across Europe in the Spring of last year, adapting and intensifying our supports and services to keep our people physically and mentally well. Our Sure Steps Counselling service persevered in the face of extraordinary challenges. They thought creatively and adjusted their service provision to ensure the most isolated and vulnerable members of our society knew they were not alone.

Throughout these strange and remarkable times, Sure Steps Counselling has continued to bring a glimmer of hope to those facing their darkest hours. As we continue to battle the anxiety and uncertainty of this crisis, those in homelessness are doing so with the added pressures of “where will I sleep safely tonight”, “where can I go to keep my family safe”, “when will I finally be able to close my own front door behind me.” The emotional support they receive from this unique service offering is needed now more than ever before.

Across all our services at Dublin Simon Community, from outreach, to housing, treatment, prevention and employability services, our role will always be to safeguard our clients and residents and give them a sense of hope for brighter days ahead.

From all of us at Simon, thank you to our donors, funders and partners in the HSE, authors of this report Kevin Cullen (WRC), Lisa Anne Kennedy (CES) and Rachel

Opening the Door to Hope 2

McDonnell Murray, the staff of Simon who gave generously of their precious time to contribute their experiences and especially the National Office For Suicide Prevention for continuing to be a valued part of our community. Our life-changing work would not be possible without you.

Sam McGuinness
Dublin Simon Community CEO

Evaluation of Out-of-Hours (OOH) Extension of Dublin Simon Community's Sure Steps Counselling Suicide Prevention Response Service

1.1 Executive Summary

This report presents the results from an evaluation of the addition of Out-Of-Hours (OOH) coverage to the Suicide Prevention Response Service (SPRS) part of Dublin Simon Community's Sure Steps Counselling service. Before the OOH service commenced Sure Steps operated mainly during the daytime and on weekdays (Monday to Friday), with some part time volunteers providing evening and weekend sessions.

Introduced in late 2018 with funding from the National Office For Suicide Prevention (NOSP), the OOH service extends the Sure Steps suicide prevention response coverage to 10.00pm during weekdays (Monday to Friday) and also operates 4.00pm to 10.00pm on Saturdays and Sundays. It focuses especially on suicide prevention, and provides support to clients and frontline staff across the Dublin Simon Community services and also a number of other homeless services. The day service continues to provide both general counselling and suicide prevention services.

Approach & Methods

The evaluation focused mainly on assessing the impact and value of the OOH extension of Sure Steps for suicide prevention amongst homeless persons, including the potential to help frontline homeless services reduce avoidable ambulance call-outs when clients present with suicidality-related incidents. It also more broadly considered the impact and value of the wider Sure Steps service that the OOH service is part of, and the overall 'end-to-end' mental health and suicide prevention service Sure Steps provides (during the daytime, evening/early night-time, and at weekends).

Methodologically, the evaluation utilised a mixed-methods approach comprising both quantitative and qualitative data gathering and triangulation of data from a number of sources. Dublin Simon’s critical incident reporting system and the Sure Steps service activity datasets provided core sources of data, covering 395 suicidality/self-harm related incidents within Dublin Simon services during 2018 and 2019, and 655 interventions/sessions provided by the Sure Steps OOH team for the full year 2019. Interviews with managers and staff from Sure Steps and from frontline Dublin Simon homeless services provided stakeholder perspectives.

Main Findings

Contribution of the OOH Extension of Sure Steps

Overall, the results of the evaluation indicate the OOH extension of the Sure Steps suicide prevention response service is working well and providing a valuable enhancement to the weekday day-time service. This is supported by quantitative and qualitative evidence from a range of sources and perspectives. Quantitatively the OOH is providing a large number of interventions, with the bulk of these concerning suicidality and comprising a mix of crisis interventions and scheduled Collaborative Assessment and Management of Suicidality (CAMS) counselling sessions. An allocation of approximately 2 whole-time-equivalents of counsellor time over the OOH shifts throughout the year provided 655 interventions in 2019.

This is a substantial caseload and achievement given the unpredictability of client presentation and the responsive nature of the service, with most interventions and scheduled sessions delivered on-site in the client's homeless accommodation and sometimes even on the street.

The other quantitative dimension concerns frontline homeless service ambulance call-outs for suicidality or self-harm related incidents. Analysis of Dublin Simon's Quality Office data on such incidents found ambulance call-outs were lower by almost one-half during the period since introduction of the OOH service (September 2018 – December 2019) compared with the eight-month period before this for which data was available.

More detailed qualitative information from the incident dataset and the OOH service activity log provides evidence of how the OOH service contributed to this. This shows how the OOH service is reaching and supporting clients and staff in frontline services through intervention and support in crisis situations, organization of proactive preventative measures through staff education and client safety plans, and supporting clients with suicidality to engage in ongoing suicidality-oriented counselling through the CAMS approach. The critical incident reports from frontline services show the suicide prevention response service, and the OOH component of this, features prominently in the real-time management of suicidality and self-harm incidents, either through call-out of a counsellor to the site or phone-based support from a counsellor.

Apart from assessment and intervention in crisis situations, client empowerment features strongly in the approach through establishment of safe plans and encouragement of clients to call the OOH service during a crisis as part of their plan. The activity logs also show the volatility and vulnerability of the client population served, and the major efforts made by the counsellors to connect with at-risk clients and establish/maintain their engagement with the service. Keeping track of clients moving between accommodation and the street and keeping in touch with them requires considerable time and tenacity.

Whole system perspective & wider systemic importance

Based on these different evidence sources and perspectives, the OOH

extension of the service is clearly making a strong contribution as part of the overall Sure Steps suicide prevention response service and helps provide an alternative to ambulance call-outs for incidents where this is appropriate and feasible. A whole systems analysis of Sure Steps shows the joint and several contributions and importance of each element of the system – day service, OOH, and training of frontline staff to assist in stabilizing the situation when suicidality-related incidents arise using a Suicide Specific Treatment Track (SSTT) protocol based on the CAMS approach. All three elements interwork in an evolving overall 24/7 suicide prevention response service comprising crisis intervention and support, aftercare planning, and ongoing efforts to maintain the engagement of clients with suicide-oriented (CAMS) or general counselling where appropriate.

Ensuring ongoing sustainability and supporting the further development of Sure Steps has a broader systemic importance and relevance, both for delivering on national mental health policy and in operational efforts to ensure responsive and integrated services are available for the entire population and especially for vulnerable groups. The importance of attention to homeless persons is already referenced in current national suicide prevention policy (Connecting for Life) under Goal 3: Focus on Priority Groups. Objectives for this Goal include improvement of the implementation of effective approaches to reducing suicidal behaviour among priority groups, and addressing the high rates of alcohol and drug misuse in this context. The National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm also makes reference to the particular vulnerability of homeless persons who present with self-harm, and the need for specific protocols to ensure that they receive continuity of care.

Recommendations

The findings from the evaluation lead to a number of recommendations for actions at various levels. The recommendations apply in the first instance to Dublin Simon and NOSP, jointly and severally, as the two parties currently providing the operational funding for the Sure Steps service. They also address issues and responsibilities identified in wider mental health policy that fall within the remit of delivery and/or funding systems for mental health services for the population as a whole and for vulnerable groups. In jointly reviewing the recommendations, Dublin Simon and NOSP might consider how best to address the issues

themselves as well as whether/how to engage with the other stakeholders for whom the recommendations also have relevance.

As the findings from the evaluation are very positive overall, some recommendations focus on ensuring sustainability of the suicide prevention response service and the wider Sure Steps service of which it is an integral part. Others address operational aspects of the Sure Steps and wider Dublin Simon frontline services that could be further developed and improved in the next stage, as well as some new areas of innovation that offer value-adding potential.

Recommendation 1: **Review current funding and seek to secure a satisfactory and sustainable arrangement**

The evaluation looked at the entire Sure Steps suicide prevention response service from a whole system perspective. Key elements comprise the day and OOH teams that together provide on-call suicide response cover from 8am to 10pm on weekdays, and 4.30pm-10pm on weekends; proactive supports and capacity building for frontline service staff (especially based on the SSTT protocol developed by Sure Steps) to help them manage incidents themselves whenever possible and appropriate; and delivery of a substantial volume of scheduled counselling sessions. The interworking of these components provides a system that already delivers more than the sum of its parts.

Current public funding arrangements cover only a portion of the system (mainly the OOH aspect) and continued funding for the other components from Dublin Simon's own resources is unlikely to be sustainable. In the context of national policy and public resource allocation frameworks for mental healthcare services, this situation appears both anomalous and inequitable. For example, Sure Steps currently delivers a large number of general counselling sessions that it funds entirely from its own resources even though the service and client base served appears to fall squarely within the remit of publicly-funded schemes such as Counselling in Primary Care (CIPC). On the suicide prevention response side, NOSP provides a portion of the costs of the overall Sure Steps service but Dublin

Simon currently must fund the remainder from its own resources. From a funding perspective, however, it may be unhelpful to focus on too rigid a demarcation between activity addressing suicide prevention and general counselling activity, as substantial added-value in Sure Steps comes from the seamless interworking of the two streams.

Joint review of funding by Dublin Simon and NOSP is important at this stage, followed by efforts to secure a more appropriate and sustainable arrangement. This might include a joint approach to relevant public funding streams for mental health services of the type provided by Sure Steps.

Recommendation 2: **Put in place capacity to cater for increased demand and maintain service responsivity**

One of the challenges faced by Sure Steps is maintaining service responsivity in the light of substantially increasing demand. In part this emanates from an exacerbating homeless crisis and in part because the service is a 'victim of its own success' in reaching large numbers of clients from Dublin Simon and the other homeless services covered. The impacts of this have been very noticeable in recent increases in waiting times, with this now averaging 16-17 days for referred clients compared with just a few days in earlier years. It may also begin to the affect capacity of the suicide prevention response service to respond promptly to urgent suicidality-related incidents. Both impacts would be very detrimental to the service, where quick and agile response is so important for the volatile and vulnerable client base concerned.

In the context of the overall review of funding arrangements, there should be a specific examination of this capacity issue and efforts to ensure it is factored-in in the establishment of sufficient capacity on a sustainable funding basis.

Recommendation 3: **Develop and implement an action plan to better link and embed Sure Steps within the wider mental healthcare ecosystem**

The evaluation found the Sure Steps and wider Dublin Simon frontline suicide prevention response, as well as the more general Sure Steps counselling service, must largely operate in a siloed manner due to the lack of proper linkage with and

embedding within the wider mental healthcare system. This applies especially for linkages between Sure Steps and hospital Emergency Department services, and more generally with secondary and specialist mental health services when needed. The current situation significantly limits the possibilities for homeless persons to access the full range of mental health care they may require, and presents major barriers to continuity of care. One area of particular concern is access to appropriate joined-up care for dual diagnosis, given the high prevalence of a combination of addictions and mental health difficulties amongst homeless persons. Another problematic area is the lack of access to properly functioning stepped care pathways for Sure Steps clients who may have more severe mental health issues (e.g. psychoses) comorbid with the more common mental health conditions falling within the scope of Sure Steps primary care counselling.

Dublin Simon and NOSP could jointly initiate a project to address this important area, bringing in other relevant parties as appropriate. This might be something that would fit well within the Sláintecare implementation framework.

Recommendation 4:

Sure Steps and other Dublin Simon services should jointly review the suicide prevention response capacity from an overall organisational perspective, and develop and implement an action plan to address areas with potential for enhancement

The evaluation identified various aspects of the internal operation of the service that could be further developed and improved in the next phase. Whilst implementation of the recommendations on some of these may be contingent on additional funding availability, some could be more readily addressed at existing funding levels.

One key area warranting attention is further development of frontline service/staff capacity to themselves manage suicidality-related issues at the local level where appropriate/possible. Wider roll-out of training in the SSTT protocol for incident stabilisation and management is one important component of this, as well as evaluation of the experiences of frontline services in applying this in practice.

Feedback from frontline staff also indicates the value of other proactive educational inputs provided by Sure Steps staff in empowering them to better manage incidents locally, and consideration of further efforts in these areas would be useful.

From a targeting perspective, data from the Sure Steps suicide prevention response service indicates the largest share of engagements is with clients from temporary accommodation settings, which may reflect both the characteristics of the client population as well as the staffing profile of these facilities. Sure Steps staff also find that frontline staff unfamiliar with residents are more likely to call them and/or call an ambulance, and this appears to be a particular issue with agency staff. More generally, Sure Steps suicide prevention response protocols have been evolving and refining with growing experience, and there may be scope to further develop the shared response protocols between Sure Steps and frontline services when incidents arise.

Joint examination by Sure Steps and other Dublin Simon services of the suicide prevention response capacity from an overall organisational operational perspective would be useful, followed by development and implementation of an action plan to address this area.

Recommendation 5: Explore further value-adding possibilities through service innovation and research

The evaluation exercise also identified some further value-adding possibilities through service innovation and research. These may be worth exploring to support service development and enhancement, as well as for addressing some of the other recommendation areas above. In the context of COVID-19 and the associated social distancing and lockdown regimes, one area that has gained considerable momentum is the utilisation of technology to support delivery of remote intervention and therapy sessions (by phone, video or other media). Sure Steps has utilised these approaches to a very limited extent in its own COVID-19 response so far and there is scope to examine the potential for much wider utilisation in various aspects of its services.

Internally in Dublin Simon and other homeless sector services supported, this might include utilisation for delivery of scheduled therapy sessions and for provision of support in crisis situations. There may also be good possibilities to explore utilisation of these technologies for linking in with other parts of the mental

healthcare ecosystem, including hospital ED and other secondary and specialist mental health services. Apart from virtual visits, other eMental health applications such as screening tools for PTSD and other conditions also warrant exploration. As well as application for internal purposes in Dublin Simon, these approaches may offer good potential to support initiatives to better link with the wider mental healthcare system and care pathways, including the additional specialist mental health services needed by many Sure Steps clients as well as the national clinical programmes on self-harm presentations in ED and on early interventions in psychosis.

Given the large numbers of clients concerned, Sure Steps and the wider Dublin Simon services also present good opportunities for research to add to the Irish knowledge base and practice guidance for mental health services and suicide prevention approaches for homeless persons. Topics of particular interest might include:

- mapping the often-multiple contacts of homeless persons across the various services and points of contact with the wider mental healthcare ecosystem, and identification of possibilities for more integrated care provision

- follow-up of Sure Steps client outcomes in the medium-to-longer term, including mental health outcomes and broader functioning and life experiences

- examination of the value-for-money dimension of homeless mental health services, including value from health gain achieved and from reduction in avoidable utilization of hospital emergency and other higher-cost services.

- Sure Steps and NOSP might jointly and severally consider these and other innovation and research possibilities, and explore ways to develop and implement them through engagement with other relevant parties and funding streams.

1.2 Introduction

This report presents the results from an evaluation of the enhancement of the Dublin Simon Community's Sure Steps Counselling's Suicide Prevention Response Service (SPRS) through the addition of Out-Of-Hours (OOH) coverage. Before the OOH service commenced Sure Steps operated mainly during the daytime and on weekdays (Monday to Friday), with some part time volunteers providing evening and weekend sessions. The day service provided and continues to provide both general counselling and suicide prevention services. Introduced in late 2018 with funding from the National Office for Suicide Prevention (NOSP), the OOH service extends the Sure Steps suicide prevention response coverage to 10.00pm during weekdays (Monday to Friday) and also operates 4.00pm to 10.00pm on Saturdays and Sundays. It focuses especially on suicide prevention, and provides support to clients and frontline staff across the Dublin Simon Community services and also a number of other homeless services.

1.2.1 Background

Before the OOH initiative commenced, Sure Steps had already operated a counselling service for homeless persons since 2012. This provided general counselling for mild to moderate mental health conditions and had also been developing its approach to addressing suicidality because of substantial numbers of clients presenting to the service with suicidal ideation. Sure Steps introduced the Collaborative Assessment and Management of Suicidality (CAMS) intervention for this purpose, selected because of the growing evidence base for its effectiveness. Interim evaluation of a pilot of the CAMS approach within Sure Steps showed potential for achieving positive client outcomes, although also identifying issues for attention in ensuring feasibility of implementation within the operational environment of the counselling service and of frontline homeless service staff (Sure Steps Counselling, 2018).

As part of the follow-on from the CAMS pilot, NOSP provided funding for a pilot Out of Hours counselling service to extend the operation of the Sure Steps suicide prevention response service to evenings and weekends. NOSP were very aware of the high prevalence of mental health difficulties amongst homeless

persons and the evidence of substantially greater risk of self-harm and suicide ideation. As suicidality and self-harm crisis situations can arise at any time of the day or night, expansion of Sure Steps with an OOH component would provide a significant enhancement to its prevention response capacity.

For both Sure Steps and NOSP, of particular relevance also was the evidence from National Self Harm Registry research showing rates of self-harm presentations at Irish hospital emergency departments (ED) more than 20-times higher amongst homeless persons compared with those living at a fixed residence. Apart from the health system cost implications of avoidable ambulance call-out and ED attendance, homeless persons arriving at ED with suicidality or self-harm issues are at greater risk of leaving before seeing anyone and therefore not receiving the support and interventions they need. When not necessary for medical reasons, ambulance call-out and subsequent presentation in a hospital Emergency Department can increase the trauma for clients and is unlikely to result in entry to an appropriate aftercare system in the mainstream mental health system. The potential of the OOH service, and the wider Sure Steps suicide prevention response service, to reduce the number of avoidable ambulance call-outs for homeless clients was therefore of particular interest in the context of the pilot.

1.2.2 Approach and methods

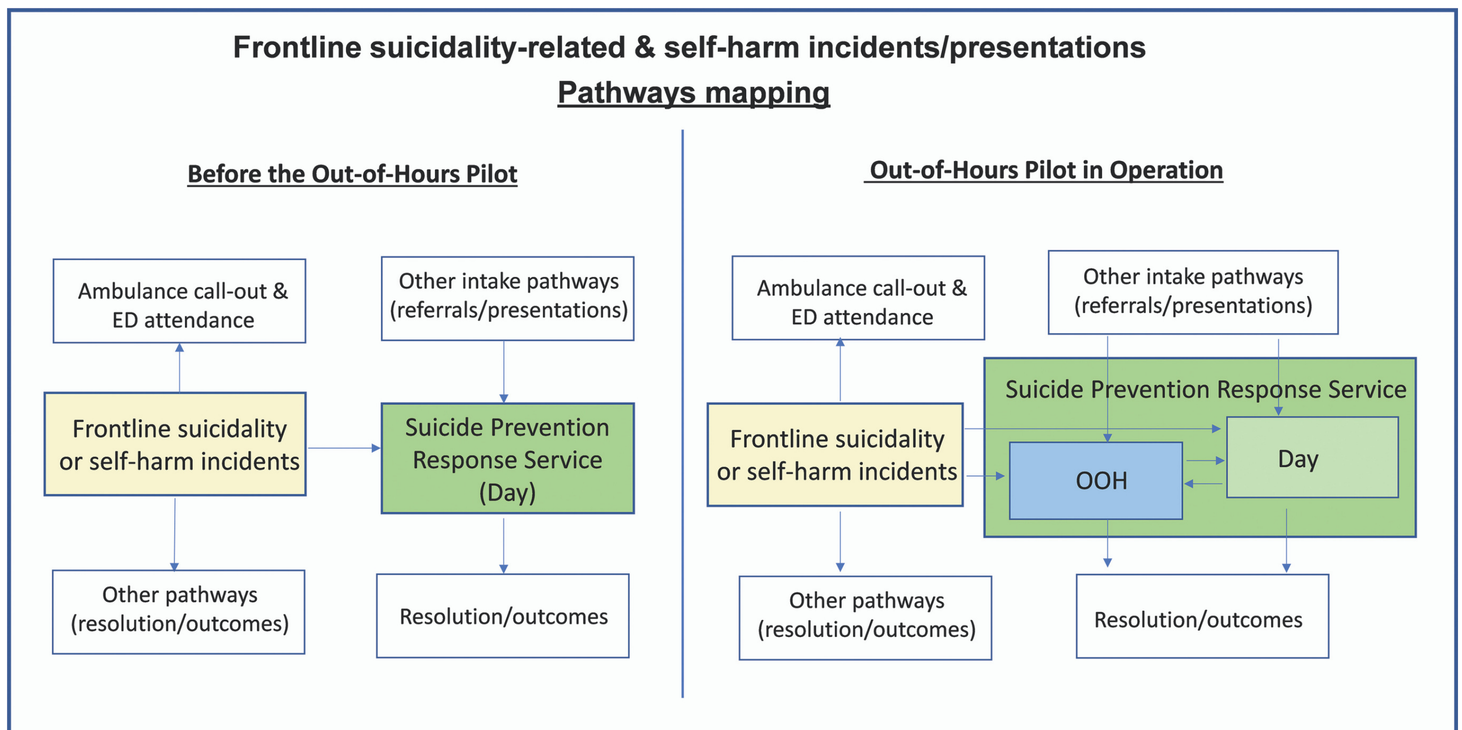
Against this background, the evaluation focused on assessing the impact and value of the OOH extension of Sure Steps for suicide prevention amongst homeless persons, including the potential to help frontline homeless services reduce avoidable ambulance call-outs when clients present with suicidality-related incidents. Although the primary focus of the evaluation and this report is on the impact and value of the OOH of service in its own right, it also considers the impact and value of the wider Sure Steps service. This is essential for understanding the overall 'end-to-end' mental health and suicide prevention service Sure Steps provides during the daytime, evening/early night-time, and at weekends, of which the OOH service is one important part.

The evaluation addressed three main themes:

- impact of the OOH service enhancement on pathways for homeless people presenting in frontline homeless services with suicidal ideation or self-harm
- how the service enhancement contributes and adds value in the overall Sure Steps service context
- considerations around continuing and further developing the enhanced service and the Sure Steps service as a whole

The methodology utilised a mixed-methods approach comprising both quantitative and qualitative data gathering and triangulation of data from a number of sources. Pathways mapping provided an overarching conceptual framework to guide the work, as shown in Figure 1.2.1.

Figure 1.2.1 Conceptual framework - pathways mapping



Quantitative analysis utilized data from two main sources: the Dublin Simon critical incident reporting system and the Sure Steps service activity datasets. Qualitative data came from interviews with key stakeholders from Sure Steps and from frontline Dublin Simon homeless services, as well as anonymised descriptive material contained in the two datasets mentioned above. Together, these data sources provided a substantial evidence base for the evaluation exercise.

This included data on:

- 395 suicidality/self-harm related incidents in Dublin Simon homeless services during 2018 and 2019

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- 655 interventions/sessions provided by the Sure Steps OOH team for the full year 2019.

Relevant Chapters of the report provide further details on these data sources and specific methods applied in different parts of the work.

1.2.3 Structure of the report

The remainder of the report has four core Chapters. Chapter 1.3 presents a description and analysis of the OOH suicide prevention response service activities during the full year 2019. Chapter 1.4 assesses impact and value of the service, including changes in ambulance call-out rates as well as other aspects of value. Chapter 1.5 takes a broader perspective and looks at the overall contribution to suicide prevention of the Sure Steps service as a whole. Finally, Chapter 1.6 provides a summary and conclusions and makes some recommendations for consideration, jointly and severally, by Dublin Simon Community, NOSP and other relevant HSE services, as well as other parties with remits to support mental health needs of homeless persons.

1.3 Profile of the Out of Hours (OOH) service and its activities

The Out of Hours (OOH) service is part of the wider Sure Steps mental health service for homeless persons. This provides both general counselling and a number of activity lines focusing on suicide prevention. This Chapter focuses on the suicide prevention aspect, particularly the OOH component of this. Chapter 4 presents some further details about the general counselling service.

1.3.1 Suicide Prevention Service

Core elements of the suicide prevention service include:

- Mental Health Crisis Intervention
- Suicide Specific and Self-Harm Specific Treatment Track (SSTT)
- Collaborative Assessment & Management of Suicidality (CAMS).

Mental Health Crisis Intervention

The crisis intervention service provides a rapid response service for suicidality- or self-harm-related incidents occurring for clients of homeless services. The service has counsellors on call to offer phone-based support and/or call-out to such incidents on an emergency basis. This is available to both Dublin Simon clients and clients of the other leading homeless service providers in the Dublin region. Sure Steps Day Service supports this from Monday to Friday, 8am to 4:30pm, and the Out of Hours Suicide Prevention Service extends the coverage until 10pm weekdays and from 4pm-10pm on Saturday and Sunday.

Where a client expresses suicidal ideation and/or is engaging in suicidal or self-harming behaviours, frontline staff can request an urgent call-out by a counsellor to see and assess the client. Depending on the situation and if it arises during Sure Steps operational hours, a counsellor may go out to see the client immediately in their accommodation, or arrange to do this within 24 hours, to conduct a crisis intervention and assess the client's needs.

Self-Harm Specific Treatment Track / Suicide Specific Treatment Track (SSTT)

The initial assessment will determine whether the client needs suicide-specific or self-harm specific counselling, as opposed to general counselling, and the service refers to the former as the suicide specific treatment track or self-harm specific treatment track (SSTT). Suicide-specific counselling follows the guidelines of the CAMS approach (see below). Self-harm specific counselling focuses on the function of the self-harm for each client and addresses the emotional regulation difficulties underlying the self-harm behaviours, utilising principles of Dialectical Behaviour Therapy (DBT) and Cognitive Behavioural Therapy (CBT).

Sure Steps has also prepared a risk assessment protocol (also referred to as SSTT protocol) based on the CAMS approach, as well as an accompanying booklet to guide and support its application. A training program has commenced for frontline staff in Dublin Simon services to help them complete an initial risk assessment and create a safety plan for a client presenting with suicidal or self-harm behaviour/ideation. This might be utilized before contacting the counselling service for call-out or to support management of the incident by the frontline staff themselves where appropriate. It also helps staff to assess the level of risk in a situation and inform the Sure Steps suicide prevention response service so the counsellor can assess the urgency of the call-out needed; someone at high risk will get an immediate response, whereas someone with low risk may get an appointment within 24 hours if no appointment available on the day.

Collaborative Assessment and Management of Suicidality (CAMS) approach

In 2016, Sure Steps recognised the need for a specific suicide management approach that would meet the complex needs of their clients who have expressed suicidal ideation. The service chose the Collaborative Assessment and Management of Suicidality (CAMS) approach for this, based on its extensive empirical research showing a decrease in suicidal ideation in clients.

CAMS is an overall process of clinical assessment, treatment planning, and management of suicidal risk. It can reduce suicidal ideation, reduce overall symptom distress, and increase hope in clients displaying suicidal and self-harming behaviours. CAMS is a flexible, therapeutic framework where suicidal clients work collaboratively with the counsellor to assess their suicidal risk and use that information to plan and manage suicide-specific, “driver-oriented” treatment.

Through their CAMS sessions, the counsellor and client will examine the client's core suicidal beliefs and reasons for living and dying, explore related suicidal behaviour and symptoms, and develop and implement an individualised treatment and stabilisation plan.

1.3.2 OOH service activity profile

The core feature of the OOH suicide prevention response service is the availability of on-call support for frontline staff and clients for suicidality-related or self-harm incidents. A substantial part of this involves offering immediate or urgent interventions/sessions where needed, through phone-based support or call-out to the incident site. It also holds drop-in clinics in a number of homeless accommodation centres, allowing flexible access and encouraging familiarity/awareness of the service amongst clients and staff. As well as the core crisis response element, the service also provides a considerable volume of scheduled counselling sessions during the OOH periods covered.

The OOH service prioritises calls or referrals relating to suicidality or self-harm, which may require immediate response or scheduling of an assessment/intervention session as soon as possible. It also provides ongoing care through regularly scheduled suicidality-related CAMS sessions for clients, where appropriate and client is willing. Additionally, it provides more general counselling sessions when capacity is available, with allocations coordinated through the Sure Steps counselling coordinator. Overall, the service provided 655 client interventions/sessions during the full year in 2019. Table 1.3.1 presents an overview of the numbers of different types of interventions/sessions provided. This comprised 203 SSTT interventions (31.0%), 298 CAMS sessions (45.5%), 138 general counselling/SSTT sessions (21.1%), and 16 self-harm counselling sessions (2.4%).

Table 1.3.1 SPRS (OOH) Interventions (full year, 2019)

		#	%
SSTT	*In person*	*133*	*20.3*
	Phone	*70*	*10.7*
	Total	203	31.0
CAMS	*In person*	*291*	*44.4*
	Phone	*7*	*1.1*
	Total	298	45.5
Self-harm counselling		16	2.4
General counselling/SSTT		138	21.1
Total		655	100.0

Of the 655 engagements, 369 (56.3%) were with Dublin Simon clients and 286 (43.7%) were from other homeless agencies. For the engagements with clients from Dublin Simon services, 231 (62.6%) were with clients in Supported Temporary accommodation, 78 (21.1%) with clients in treatment services, 40 (10.8%) with clients in Supported Long Term accommodation, and 20 (5.4%) with clients from outreach and other such services.

Most interventions/sessions are suicidality-related, either SSTT (Suicidality and Self-harm Treatment Track) or full CAMS (Collaborative Assessment and Management of Suicidality). SSTT interventions follow the Dublin Simon counselling service protocol for immediate intervention in suicidality-related presentations. This is a short version of the more extensive and CAMS protocol the service uses for ongoing (multi-session) treatment of suicidal ideation. For both types of intervention, the engagement with the client is mainly in-person, although quite often SSTT interventions are delivered over the phone because of the immediacy of the need and/or logistical issues around organizing an in-person session. Additionally, the service provided a small number of specifically self-harm-oriented counselling sessions.

The OOH service also provided a substantial number of general counselling sessions, sometimes as follow-on from initial SSTT assessment/intervention. These would be for clients where general counselling was most appropriate for their presenting situation and needs.

1.4 Impacts and value

This Chapter examines the impacts and value of the OOH service from a number of perspectives. Section 1.4.1 looks at changes in ambulance call-out rates for suicidality- and self-harm-related incidents reported by Dublin Simon frontline homeless services since the OOH service began operations. Section 1.4.2 presents a deeper profiling of the presenting needs/circumstances of clients in urgent suicidality or self-harm situations, and how these are resolved. Section 1.4.3 then presents stakeholder assessments of the value and impacts or the OOH service, including the Sure Steps teams and frontline homeless services in Dublin Simon.

1.4.1 Ambulance call-outs

Dublin Simon services across the Dublin region report centrally all critical incidents that occur with clients, including incidents arising due to suicidality or self-harm. This allows examination of changes in ambulance call-out rates occurring since the OOH service was introduced, as well as exploration of how incidents are dealt with by frontline service staff in Dublin Simon homeless accommodation.

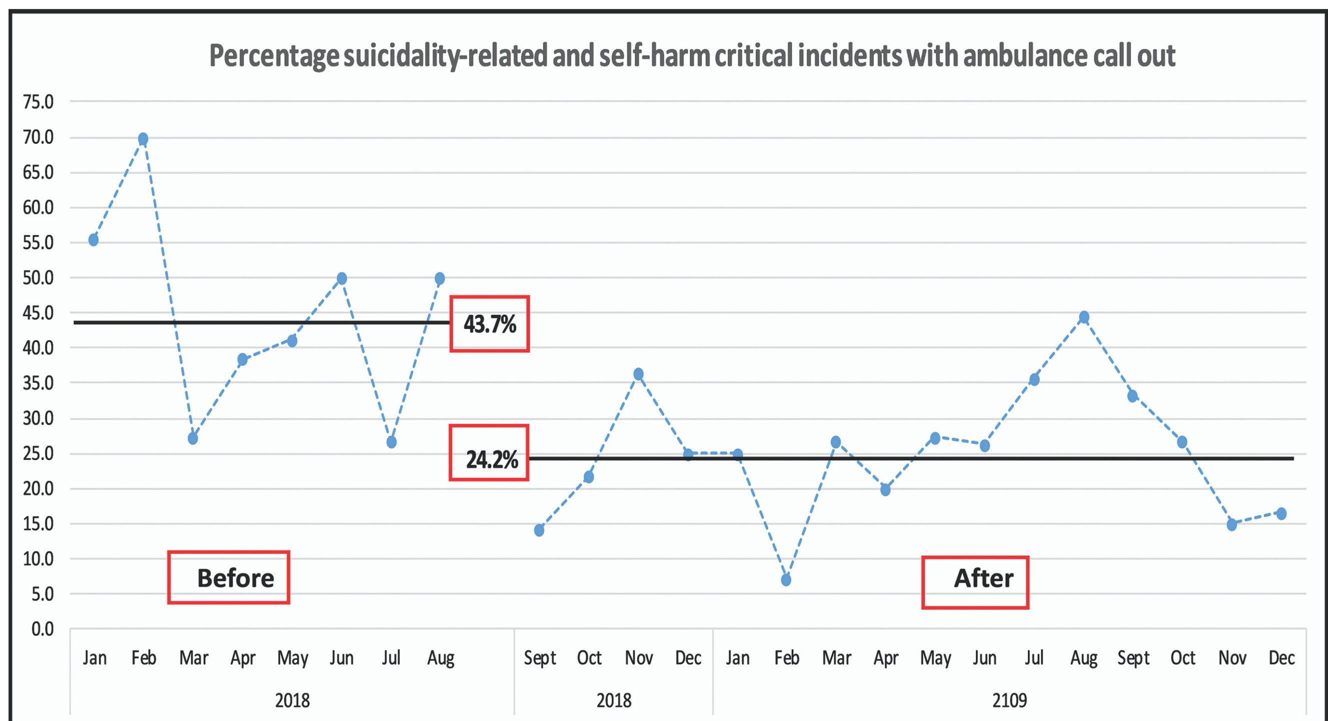
Changes in ambulance call-out rates

Figure 1.4.1 presents the patterns of ambulance call-out for critical incidents (suicidality-related or self-harm) in Dublin Simon services over the period covered by the evaluation. This comprised the eight-month period (January – August, 2018) before the extended service commenced[1] and the first sixteen months

[1] Ambulance call-out data was not available for incidents earlier than this

after the introduction of the extended service (September 2018 – December, 2019).

Figure 1.4.1 Likelihood of ambulance call-out (before) and after)



This shows the monthly average rate of ambulance call-out (the percentage of critical incidents for which an ambulance was called) over the sixteen months since the introduction of the extended service was lower by almost one-half compared to the previous eight-month period.

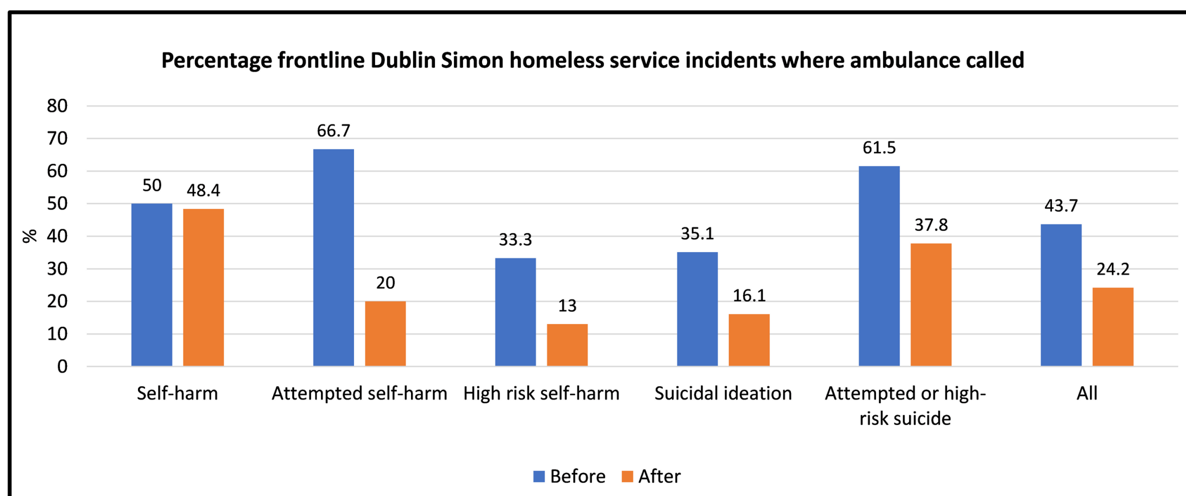
Table 1.4.1 presents a more detailed profile of incident types and likelihood of ambulance call-out.

Table 1.4.1 Incident types and likelihood of ambulance call-out

		Self-harm	Attempted self-harm	High risk self-harm	Suicidal ideation	Attempted or high-risk suicide	All
Before	Jan-Apr, 2018	19	3	4	24	6	56
	May-Aug, 2018	25	0	5	33	7	70
	All	44	3	9	57	13	126
	Ambulance (#)	22	2	3	20	8	55
	Ambulance (%)	50.0	66.7	33.3	35.1	61.5	43.7
After	Sept-Dec, 2018	21	2	9	27	9	68
	Jan-Apr, 2019	19	0	2	37	5	63
	May-Aug, 2019	10	3	7	33	11	64
	Sept-Dec, 2019	12	5	5	40	12	74
	All	62	10	23	137	37	269
	Ambulance (#)	30	2	3	22	14	65
	Ambulance (%)	48.4	20.0	13.0	16.1	37.8	24.2

Figure 1.4.2 presents a comparative view of the two time periods. Apart from incidents involving actual inflicted self-harm, the pattern of reduced likelihood of ambulance call-out after the introduction of the OOH suicide prevention response service applied across all types of suicidality-related and self-harm-related incident.

Figure 1.4.2 Likelihood of ambulance call-out by incident type

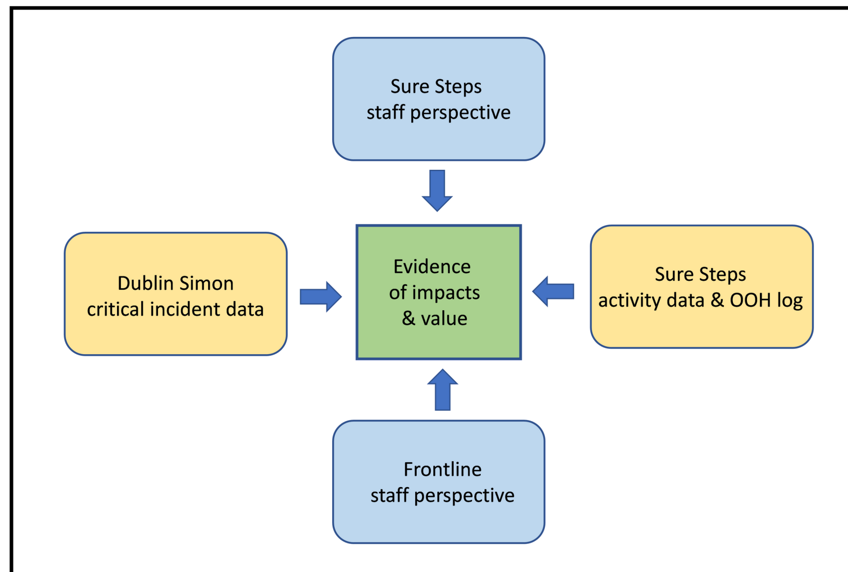


Multivariate analysis (logistic regression) confirmed the overall pattern of reduced likelihood of ambulance call-out since the OOH service commenced. This analysis showed that other variables – incident type (form of suicidality-related or self-harm-related incident) and location of incident (which Dublin Simon frontline homeless service it occurred in) – also significantly influenced likelihood of ambulance call-out. Controlling for these variables, the multivariate analysis showed the likelihood of ambulance call-out for reported critical incidents in Dublin Simon frontline services was 2.1 times lower in the period since OOH introduction compared to the baseline period. This would represent about 61 call-outs avoided by Dublin Simon services over the period, which pro-rates to about 46 call-outs 'avoided' on an annualized basis. It is likely that ambulance call-outs also reduced for the other (non-Simon) homeless agencies covered by the suicide prevention response service, although specific data on this was not available for the evaluation exercise.

Attributing impacts

Although the data above indicates a reduction in ambulance call-out rates since the introduction of the OOH service, further examination is necessary to tease out what factors have influenced this. Whilst the OOH and/or wider suicide prevention response service is likely to have played a significant role, other factors may also be involved. More generally, it is important to better understand the mechanisms whereby the suicide prevention response service may be having an impact. Figure 1.4.3 presents an overview of the data sources and perspectives that can help in the attribution of impacts and understanding of underlying mechanisms. These include Dublin Simon and Sure Steps datasets and the feedback provided by frontline staff and the Sure Steps team members.

Figure 1.4.3 Data sources and perspectives



The remainder of this section focuses on the information from the datasets and section 1.4.3 presents and discusses the feedback from staff. As the two core datasets – Quality Office and OOH - are not linked (e.g. they do not apply a common client ID), it is not possible to directly cross-link the two for purposes of this evaluation. Nevertheless, separate examination of each provides useful insight into the mechanisms involved in incident response and resolution.

Critical incidents reports

The Quality Office's critical incident dataset includes information about the incident type, location, date and time, whether staff called an ambulance (and/or GP, fire brigade, Gardai), and some information about the response to the incident and its resolution. As not all of the information of interest for the evaluation was already available in electronic format, the Quality Office extracted some additional data to compile a complete profile of ambulance call-out or not for the full years of 2018 and 2019. This was the data utilized in the analysis of changes in ambulance call-out rates above. As an additional input to the evaluation exercise, the Quality Office also extracted some brief descriptive information about the incident, and how it evolved and was resolved. This was a time-consuming job and therefore limited to the 2019 data, for which some information was available for most but not all incidents.

Exhibit 1.4.1 presents excerpts showing mentions of OOH or counselling more generally.

Exhibit 1.4.1 Direct/immediate involvement or broaching of counselling in incidents

Incident type	Ambulance called	Involvement or broaching of counselling
Attempt or high risk of suicide	Yes	Client offered emotional support, contacted Sure Steps. Increased checks. Client gave verbal consent to link in with psychologist and social worker, written consent to be obtained for wrap around supports.
Suicidal Ideation	No	Counsellor called to meet with client. Housing First Intake and Freephone called to source bed for client, who declined and decided to rough sleep. Emergency services were informed, and a street search for the client was carried out.
Suicidal Ideation	No	Sure Steps was called to organize counselling for client. Emergency services and guards contacted and informed of client's ideation, as he decided to self-discharge from service.
Suicidal Ideation	No	Client expressed suicidal ideation to staff, informing they needed to talk to someone. Staff offered to listen to client, while counselling service was called. Counsellor came to service and engaged with client, sharing with staff that they did not have any plans of suicide but needed to vent/express themselves. Staff to be informed about client's suicidal ideation, engagement with client to be maintained and their status assessed.
Suicidal Ideation	No	Client informed staff of suicidal ideation. One staff offered support and talked with client, while another arranged a counsellor meeting. Client was feeling better after talking to staff and was happy with counsellor coming. Staff to link in with counsellor once they arrive, activity plan to be set up for client to improve mental health.
Self Harm	Yes	Staff offered support; ambulance called to treat self-inflicted injuries. Client refused offer of counselling referral. Keyworker to discuss alternative behaviours to replace self-harm.
Self Harm	Yes	Staff provided first aid to client; out-of-hours counselling was offered but client refused. Ambulance was called but client was not present in service when they arrived. Supervisor stated placement of clients to be reviewed, swap to be looked at, if similar incident occurs again staff are not to engage and call paramedics/guards.
Suicidal Ideation	No	Client offered support, placed on increased wellbeing checks, convinced to call Sure Steps or go to hospital if feeling unwell.
Suicidal Ideation	No	Client recommended the Sure Steps service. Client asked if she would like a detox referral and agreed to this. Additional wellbeing checks to be carried out.
Suicidal Ideation	No	Staff provided support. Safe plan and link with counselling offered.
Suicidal Ideation	No	Safe plan, sleep on sofa, counselling referral, Sure Steps & Samaritans, risk assessment.
Suicidal Ideation	No	Increased checks, contact emergency services if client is at risk. Staff to reassess safe plan with client. Keyworker to link in, discuss suicidal ideation with client. Manager to assist in communication with client, referral made to counselling.
Self Harm	No	Staff create a self-harm box with client, referral done for counselling, update risk assessment.

Examination of the 2019 incident reports showed that, overall, almost one-in-four (22.0%) mentioned the Sure Steps counselling service in some manner, with this somewhat more likely for incidents where an ambulance was not called (23.1%) than incidents where one was (18.4%). The out-of-hours and/or the drop-in clinics were often specifically referenced in this context. Closer examination of the ways reports mentioned counselling indicates two common forms of involvement or potential involvement: direct/immediate intervention of counselling service during the incident (e.g. call-out or phone contact by staff); and staff bringing counselling into the equation with the client during the incident, although counselling not necessarily immediately availed of (e.g. offer to call counselling if client wishes). Exhibit 1.4.1 presents excerpts illustrating both types of involvement. Quite often, the reports also mention more indirect/preventative intention to involve counselling service in follow-up plan (e.g. plan to make a referral or encourage/support client to make connection with counselling). Chapter 4 examines this aspect in more detail.

1.4.2 Client benefit - better care pathways and outcomes

The analytic perspective in section 1.4.1 focuses mainly on immediate interventions and impacts on ambulance call-out rates. Other than in situations where clients clearly require hospital treatment and/or admission, it is generally preferable to avoid ambulance call-out and subsequent presentation at hospital ED. This can add additional trauma for the client. Anyway, the evidence shows that clients often refuse to go in the ambulance when called and, if they do go, quite often leave the ED before assessment. If they are seen in ED, the experience may be unsatisfactory and/or unlikely to lead to optimal aftercare and routing on to appropriate care pathways. The examples from the frontline critical incident reports illustrate how the suicide prevention response service supports frontline staff to provide an alternative to ambulance call-out, whether through staff bringing the counselling option into the equation in the context of the immediate crisis and its resolution or as part of the frontline service's after care plan. Exhibit 1.4.2 provides some examples where the interaction was initiated by the client. Calling the service is often part of a client's safety plan, a key element of the suicide prevention approach for at-risk clients. The act of calling the service is also empowering in its own right for the client. Additionally, both staff- and client-initiated excerpts in Exhibit 1.4.2 show that, for clients with suicidality-related issues not

already participating in regular CAMS counselling, the crisis assessment and intervention can often lead to the client agreeing to engage in the SSTT programme and sign-up for a first full CAMS session. Other calls may be from clients already known to Sure Steps and engaging in counselling either on a regular or irregular basis. The flexible access and possibility to move from CAMS to general counselling, and vice versa, is an important element of the service, providing responsive care pathways for the often-volatile client group concerned. Chapter 1.5 provides further discussion of this and its contribution to better outcomes for clients.

Exhibit 1.4.2 Engagement and Aftercare

SSTT phone; Low to Medium Risk: Client rang (has new phone number), set an appointment with me. Client then talked with me for 45 mins and disclosed having suicidal thoughts. Was calmer when finished on phone and has plan to stay safe until our appointment. Next appointment scheduled. No further actions required.
SSTT-In person; High Risk. Client highly intoxicated with alcohol. Voiced suicidal ideation, threatened suicide. I said that I would need to call an ambulance if client is in imminent danger, as was saying. Finally agreed to take suicide off the table and to see me again tomorrow to touch base. I liaised with staff regarding checking on client as often as possible; they informed me about low likelihood of lethal means. Agreed with staff and client to see him tomorrow at start of my shift…met client next day, agreed to CAMS process and set first appointment.
SSTT-In person; Medium Risk. Did assessment using SSTT - young client who feels there is very little to live for. They have agreed to engage in CAMS. Appointment scheduled for next Monday.
SSTT-In person; High Risk. Client phoned crying in distress. We spoke over the phone and I guided them to a mindful breathing exercise until calmed themself down. Gave positive reinforcement as client had rung the service as stated in their safety plan instead of acting on the thoughts. Client felt calmer at the end of the call. Gave client some tips about how to get back to sleep if wakes up in fear. Appointment scheduled with client tomorrow.
SSTT-In person; Medium Risk. Client seen during drop-in. Was agitated and intoxicated - kept falling asleep, and wanted to go to bed. It was hard to make sense of what the client was saying. Staff to keep eye on client and call us or emergency services if any more support is needed.
SSTT-In person; Medium Risk. Client rang - I believe this is the client accommodation staff rang about yesterday. Client is feeling suicidal, tried twice before; agreed to engage with CAMS. Scheduled appointment for next week.
SSTT-In person; Medium Risk. Saw client at drop-in. Is in a very low place but engaged and has agreed to see me next week, and call if needs any more support. Staff are keeping an eye on client. Will see client next week in drop-in-clinic.

1.4.3 Dublin Simon frontline service perspectives

To complement the data and information available from the various datasets and activity logs, the evaluation also sought feedback frontline services in Dublin Simon. Interviews with frontline service managers and staff from three accommodation facilities explored their perspectives on the role and

contribution of the Sure Steps suicide prevention response service when suicidality-related issues arise with their clients. All were from supported long-term accommodation for people who have experienced homelessness, one medium support and two high support. The medium support facility has staff during the day but no onsite staff at night, whereas the high support facilities have 24/7 staffing. Residents receive support with day-to-day life skills, health and welfare, and education and training, as well as social support to alleviate loneliness and social isolation.

Medium support facility

The medium support facility has no staff onsite at night, although a manager is on-call. As the manager had been receiving many calls, they reviewed the call log and found they often concerned mental health issues or loneliness. In response to this, the lobby phone in the facility was programmed with the OOH service number. If a call comes in to the OOH during operating hours they will link with the client by phone (do not go out as no staff on the premises). In case of an emergency call, OOH will link with the emergency services. A Sure Steps counsellor may call out to see a client the next day, if appropriate.

Staff are trained in SSTT and use this approach when dealing with incidents, calling the Sure Steps suicide prevention response service for advice when necessary. On occasion they may call an ambulance for suicidality- or self-harm-related incidents depending on the level of need/risk. With agreement of the client, they also make referrals to Sure Steps for counselling where appropriate.

As the facility has a significant number of residents with mental health issues, Sure Steps staff have also provided onsite staff education sessions on mental health topics. An example concerned a client with frequent/substantial self-harming. OOH staff came out and held a Q&A session with staff, which they found very helpful and reassuring that they were doing the right things. The OOH also helped in linking the facility staff with a community mental health team, which came out and did an education session with staff about a client with complex issues. This made a big difference, helping staff understand the diagnosis and how to deal with issues.

For suicidal ideation, staff often find their SSTT training equips them to deal with

ithe incident themselves and having easy access to Sure Steps for advice/support is helpful for this. In cases of self-harm requiring medical attention, staff call an ambulance. One helpful factor for staff in managing incidents at this facility is that clients are long-term residents and they generally know them very well – they know their normal patterns and what's unusual. They also report that the regular contact/monitoring/linking with Sure Steps definitely has a preventative impact – makes critical incidents less likely to arise.

Overall, staff at the facility feel well trained and supported in dealing with suicidality or self-harm, and widely use Sure Steps/OOH as a 'go to' service for this. They know they can pick up the phone, email or send a referral form to Sure Steps /OOH, and know they are always available to help/advise. OOH came out to meet the team and this gave them confidence that they knew what they were doing; also introduced the team to SSTT and arranged training in this for them. They find the SSTT booklet very useful – it's practical and easy to understand. Some residents have also shown an interest in this – the booklet is visually attractive and a copy is beside the phone in the facility. Staff also have training in ASSIST, which they have found useful up to a point.

High support facility A

In this high support facility, the frequency of occurrence of suicidality or self-harm incidents varies over time, and depends on who is living in the facility. They can have numerous incidents for one person but much fewer when that person moves on to other accommodation. All staff are trained in SafeTalk suicide prevention, and some of the longer serving staff have received SSTT training but not more recent staff. The team have ongoing discussions around dealing with these issues. Many clients use Sure Steps counselling service, some have long-term/regular engagement and others may dip in and out, but they find Sure Steps very flexible/patient on this. Staff also get advice over the phone from counsellors when required.

When an incident involving suicidal ideation occurs staff sit down with the client and get a cup of tea. They then work to get a Safe Plan in place; this may be formal or informal, depending on the client and what they are comfortable with. After agreement of the safe plan, clients are expected to hand over possible means (e.g. pills) and agree to 15-minute staff checks (this may extend to 30 mins after a

while). Staff know their clients well and this helps them in dealing with incidents when they arise. For other incidents where this approach is not appropriate/possible, staff call an ambulance and the Gardai. If enough staff are available on the shift, someone will accompany the client in the ambulance and to ED. However, they try to avoid ambulance call-out/ED attendance, as this usually does not work out well – clients are not linked into ongoing mental health supports (psychiatrist etc.), they are rarely kept in and typically sent back with a script (e.g. clients with benzodiazepine issues) and GP referral.

They have called the OOH service a few times to help with a crisis incident. One incident concerned a client with suicidal ideation and history of relatively superficial self-harm who had a more significant self-harm incident and required an ambulance call-out. The client would not go with the ambulance so the paramedics patched them up. Staff also called the OOH team and a counsellor came out. This calmed the client and also gave them a sense of security/significance that someone with expertise had come out to see them.

High support facility B

This facility has a number of residents who have ongoing suicidality ideation issues. All are engaged with the Sure Steps counselling service, and have regular counselling sessions (counsellor comes out to the facility) as well as ad hoc access when the need arises. The connection with Sure Steps commenced in late 2018 when counsellors began to come out to the facility some days to mingle with clients and staff for a period. As residents became familiar with the counsellors, a number disclosed suicidal ideations and worked with a counsellor to jointly develop a Safe Plan.

These residents with Safe Plans now know what to do (and do it) when experiencing suicidality, and will call the OOH on own initiative or with a staff member if they are in crisis. The OOH counsellor would come out to see the resident if necessary or provide phone counselling alongside working through the Safe Plan. This worked very well until the interruptions caused by COVID-19; during this period a few incidents have arisen where calls to the OOH went to voice mail and the response has not been as quick/reliable.

Before the engagement with Sure Steps and residents establishing connections

with the service, staff would call an ambulance for incidents involving suicidal ideation. Since then they have not needed to call one. If they cannot get the OOH, staff and the client can cope – they have the plan and it works. Anyway, there may sometimes not be much point in calling out the OOH in the middle of a crisis. The engagement with Sure Steps, and having the safe plan, has been strongly preventative in management of suicidal ideation; and the prior preparatory work with Sure Steps is very important from the preventative perspective (and ambulance call-out avoidance). Staff in the facility have received some training in SafeTalk but feel this is not practically useful in managing a suicidality-related incident when it arises.

The facility also has some residents who self-harm, but their issues are different and require a different response that addresses the behavioural patterns and triggers. If a self-harming resident needs medical attention the service calls an ambulance. However, staff do not get any feedback/report from the hospital when the resident comes back (for reasons of client confidentiality). Staff feel that more support on preventative/behavioural aspects of self-harming residents would be helpful, for example tracking behavioural patterns and triggers and developing interventions to address these.

Difficulties referring/linking clients with community mental health services and care pathways

All facilities reported that although they can often manage issues as they arise in the moment, they experience many problems with lack of aftercare and the general lack of care pathways for clients with enduring mental health conditions who require more than counselling-type interventions and support. They find it can be very difficult to make a referral to a community mental health team as the client generally must already be a client of theirs. Also, if an ambulance is called and the client goes to ED, they are unlikely to be connected into an appropriate aftercare pathway. More generally, it can be difficult to physically get a client to a GP (to make a referral to a psychiatrist, for example). Overall, it would be very helpful to have better access to and linkages with community mental health services, so clients could have a proper assessment, identify any un-diagnosed mental health issues, have medication reviewed, and receive other relevant care.

1.5 The overall contribution of the Sure Steps service as a whole

Based on the data and analysis presented in Chapter 1.4, the Sure Steps OOH service is clearly playing an important suicide prevention rolefor clients in Dublin Simon and the externally involved homeless services. This includes immediate real-time intervention and support when suicidality or self-harm crises arise in frontline services, as well as a range of other inputs including drop-in clinics and scheduled suicide-specific and other counselling sessions during OOH hours. Since the OOH expansion to the Sure Steps service commenced, an approximate halving of ambulance call-out rates for suicidality or self-harm related incidents is observable. A range of corroborating evidence suggests that the OOH service has played a significant role in this.

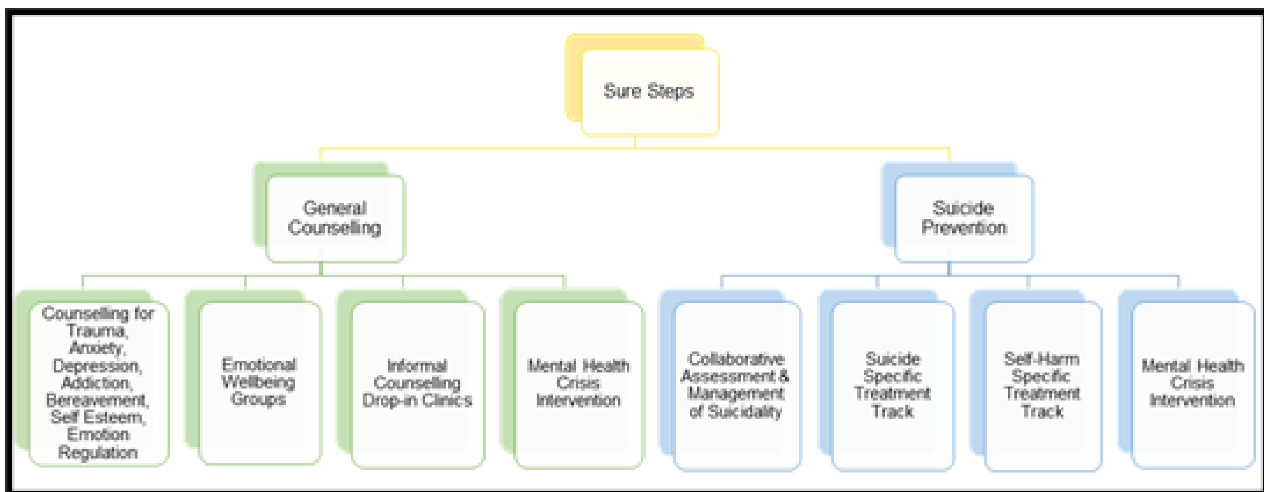
This Chapter provides a broader analysis of the role and contribution of the entire Sure Steps counselling service, including crisis intervention for incidents involving suicidality or self-harm, ongoing suicidality-related counselling for people who have had such a crisis, and general counselling for homeless persons for whom this is appropriate. Flexible access and availability during the day time and out-of-hours enables a responsive service, with easy and effective access and routing into appropriate pathways for clients in case of immediate need and in the longer term as needs change. Given the vulnerability and volatility of the client group, the possibility to dip in and out of the service as required is an important element of this.

1.5.1 Overall profile of Sure Steps service

Dublin Simon Community's Sure Steps Counselling service commenced in 2012 to provide frontline mental health care for vulnerable adults experiencing homelessness. The service supports people with mild to moderate mental health needs, and works to prevent an escalation to more severe and/or enduring mental health difficulties. It has a number of paid counsellors as well as a substantial number of counsellors providing a voluntary service. Paid staff include an overall service manager, a counselling coordinator and an out of hours team leader. The day service also has two full-time paid counsellors and the OOH service has three part-time paid counsellors.

Counsellors are fully qualified and accredited with a professional counselling organisation such as the Irish Association for Counselling and Psychotherapy (IACP), Addiction Counsellors Ireland (ACI), or the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP). The service provides both general counselling and a number of activity lines focusing on suicide prevention (Exhibit 1.5.1).

Exhibit 1.5.1 Sure Steps overview - general counselling and suicide prevention



Since its establishment, Sure Steps has developed and evolved to meet the needs of its client group and has grown to meet the demand for mental health support as the homelessness crisis intensified over the last number of years. The volume of referrals has increased more than six-fold over the period, from 58 referrals in its first year to 385 referrals in 2019. To date, Dublin Simon has funded most of the service from its own fund-raising resources, with NOSP providing funding for the OOH service since autumn of 2018.

Most general counselling is provided from Monday to Friday 9am-4.30pm, with some part-time volunteers providing evening and/or weekend sessions. It is available to Dublin Simon clients and clients from external services via the HSE ACCESS Team and SafetyNet Primary Care, clients residing in Salvation Army residences and clients in private emergency accommodation (PEA's). The service provides 1:1 counselling for issues including trauma, anxiety, depression, addiction, bereavement, self-esteem, and emotion regulation. Counsellors work from the principles of trauma informed care and use a humanistic approach that considers

the specific needs of the client, employing Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), Motivational Interviewing and other techniques.

Sure Steps also runs counselling drop-in clinics in informal settings in Dublin Simon treatment services and Supported Temporary Accommodation (STA) services. Counsellors visit the site at a specific time each week for 2-3 hours and clients can 'drop-in' if they feel they want support. These clinics are aimed at clients who may be too unwell or chaotic to attend regular appointments, with no referral necessary, no waiting list and no need for any commitment. Drop-in clinics are a non-pressurised way for clients to begin building a therapeutic relationship and then move on to formal counselling if they wish.

The service also conducts Emotional Wellbeing groups in Dublin Simon's Alcohol & Benzodiazepine Detox service and the Blood Borne Virus Unit. These aim to help clients learn how to manage or cope with their emotions without needing to resort to behaviours such as substance use or self-harm to regulate them. The groups are both trauma-informed and DBT-informed.

Exhibit 1.5.2 presents an overall activity profile for Sure Steps for 2019, taken from the annual Dublin Simon Treatment Services Report. The service provided 2,850 hours of free counselling to people experiencing homelessness in the year, a 17% increase on 2018.

Exhibit 1.5.2 Overall Sure Steps activity profile (2019)

Category (Day Service)	2016	2017	2018	2019
Caseload *(Only Referred Cases)*	461	348	377	391
New Cases *(Only Referred Cases)*	314	348	307	308
Closed Cases *(Only Referred Cases)*	248	187	298	293
Unique Client Count *(Only Referred Cases)*	Not Available	Not Available	360	353
Drop in Clinics/Visits Count		Not Available		281
Engaged in Ad-Hoc Interventions *(Crisis Call-outs etc)*				Not Available
% Prior Admissions *(Only Referred Cases)*		25%	30%	36%
Waiting Period in Days *(Avg.) (Only Referred Cases)*		5	16	17
Total New Referrals Received		348	337	327
Number of Sessions Attended *(Avg.) (Only Referred Cases)*		2	4	5

Category (Out Of Hours Service)	2016	2017	2018	2019
Caseload *(Only Referred Cases)*	Not Applicable		13	62
New Cases *(Only Referred Cases)*			13	54
Closed Cases *(Only Referred Cases)*			5	41
Unique Client Count *(Only Referred Cases)*			13	59
Drop in Clinics/Visits Count			Not Available	72
Engaged in Ad-Hoc Interventions *(Crisis Call-outs etc.)*				182
% Prior Admissions *(Only Referred Cases)*			39%	44%
Waiting Period in Days *(Avg.) (Only Referred Cases)*			1	4
Total New Referrals Received			13	58
Number of Sessions Attended *(Avg.) (Only Referred Cases)*			2	3

Category (All) *	2016	2017	2018	2019
Total Planned Counselling Hours *(Incl. Drop in Clinics)*	Not Available	Not Available	3572	4332
Actual Counselling Hours		2135	2438	2850
Emotional Wellbeing Groups Hosted *(Includes 1 or more: BBV unit, Detox and Recovery groups)*		Not Available	63	84
Unique Client Count *(Only Referred Cases)*			370	406
Drop in Clinics/Visits Count			Not Available	353

*These numbers include Day Service and Out of Hours Services.

- 77% of the referrals received for 'Day Service' counselling in 2019 were from other Dublin Simon services compared to 83% in 2018.
- 50% of the referrals received for 'Out of Hours' counselling in 2019 were from other Dublin Simon services compared to 92% in 2018.

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This shows the extensive activity of both the day and OOH services, and the large number of counselling sessions provided. Chapter 1.3 provides further detail on the OOH service activity, based on additional recording, classification and profiling provided by the OOH team for evaluation.

For referrals, the unique client count in 2019 was 406, with an average of 5 sessions attended by clients at the day service and 3 sessions by clients at the OOH service. Other data from the 2019 annual report shows that just under two-thirds of the caseload were first admissions, a little under one-third (31.1%) were second or third admissions, and a smaller proportion (5.7%) has more frequent admissions. Waiting times for referred clients have been growing in the past two years, especially for the day service where the average wait time was 17 days in 2019.

1.5.2 A whole system approach to suicide prevention

Both the OOH and day service contribute directly and indirectly to suicide prevention, and frontline staff training in SSTT (the Sure Steps' brief suicide response protocol based on the CAMS approach) also has an important role. Chapter 1.3 already described the core elements of the suicide prevention

response service from Monday to Friday, 8am to 10pm, and 4pm-10pm on Saturday-Sunday, available to clients of all the leading homeless service providers in the Dublin region. On weekdays, the day service covers the day shift and the OOH covers the evening shift until 10.00pm; the OOH covers the weekend shifts.

Excluding suicide-prevention-oriented crisis interventions (the core of the OOH service and comprising a portion of the day service workload as well), Sure Steps estimate that about 20% (~570) of the 2,850 scheduled in 2019 were directly suicidality related (CAMS/SSTT). However, clients coming in through the SSTT/CAMS track often move to general counselling, and vice versa if suicidality issues are picked up through general counselling. Also, clients may have contacts with more than one counsellor; for example, an OOH counsellor may see a client on an urgent basis who is already seeing another counsellor on a more regular sessional basis.

Chapter 1.4 provides considerable evidence of the direct contribution of the OOH service through call-out or phone-based interventions when suicidality or self-harm incidents arise in frontline homeless services, as well as the generally supportive role played by the service through helping frontline staff manage incidents themselves. Often the frontline incident reports mention connection to counselling, sometimes referring to OOH but generally not distinguishing whether the OOH or day service is concerned. This fits with the intended seamless suicide prevention response provided by Sure Steps over the entire day and OOH periods.

Interworking of the day and OOH services in suicide prevention response

The current Sure Steps operational model provides for a certain degree of division of labour between the OOH and day services. Under this arrangement, the OOH is primarily focused on rapid response for suicide prevention as well as picking up on non-urgent call-out requests received during the day and passed on by the day service for attention when the OOH shift comes on. It also provides a substantial number of scheduled appointments that it aims to fit in around its urgent response capacity. The day service responds to urgent suicidality-related incidents during its shift as well as providing the large bulk of general counselling sessions. This

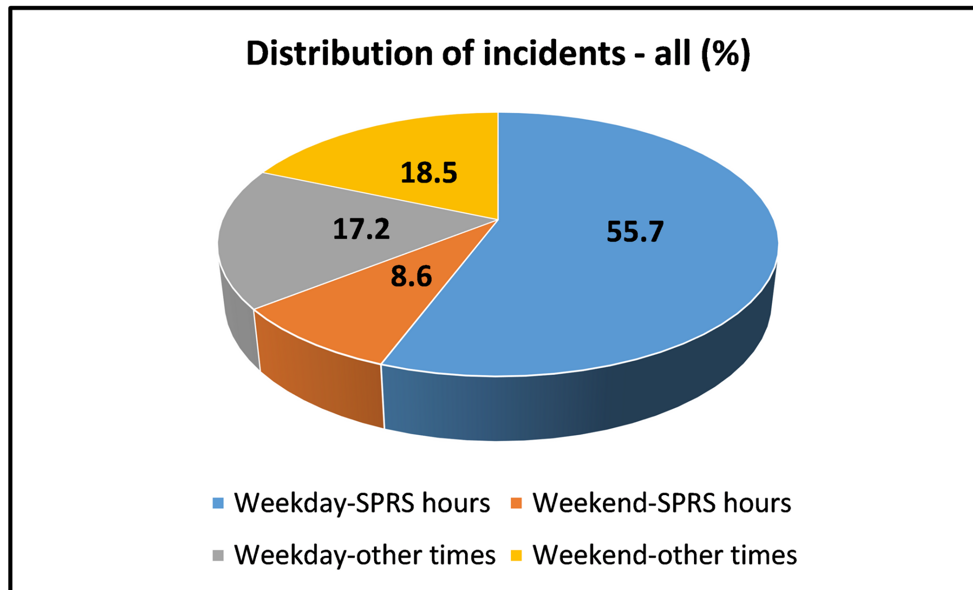
arrangement is in part linked to the current funding situation, with external funding only available for the OOH component (funded by NOSP). Dublin Simon funds the day service from its own resources, supplemented by a substantial input from volunteer counsellors.

From the wider national mental health system perspective, lack of funding for the day service – both for its contribution to the suicide prevention response service and for the substantial number of CAMS and general counselling sessions provided – is surprising. Given the high levels of need amongst the very vulnerable client population served, the situation seems both anomalous and inequitable in the national mental health policy and resource allocation contexts. Chapter 1.6 returns to this issue and recommends rectification through establishment of a sustainable funding base for the entire Sure Steps service.

Ongoing preventative model & immediate suicide prevention response service

Sure Steps considers itself a holistic service from a suicide prevention perspective, operating an ongoing preventative model as well as providing an immediate suicide prevention response service on an on-call basis during operating hours. About two-thirds (64.3%) of suicidality-related incidents occur during Sure Steps operating hours and one-third (35.7%) occur outside these hours (Exhibit 1.5.3), so the broader preventative dimension is of considerable importance. The pattern of reduced rates of ambulance call-out since the OOH commenced was observable both during the Sure Steps operating hours and outside them.

Exhibit 1.5.3 Distribution of frontline suicidality or self-harm incidents recorded in central dataset by day/time of occurrence (Sept 2018 - Dec 2019)



Feedback received from frontline homeless accommodation staff also identified the preventative dimension. Some felt that the Sure Steps broader preventative role is equally and sometimes even more important than its immediate crisis response dimension, both in enabling better management of suicidality-related incidents by frontline staff and avoiding ambulance call-out whenever possible. From a real-time perspective, frontline staff suggested that although the possibility of immediate Sure Steps intervention (through call-out or phone engagement) is important and helpful in managing incidents, this may not always be practicable during a crisis.

Evidence from the critical incidents dataset

The Dublin Simon critical incident dataset also provides strong corroborative evidence of Sure Steps contribution to suicide prevention – both through establishment of safe plans and the more general linking-in of clients to Sure Steps for aftercare as part of the frontline incident follow-up plan.

Safe Plans

One important area of proactive input from Sure Steps is through its development

of relationships with clients experiencing recurring suicidal ideation and joint formulation of safe plans with them. If clients (and staff) know what to do (and do it) when suicidal ideation arises, this reduces likelihood of ambulance call-out as well as need for immediate crisis call-out of a Sure Steps counsellor. Where staff have received SSTT training this can also be helpful for them in managing incidents with clients themselves and/or for making an initial assessment to help Sure Steps decide whether an immediate call-out is necessary. In some homeless services, Sure Steps has provided additional onsite educational sessions for staff on mental health issues, and these have been helpful afterwards in locally managing suicidal ideation incidents when they arise. Staff in some frontline services also have had training in other suicide response protocols, such as SafeTalk and ASSIST.

Operational and performance issues

Discussions with the Sure Steps OOH and Day service teams indicated the suicide prevention response service and its protocols have been evolving and developing over time as experience has grown. Based on this, staff identified a number of additional operational issues that may warrant further attention in the next phase, and frontline staff also indicated some aspects with potential for improvement or fine-tuning.

Staffing levels and funding

Feedback from both the Day and OOH team suggests that staffing levels are tight for provision of an optimal service and management of the growing caseloads. Referrals from external homeless agencies have been increasing substantially, and referrals ostensibly for suicidality issues can often turn out to be more suited to general counselling. As shown earlier in Exhibit 1.5.2, waiting times have grown significantly in the past two years and the previously very-quick response service now has an average waiting time of 16-17 days. This is an important challenge given the vulnerable and volatile client base concerned and the need to engage quickly with referred clients before the opportunity is lost and the client loses contact.

Another issue for the OOH service is that it is not always possible to achieve the aim to have two staff working on each shift. This can be problematic in various ways – one aspect is that safety protocols require having a second staff member available for some clients, and anyway having only one staff working limits the responsiveness of the service on particularly busy shifts.

Both teams also noted the challenges to juggle on-call availability to deal with urgent client situations and managing a caseload of scheduled counselling sessions. Sometimes this leads to postponement of scheduled client sessions which, as well as being inconvenient for the client, also raises staff concerns that it might signal a lack of importance to the client and thereby affect their self-esteem and therapeutic progress.

Another important issue for the day service staff is the absence of external funding for their part of the service. This is an important limitation on service capacity as well as a source of frustration for staff as they feel the service (and client base served) is not sufficiently valued or appreciated by the wider mental health system. Only paid staff (and not volunteers) operate the on-call suicide response service, and may have to do considerable juggling and rescheduling if many call-outs occur. The management of a large pool of volunteers also requires significant staff time.

More roll-out of SST training for frontline staff & improved capacity to address issues locally

As mentioned earlier, Sure Steps have produced an SSTT protocol and guidance booklet, essentially a stripped-down version of the more elaborate CAMS approach. Counsellors utilize the SSTT protocol in the suicide prevention response service, both for initial assessments and for a lighter touch treatment track than CAMS for some clients. Dublin Simon also commenced a training programme on SSTT for frontline staff, although this has not yet reached many services and their staff. Feedback from services where staff have received SSTT training suggested it is a useful and practical support in helping manage suicidality-related incidents. Where clients were well known to them, it is helpful for assessing the level of risk and deciding on the best course of action. Some frontline staff also mentioned mental health educational sessions provided onsite by Sure Steps staff, and that

these gave more confidence and skills to address issues locally where possible. From the Sure Steps side, suicide prevention response service staff noted more requests for call-out support from frontline services when shifts changed and staff on shift were less familiar with the clients. They also noted issues arising from the reliance of some services on agency staffing. In these situations, Sure Steps staff felt they were called-out more often than necessary, either because staff did not have the time or interest to work with the client themselves or because they tended to panic and call OOH or an ambulance. However, they did recognise that resource limitations may affect this, for example, many hostels only have two staff on shift at night and run risks if one is taken up with a client for too long. More generally, the OOH activity data presented in Chapter 1.3 indicates that around sixty-percent of their engagements within Dublin Simon services were with clients in supported temporary accommodation.

The OOH service itself has been learning with experience and improving its response protocols to better manage resources and prioritise more urgent cases. This includes pre-assessments by phone before going out to a site and development of working relationships with frontline services/staff to agree protocols and jointly manage situations in resource-efficient ways.

All these aspects warrant further attention and refinement/improvement in the next phase of development of the suicide prevention response service, especially further development of shared protocols with frontline staff and wider roll-out of SSTT training and evaluation of its impacts.

Information and data systems

As indicated in the excerpts from the Dublin Simon treatment services annual report in section 1.5.1, Sure Steps already has quite well-developed activity recording and reporting systems. The service developed and refined some aspects of this as part of the evaluation exercise, especially in the coding of the OOH service activities and interventions. There is also good potential for further enhancement and improvement of the Sure Steps information and data systems in the next period, although this will be subject to resource availability given the tight staffing situation under current funding arrangements.

Aspects warranting consideration include further refinement of the activity logging and reporting for the overall suicide prevention response service, as well as introduction of client outcome monitoring and reporting systems addressing both clinical/wellbeing gain and care pathway optimization. The latter includes contacts and support utilization within the homeless sector (internally within Dublin Simon services and externally within the wider homeless service sector serviced by Sure Steps) and in the wider health and mental healthcare systems, including hospital EDs and the ambulance service and the wider community and specialist mental health system and services. Improved systems for tracking of homeless client care pathways and system/ service utilization patterns would be very valuable.

Wider Dublin Simon information systems maintained by the Quality Office are also quite well-developed, including frontline critical incident reporting to a centralized system and reports issued on this. These systems identify suicidality- and self-harm related incidents in frontline services, and allowed extraction of ambulance call-out data for 2018 and 2019 for the evaluation exercise. More qualitative descriptive information is often available with incident reports, and the Quality Office extracted some of this for the evaluation exercise as well. One cross-cutting issue for joint attention by Sure Steps and the Quality offices concerns development of more integrated systems, including exploration of the potential for cross-linkage of data across the two systems where possible and appropriate.

Improved linkages and interworking with other components of the healthcare system

Apart from improved information systems that cross-cut the homeless and wider health and mental healthcare systems as mentioned above, improved substantive linkages and interworking between the homeless sectors and wider ecosystem is also essential for optimal client experience and outcomes as well as for overall resource allocation and utilisation efficiency. Feedback from both Sure Steps and frontline service staff indicate a largely siloed system at the moment, with little or no real interworking and integration between the homeless sector and other components of the overall system. This results in very sub-optimal care pathways

and outcomes for homeless clients. Aspects of this include both the unsuitability of ambulance call-out and subsequent presentation at hospital ED in meeting homeless client needs in time of crisis, and the lack of effective aftercare pathways after crisis presentations in ED. Wider ongoing barriers to access to mainstream mental health services for homeless persons is also very problematic, as well as possibilities for homeless services to interwork with and get required support from community and specialist mental health services where clients require this. Difficulties of access to appropriate care and support for homeless persons with dual (mental health and addiction) diagnoses are a particularly problematic area.

These issues also warrant focused attention and improvement in the next period, and this will require appropriate levels of engagement with and by the various services concerned, especially hospital ED, community and specialist mental healthcare services.

Impacts of Covid-19

Finally, the impacts of COVID-19 and the associated lockdowns and social distancing regimes have been challenging for Sure Steps as well as for frontline services seeking crisis support. Like other organisations and sectors, Sure Steps have begun to utilize technologies to support remote client sessions by phone or video to a certain degree, although the characteristics of the sector and client base pose various difficulties in this regard. Nevertheless, there may be opportunities to explore further usage of video consultations and other eMental health applications for helping to address logistical challenges in delivering the service as well as in linking in with other parts of the mental health service ecosystem. Examples might include virtual visits instead of staff having to go out to the client's accommodation, connecting with staff at ED before, during or after a client attendance, and more general applications to increase engagement with and access to community and specialist mental health services (e.g. psychiatrists) as required. Opportunities to trial eMental health assessment tools are also of interest, such as PTSD screening/assessment applications.

1.5.3 Value for money

Appraisal of the value and contribution of the Sure Steps suicide prevention response service requires consideration both of its inherent value as a service for this very vulnerable client group, as well as its more general value-for-money from a health system resource allocation perspective. Central elements of the inherent value include the reduction in trauma for clients with suicidality-related episodes, enabled by the availability of a more appropriate care pathway option than ambulance call-out and/or presentation at hospital Emergency Department, and the linking-in of clients to Dublin Simon's suicide-specific counselling service. This may have both immediate and longer-term benefits for clients, including reduction in likelihood of future suicidality-related or self-harm episodes and potential prevention of suicide completion. Apart from the direct client benefit, the service supports the objectives of a number of key national policies. These include 'Connecting for Life' and broader mental health policy outlined in the recently published 'Sharing the Vision'. Operationally, the service also fills a key gap in primary care level mental healthcare services for homeless persons.

From the value-for money perspective, a range of sources provide useful yardsticks for estimating the likely monetised value of the service. For example, recent health economics research calculates the average lifetime costs of each completed suicide are around €2 million in EU countries (McDaid D, Bonin E, Park A et al, 2010). Although putting a value on human life in this way is not unproblematic, applying this yardstick suggests that just one suicide prevented by the service every few years would yield very good value for money even if there were no other benefits.

Another cost-effectiveness modelling approach of possibly even more relevance focuses on monetising the value of health-related quality of life (QALY) gains from interventions in this field. Application of this to assess interventions to reduce suicide risk among hospital emergency department patients provides strong evidence of value for money across a range of interventions (Denchev P, Pearson J, Allen M, et al, 2018). Research has also begun to provide supportive evidence on the cost-effectiveness of interventions addressing suicidal ideation (Van Spijker B, Majo M C, Smit F, van Straten A, Kerkhof A, 2012).

From a ‘clinical’ benefit perspective, therefore, the QALY gains associated with mental health and wellbeing outcomes for clients supported by the suicide prevention response service would almost certainly support a strong value for money case. This is without even considering any direct or indirect cost-savings/cost-avoidance from the health system perspective.

In relation to the cost-saving/cost-avoidance aspect, one important aim of the service is to reduce the need for ambulance call-outs and attendance at emergency departments. This is against a background where national data shows homeless persons are vastly over-represented in ED attendances for suicidality and self-harm. The evidence available for the evaluation suggests an almost halving of ambulance call-outs since the introduction of the OOH component of the service, equating to around 46 call-outs per year within Dublin Simon services and the possibility of similar impacts in the other homeless services supported (although no data was available to the evaluation on this). Without established unit cost yardsticks for these elements of the Irish healthcare system, calculating precise cost-savings or cost-avoidance from reduction of ambulance call-outs (and associated presentation at hospital ED) is not straightforward. However, the scale of ambulance call-out avoidance indicated suggests considerable return on investment for the health system from this aspect.

Taking the current Sure Steps annual throughput of about 3,000 scheduled counselling sessions a year, a ‘standard’ counselling service delivering this volume of sessions could be roughly valued at 300,000-plus euro per annum for resource allocation purposes. This applies estimates for the HSE-funded Counselling in Primary Care (CIPC) service suggesting an average cost to the HSE of €95.8 per session delivered under the CIPC programme (including the supervisory and other support infrastructure components) (HSE response to PQ, 1st May 2019).

However, the Sure Steps service goes considerably beyond a standard service model where counsellors see scheduled clients on a regular basis and the client comes to the counsellor rather than the other way round. The ‘non-standard’ dimensions of the service include its responsivity and proactivity, flexible access, delivery of many crisis interventions on a call-out basis and many scheduled counselling sessions in the client’s homeless accommodation setting. It also has a particular expertise in counselling for clients presenting with suicidality, and utilisation of the CAMS approach in this context. Other added-value dimensions

include provision of many ad-hoc interventions to support clients and frontline staff when the need arises, and the time spent by counsellors to make contact with and maintain continuity of contact with clients, as well as provision of frontline service staff education and support, and development of frontline crisis intervention protocols and guidance. Given this, it is likely that the healthcare system resource allocation value of the service would be at least twice the figure coming from a simple valuation based on scheduled session volumes.

1.6 Discussions and Conclusions

This Chapter brings together and discusses the results of the various strands of the evaluation and draws some overall conclusions. Based on this, a number of recommendations are made regarding next steps to build on achievements so far and optimise the contribution and impacts of Sure Steps in addressing suicidality and other mental health needs of homeless persons, both internally within the homeless sector and as part of the wider mental healthcare ecosystem.

1.6.1 Overall Assessment

Overall, the results of the evaluation indicate the OOH extension of the Sure Steps suicide prevention response service is working well and providing a valuable enhancement to the weekday day-time service. This is supported by quantitative and qualitative evidence from a range of sources and perspectives.

Quantitative Perspectives

Quantitatively the OOH is providing a large number of interventions, with the bulk of these concerning suicidality and comprising a mix of crisis interventions and scheduled CAMS counselling sessions. An allocation of approximately 2 whole-time-equivalents of counsellor time over the OOH shifts throughout the year provided 655 interventions in 2019. This is a substantial caseload and achievement given the unpredictability of client presentation and the responsive nature of the service, with most interventions and scheduled sessions delivered on-site in the client's homeless accommodation and sometimes even on the street.

The other quantitative dimension concerns ambulance call-out rates for suicidality or self-harm related incidents. Analysis of Dublin Simon's Quality Office data on such incidents shows ambulance call-outs rates during the period since the OOH service was introduced (September 2018 – December 2019) were lower by almost one-half compared with the eight-month period before this for which data was available. Although it is not possible to directly attribute all this change to impacts of the OOH service, per se, more detailed qualitative information from the incident dataset and from the OOH service activity log suggest the availability of the OOH service is likely to have been an important contributing factor.

Qualitative Perspective

More in-depth examination of the activity of the OOH service provides evidence of how the OOH service is reaching and supporting clients and staff in frontline services. This includes intervention and support in crisis situations, organization of proactive preventative measures through staff education and client safe plans, and supporting clients with suicidality to engage in ongoing suicidality-oriented counselling through the CAMS approach. Corroboration for this comes from frontline critical incident report data as well as directly from interviews with frontline service staff.

Analysis of critical incident reports from frontline services show how the suicide prevention response service, and the OOH component of this, features prominently in the real-time management of suicidality and self-harm incidents, either through call-out of a counselor to the site or phone-based support from a counsellor. The incident reports also show referral to Sure Steps OOH and/or day service featuring prominently in frontline follow-up and aftercare plans. Feedback from interviews with frontline staff provided corroboration of the valuable role of the OOH and/or day service both for crisis intervention/support and from a broader preventative perspective. This included onsite educational sessions for staff and establishment of safe plans with clients.

From the OOH service vantage point, analysis of detailed activity logs for a two-month period show how the OOH counsellors deliver a very responsive, client-focused approach. Apart from assessment and intervention in crisis situations, client empowerment features strongly in the approach through establishment of

safe plans and encouragement of clients to call the OOH service during a crisis as part of their plan. The activity logs also show the volatility and vulnerability of the client population served, and the major efforts made by the counsellors to connect with at-risk clients and establish/maintain their engagement with the service. Keeping track of clients moving between accommodation and the street and keeping in touch with them requires considerable time and tenacity.

Whole system perspective

Based on these different evidence sources and perspectives, the OOH extension of the service is clearly making a strong contribution as part of the overall Sure Steps service's approach to suicide prevention and helps provide an alternative to ambulance call-outs for incidents where this is appropriate and feasible. A whole systems analysis of Sure Steps shows the joint and several contributions and importance of each element of the system – day service, OOH, and SSTT training of frontline staff to assist in stabilizing the situation when suicidality-related incidents arise. All three elements interwork in an evolving overall 24/7 suicide prevention response service, comprising crisis intervention and support as well as aftercare planning and ongoing efforts to maintain the engagement of clients with suicide-oriented (CAMS) or general counselling where appropriate.

However, many frontline staff have not yet received SSTT training so frontline service capacity to manage suicidality-related incidents without support is not as extensive as it could be. An evaluation of how the SSTT approach is working on the ground for frontline staff (and clients) is also necessary to guide further roll-out and leveraging of the local response capacity. In the next phase of Sure Steps development, it would also be useful to conduct a full 'whole system' evaluation to further explore how best to organize, integrate and improve the various components to maximise its effectiveness as an entire system of suicide prevention and ongoing mental healthcare for homeless persons experiencing suicidality or self-harm.

In this context, the interworking of Sure Steps with, and as part of, the wider mental healthcare ecosystem also requires further examination and development. The current somewhat siloed nature of the service in the homeless sector limits the potential to provide integrated continuity of mental healthcare and access to appropriate stepped care pathways for homeless persons. Attention to linkages

and interworking with hospital ED services, and with the wider mainstream community and specialist mental health services, is important in this context.

1.6.2 Systemic importance and relevance

Ensuring ongoing sustainability and supporting the further development of Sure Steps has a broader systemic importance and relevance, both for delivering on national mental health policy and in operational efforts to ensure responsive and integrated services are available for the entire population and especially for vulnerable groups.

Evidence of high levels of need

Similar to other countries, Irish research has found high levels of depression, self-harm and attempted suicide amongst homeless persons (O'Reilly F, Barror S, Hannigan A et al, 2015) as well as high levels of schizophrenia and other psychoses (Murphy R, Mitchell K, and McDaid S, 2017). Analysis of data from the National Self Harm Registry found an age-standardised incident rate of self-harm 30 times higher among the homeless population compared with domiciled people in Ireland (2010-2104), as well as significantly higher likelihood of repetition of self-harm within 12 months of first presentation (Barrett P, Griffin E, Corcoran P, O'Mahony M, and Arensman E, 2018). Another analysis of this data source found homeless persons were 22 times more likely to present in ED for self-harm than domiciled individuals (Arensman E, Ni Mhuircheartaigh E, and Corcoran P, 2014). This study also found homeless persons had a higher likelihood to leave before completion of assessment and aftercare decision.

National policy and practice protocols

The importance of attention to homeless persons is already referenced in current national suicide prevention policy (Connecting for Life) under Goal 3: Focus on Priority Groups. Objectives for this Goal include improvement of the implementation of effective approaches to reducing suicidal behaviour among priority groups, and addressing the high rates of alcohol and drug misuse in this context.

The *National Clinical Programme For the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm* also makes reference to the particular vulnerability of homeless persons who present with self-harm, and

the need for specific protocols to ensure that they receive continuity of care (HSE, 2016). The review of the operation of the programme recommended development of specific approaches where ED staff and mental health services work together to ensure assertive follow-up for patients who have self-harmed but leave before receiving a biopsychosocial assessment (HSE, 2017). The data cited earlier indicate homeless people are over-represented in this grouping. The Standard Operating Procedure for the service includes an 'assertive follow-up to next care appointment' protocol, involving phone follow-up by ED with the patient to ensure linkage to appropriate care pathways (HSE, 2018). Stakeholder feedback in the current evaluation indicated little apparent delivery on this aspect for homeless clients.

1.6.3 Recommendations

The findings from the evaluation lead to a number of recommendations for actions at various levels. The recommendations apply in the first instance to Dublin Simon and NOSP, jointly and severally, as the two parties currently providing the operational funding for the Sure Steps service. They also address issues and responsibilities identified in wider mental health policy that fall within the remit of delivery and/or funding systems for mental health services for the population as a whole and for vulnerable groups. In jointly reviewing the recommendations, Dublin Simon and NOSP might consider how best to address the issues themselves as well as whether/how to engage with the other stakeholders for whom the recommendations also have relevance.

As the findings from the evaluation are very positive overall, some recommendations focus on ensuring sustainability of the suicide prevention response service and the wider Sure Steps service of which it is an integral part. Others address operational aspects of the Sure Steps and wider Dublin Simon frontline services that could be further developed and improved in the next stage, as well as some new areas of innovation that offer value-adding potential.

Ensuring Sustainability

Recommendation 1 **Review current funding and seek to secure satisfactory and sustainable arrangement**

The evaluation looked at the entire Sure Steps suicide prevention response service from a whole system perspective. Key elements comprise the day and OOH teams that together provide on-call suicide response cover from 8am to 10pm on weekdays, and 4.30pm-10pm on weekends; proactive supports and capacity building for frontline service staff (especially based on the SST protocol developed by Sure Steps) to help them manage incidents themselves whenever possible and appropriate; and delivery of a substantial volume of scheduled counselling sessions. The interworking of these components provides a system that already delivers more than the sum of its parts.

Current public funding arrangements cover only a portion of the system (mainly the OOH aspect) and continued funding for the other components from Dublin Simon's own resources is unlikely to be sustainable. In the context of national policy and public resource allocation frameworks for mental healthcare services, this situation appears both anomalous and inequitable. For example, Sure Steps currently delivers a large number of general counselling sessions that it funds entirely from its own resources even though the service and client base served appears to fall squarely within the remit of publicly-funded schemes such as Counselling in Primary Care (CIPC). On the suicide prevention response side, NOSP provides a portion of the costs of the overall Sure Steps service but Dublin Simon currently must fund the remainder from its own resources. From a funding perspective, however, it may be unhelpful to focus on too rigid a demarcation between activity addressing suicide prevention and general counselling activity, as substantial added-value in Sure Steps comes from the seamless interworking of the two streams.

Joint review of funding by Dublin Simon and NOSP is important at this stage, followed by efforts to secure a more appropriate and sustainable arrangement. This might include a joint approach to relevant public funding streams for mental health services of the type provided by Sure Steps.

Maintaining service responsibility

Recommendation 2

Put in place capacity to cater for increased demand and maintain service responsibility

One of the challenges faced by Sure Steps is maintaining service responsivity in the light of substantially increasing demand. In part this emanates from an exacerbating homeless crisis and in part because the service is a 'victim of its own success' in reaching large numbers of clients from Dublin Simon and the other homeless services covered. The impacts of this have been very noticeable in recent increases in waiting times, with this now averaging 16-17 days for referred clients compared with just a few days in earlier years. It may also begin to the affect capacity of the suicide prevention response service to respond promptly to urgent suicidality-related incidents. Both impacts would be very detrimental to the service, where quick and agile response is so important for the volatile and vulnerable client base concerned.

In the context of the overall review of funding arrangements, there should be a specific examination of this capacity issue and efforts to ensure it is factored-in in the establishment of sufficient capacity on a sustainable funding basis.

Better interworking and integration with the wider mental healthcare system

Recommendation 3

Put in place capacity to cater for increased demand and maintain service responsibility

The evaluation found the Sure Steps and wider Dublin Simon frontline suicide prevention response, as well as the more general Sure Steps counselling service, must largely operate in a siloed manner due to the lack of proper linkage with and embedding within the wider mental healthcare system. This applies especially for linkages between Sure Steps and hospital Emergency Department services, and more generally with secondary and specialist mental health services when needed. The current situation significantly limits the possibilities for homeless persons to access the full range of mental health care they may require, and presents major barriers to continuity of care. One area of particular concern is access to appropriate joined-up care for dual diagnosis, given the high prevalence of a

combination of addictions and mental health difficulties amongst homeless persons Another problematic area is the lack of access to properly functioning stepped care pathways for Sure Steps clients who may have more severe mental health issues (e.g. psychoses) comorbid with the more common mental health conditions falling within the scope of Sure Steps primary care counselling.

Dublin Simon and NOSP could jointly initiate a project to address this important area, bringing in other relevant parties as appropriate. This might be something that would fit well within the Sláintecare implementation framework.

Operational Improvements

Recommendation 4

Sure Steps and other Dublin Simon services should jointly review the suicide prevention response capacity from an overall organisational operations perspective, and develop and implement an action plan to address areas with potential for enhancement

The evaluation identified various aspects of the internal operation of the service that could be further developed and improved in the next phase. Whilst implementation of the recommendations on some of these may be contingent on additional funding availability, some could be more readily addressed at existing funding levels.

One key area warranting attention is further development of frontline service/staff. Wider roll-out of training in the SSTT protocol for incident stabilisation and management is one important component of this, as well as evaluation of the experiences of frontline services in applying this in practice. Feedback from frontline staff also indicates the value of other proactive educational inputs provided by Sure Steps staff in empowering them to better manage incidents locally, and consideration of further efforts in these areas would be useful.

From a targeting perspective, data from the Sure Steps suicide prevention response service indicates the largest share of engagements is with clients from temporary accommodation settings, which may reflect both the characteristics of the client population as well as the staffing profile of these facilities. Sure Steps staff also find that frontline staff unfamiliar with residents are more likely to call

them and/or call an ambulance, and this appears to be a particular issue with agency staff. More generally, Sure Steps suicide prevention response protocols have been evolving and refining with growing experience, and there may be scope to further develop the shared response protocols between Sure Steps and frontline services when incidents arise.

Joint examination by Sure Steps and other Dublin Simon services of the suicide prevention response capacity from an overall organisational operational perspective would be useful, followed by development and implementation of an action plan to address this area.

Thematic Innovation Projects

The evaluation exercise also identified some further value-adding possibilities through service innovation and research. These may be worth exploring to support service development and enhancement, as well as for addressing some of the other recommendation areas above.

In the context of COVID-19 and the associated social distancing and lockdown regimes, one area that has gained considerable momentum is the utilisation of technology to support delivery of remote intervention and therapy sessions (by phone, video or other media). Sure Steps has utilised these approaches to a very limited extent in its own COVID-19 response so far and there is scope to examine the potential for much wider utilisation in various aspects of its services.

Internally in Dublin Simon and other homeless sector services supported, this might include utilisation for delivery of scheduled therapy sessions and for provision of support in crisis situations. There may also be good possibilities to explore utilisation of these technologies for linking in with other parts of the mental healthcare ecosystem, including hospital ED and other secondary and specialist mental health services. Apart from virtual visits, other eMental health applications such as screening tools for PTSD and other conditions also warrant exploration. As well as application for internal purposes in Dublin Simon, these approaches may offer good potential to support initiatives to better link with the wider mental healthcare system and care pathways, including the additional specialist mental health services needed by many Sure Steps clients as well as the national clinical programmes on self-harm presentations in ED and on early interventions in psychosis.

Given the large numbers of clients concerned, Sure Steps and the wider Dublin Simon services also present good opportunities for research to add to the Irish knowledge base and practice guidance for mental health services and suicide prevention approaches for homeless persons. Topics of particular interest might include:

- mapping the often-multiple contacts of homeless persons across the various services and points of contact with the wider mental healthcare ecosystem, and identification of possibilities for more integrated care provision
- follow-up of Sure Steps client outcomes in the medium-to-longer term, including mental health outcomes and broader functioning and life experiences
- examination of the value-for-money dimension of homeless mental health services, including value from health gain achieved and from reduction in avoidable utilization of hospital emergency and other higher-cost services.

Sure Steps and NOSP might jointly and severally consider these and other innovation and research possibilities, and explore ways to develop and implement them through engagement with other relevant parties and funding streams.

Part Two: CAMS Findings

Findings from an analysis of data from the Collaborative Assessment and Management of Suicidality in Dublin Simon Community

2.1 Findings from Clinical Interventions

2.1.1 Background

CES were commissioned to analyse data from the Collaborative Assessment and Management of Suicidality (CAMS) intervention implemented by the Dublin Simon Sure Steps Counselling Service. This section reports on the analysis of the clinical data from the implementation of the CAMS intervention model by the Dublin Simon Community's Sure Steps Counsellors. The aim of the data analysis is to add to the initial evidence base for the use and efficacy of CAMS as an appropriate suicide intervention model within the Sure Steps Counselling Service.

2.1.2 Aim

The analysis examined the following research questions, reflecting those explored in the 2018 'Opening the Door to Hope' report:

- Is there a reduction from pre-post evaluations of Core SSF suicidal risk self-ratings?
- Are there any trends in previous suicidal behavior and risk variables among clients?

- How can clients' core SSF ratings, as well as their indicated reasons for living and dying be categorized in terms of their personal experiences?

- Are there gender differences in how effective the CAMS approach is with clients?

2.1.3 Method

The methods used were informed by those used on the 2018 'Opening the Door to Hope' report. A chart review of routine data collected in the SSF was undertaken. While the 2018 report included only those service users who completed the intervention (that is, they had a 'resolution session'), this report includes all participants who received the CAMS intervention, with analysis focusing on those who received more than one session (where a difference between time one and time 2 could be calculated).

2.1.4 Participants

All participants were service users who were referred to the CAMS intervention team by the Dublin Simon Community between 2016 (1 case) and November 2019. As this was a review of collected data, no other specific inclusion or exclusion criteria were employed.

2.1.5 Procedure

Clients attended sessions in various locations attached to the Sure Steps Counselling Service across Dublin city. Initial sessions included the completion of pre-session SSF forms as well as the construction of stabilisation and treatment plans for each client, to be developed and implemented over the course of treatment. Clients engaged in CAMS sessions with their respective counsellors over several months, with the range of completed sessions and time between sessions varying for each participant.

The same intervention model was used across all clients. Successful completion of the intervention and the resolution of suicidal risk is indicated by three consecutive sessions of no suicidal thoughts, feelings, or behaviours. This was done through collaborative assessment, tracking and judgement by both counsellors and clients

throughout the course of their respective interventions. The analysis is concerned with changes over time, and looks at differences for all clients, regardless of whether they successfully completed CAMS or not. This is in contrast with the 2018 report, which focused on those service users who successfully completed the CAMS intervention.

2.1.6 Findings

Quantitative Findings

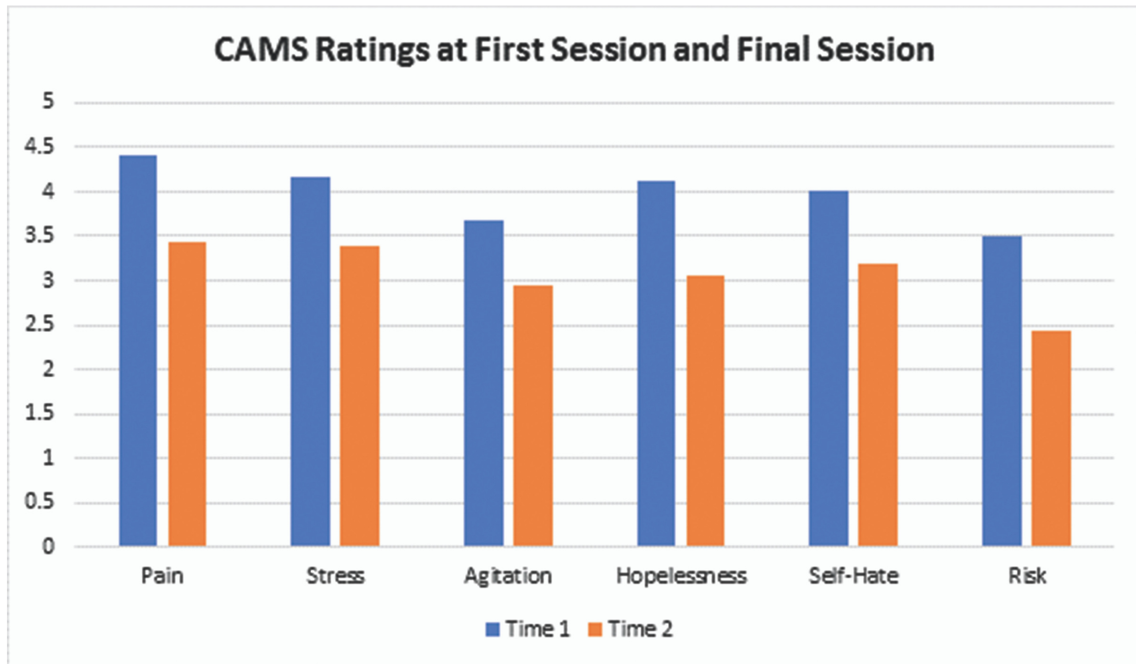
61 clients received the CAMS intervention between 2016 and November 2019 (23 Female and 38 Male, aged between 21 and 78 years). Forty-eight of these cases were identified as closed, 9 were open and 4 were noted as other or unknown. Clients had attended on average 4.90 sessions. 21 clients had attended one CAMS session only.

Wilcoxon Signs Tests as shown in Table 1 indicated statistically significant reductions for all five core SSF ratings and for self-rated risk among service users where there were data from more than one
CAMS session.

Table 2.1.1 Initial and final ratings on SSF domains

SSF Rating	Session	Mean	N	Std. Deviation	Z-Score	p
Pain score	First session	4.42	36	.80623	-4.101	.000**
	Final session	3.44	36	1.22927		
Stress score	First session	4.17	36	1.18322	-2.808	.005**
	Final session	3.39	36	1.47895		
Agitation score	First session	3.68	34	1.38653	-2.717	.007**
	Final session	2.94	34	1.34708		
Hopelessness score	First session	4.12	33	1.11124	-3.374	.001**
	Final session	3.05	33	1.42721		
Self-Hate score	First session	4.01	36	1.29000	-2.923	.003**
	Final session	3.19	36	1.48938		
Risk score	First session	3.50	34	1.33144	-3.376	.001**
	Final session	2.44	34	1.41830		

Figure 2.1.1 Risk Profile of Clients at Final Session



There are 33 clients for whom two or more data points are available for self-reported risk. The first available self-reported risk ratings and last available risk ratings were categorised into low (a score of 1 or 2), medium (a score of 3) and high (a score of 4 or 5) risk. The numbers of those in each category are outlined in table 2.1.2, and in figures 2.1.2 and 2.1.3.

Table 2.1.2 Self-reported risk categories of clients at their initial and final sessions

Self-Reported Risk	Pre-Intervention		Post-Intervention	
Low	7	21%	17	52%
Moderate	9	27%	8	24%
High	17	52%	8	24%

Figure 2.1.2 Risk Profile of Clients at First Session

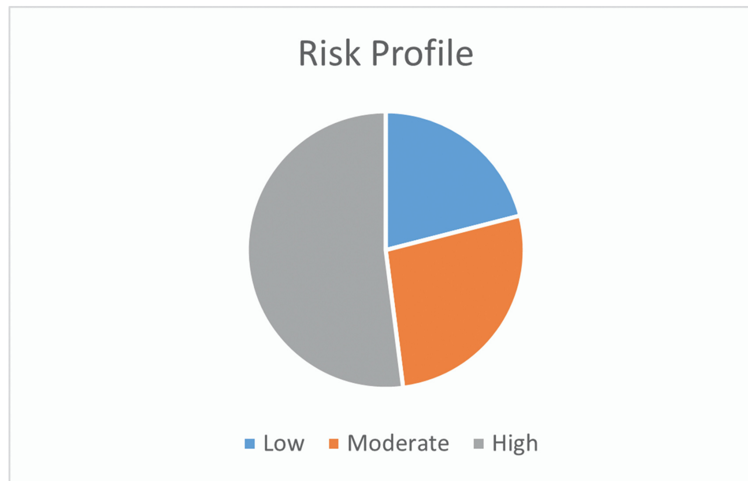
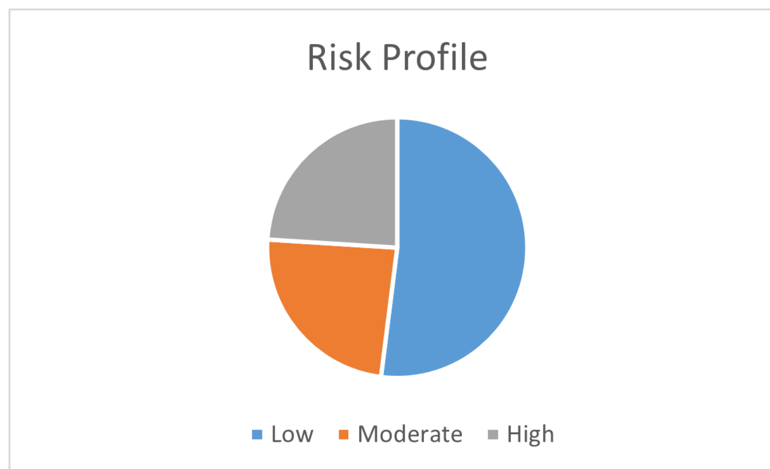


Figure 2.1.3 Risk Profile of Clients at Final Session



Qualitative findings on SSF ratings

Two researchers coded responses for the five SSF ratings into the 12 categories used in the 2018 'Opening the door to Hope' report. These categories included 11 categories identified in Jobes et al (Jobes et al, 2004), and an additional code 'Homelessness/Accommodation'. A small number of responses were coded as 'could not interpret', either because the handwriting or the intended meaning could not be determined.

In calculating the frequency of codes across the five SSF ratings, in keeping with the 2018 report the coders did not differentiate between the individual SSF domains but grouped them together to calculate an overall frequency for each code. It should be noted that Jobes et al (Jobes et al, 2004) suggested that some codes are

specific to certain SSF domains, e.g. ‘compelled to act’ is only relevant to ‘agitation’; ‘external descriptors’ is only relevant to ‘self-hate’. One-hundred-and-eighty-three qualitative responses across the five SSF domains and self-reported risk were analysed. Table 2.1.6 shows that ‘relational’ was the most populated category of response at 24.04%, followed by ‘unpleasant internal states’ (17.48%), ‘global/general’ (14.75%), and then ‘homelessness/accommodation’ and ‘situation specific’, both at 9.29%.

Table 2.1.3 Frequencies of the codes applied to qualitative responses on SSF ratings

Code	Frequency	%
Relational	44	24.04%
Unpleasant internal states	32	17.48%
Global/General	27	14.75%
Homelessness/Accommodation	17	9.29%
Situation Specific	17	9.29%
Helpless	11	6.01%
Internal Descriptors	9	4.92%
External Descriptors	8	4.37%
Could not interpret	7	3.83%
Future	6	3.28%
Self	2	1.09%
Role Responsibilities	2	1.09%
Compelled to Act	1	0.55%
Total	183	

These findings are comparable to the 2018 report, where the most frequently used code was also ‘relational’, followed by ‘unpleasant internal states’, then ‘external descriptors’, and then ‘homelessness/accommodation’. The coders in each study may have made different decisions on how to code data, for example the 2018 research team may not have limited certain codes to certain SSF ratings, e.g. ‘external descriptors’ to self-hate, as the present researchers did in line with previous research.

Qualitative Findings on 'Reasons for Living' and 'Reasons for Dying'

The researchers coded the reported ‘reasons for living’ and ‘reasons for dying’ into

the eight and ten categories respectively used in the 2018 'Opening the door to Hope' report. Five of the 'reasons for living' (RFL) categories were identified from a study by Jobes et al (Jobes et al, 1999) and three were newly generated for the 2018 report. Seven of the 'reasons for dying' (RFD) categories were identified from Jobes et al (1999), three were generated for the 2018 report. A small number of responses were coded as 'could not be interpreted', because either the handwriting or the intended meaning could not be deciphered.

A total of 159 and 151 responses were given for RFL and RFD respectively. Table 2.1.4 shows that 37.10% of responses to RFL were coded as 'family', 15.09% as 'friends', and 11.94 as 'self'. Table 2.1.5 shows that 'others/relationships' was the most popular code for RFD (25.17%), followed by 'general descriptors of self' (15.23%), and 'escape - general' (13.90%).

Table 2.1.4 Frequencies of codes applied to qualitative responses to 'Reasons for Living'

Code	Frequency	%
Family	59	37.10%
Friends	24	15.09%
Self	19	11.94%
Enjoyable things	17	10.69%
Future - Vague	13	8.18%
Basic Needs	9	5.66%
Financial/Career	9	5.66%
Personal Health Outcomes	8	5.03%
Could not interpret	1	0.62%
Total	159	

Table 2.1.5 Frequencies of codes applied to qualitative responses to 'Reasons for Dying'

Code	Frequency	%
Others/Relationships	38	25.17%
General descriptors of self	23	15.23%
Escape - general	21	13.90%
Accommodation/Homelessness	15	9.93%
Escape - pain	13	8.60%
Illness concerns	12	7.94%
Hopelessness	12	7.94%
Feeling Alone	11	7.28%
Feeling stressed/worried	4	2.65%
Could not Interpret	2	1.32%
Escape - past	0	0.00%
Total	151	

These findings are comparable to the previous 2018 report, where the most common codes used for RFL were ‘family’ (43.14%), ‘basic needs’ (13.73%), ‘self’ (13.73%), and ‘friends’ (11.76%). The most common codes applied for RFD were ‘others/relationships’ (25.49%), ‘escape – general’ (21.57%), ‘general descriptor of self’ (13.73%), and ‘illness concerns’ (11.76%).

Inter-Rater Reliability

Two CES employees separately coded the qualitative feedback, and thenompared decisions.

- For reported 'reasons for living', initial internal consistency was 76.4%
- For reported 'reasons for dying', initial internal consistency was 77.2%
- For the SSF item on 'pain', initial internal consistency was 59.5%
- For the SSF item on 'stress', initial internal consistency was 59%
- For the SSF item on 'agitation', initial internal consistency was 59%
- For the SSF item on 'hopelessness', initial internal consistency was 66%
- For the SSF item on 'self-hate', initial internal consistency was 47.1%

After this first coding exercise, each coder reviewed the decisions made by the other and indicated whether they agreed with that code, still felt their code was most appropriate or if they felt an alternative code was most appropriate. Once

this was completed, the coders discussed any remaining inconsistencies and agreed the final code to be applied.

Clinical Symptoms

Clients were also asked to indicate the presence of a variety of symptoms and concerns as illustrated in Table 2.1.6 below. Not all participants completed this section, and those who did complete the section did not necessarily offer a response to all questions.

Table 2.1.6 Frequencies of clinical symptoms reported by Dublin Simon clients

Item	f	%
Suicide Ideation	36	61%
Significant loss	35	59%
Shame	34	58%
History of Suicidal behaviour[1]	31	53%
Impulsivity	28	47%
Burden to others	27	46%
Health/Pain problems	27	46%
Sleep Problems	26	44%
Relationship problems	25	42%
Substance abuse	22	37%
Suicide Plan	18	31%
Suicide Preparation	10	17%
Suicide rehearsal	9	15%
Legal/Financial issues	8	14%

[1] Nine responses of the responses indicated a history of multiple previous attempts

2.2 Comparative Findings - Comparing the analysis of CAMS data from Dublin Simon and the North Dublin Suicide Assessment and Treatment Service

2.2.1 Background

This report compares findings from an analysis of the clinical data from the implementation of the Collaborative Assessment and Management of suicidality (CAMS) intervention model by the Dublin Simon Community's Sure Steps Counsellors to data gathered by the North Dublin Suicide Assessment and Treatment Service. It should be noted that these findings are based on available service data, where the 'outcome measure' is part of intervention.

2.2.2 Aim

The analysis compared findings from both services on the following:

- Differences in ratings on the SSF domains and suicidal risk self-ratings (including gender differences)
- Differences in the magnitude of change between pre and pst SSF suicidal risk self-ratings (including gender differences)
- Differences in how service users/clients core SSF ratings and their indicated reasons for living and dying are categorised in terms of their personal experiences

2.2.3 Method

Qualitative and quantitative data from the Dublin Simon Community's Sure Steps Counsellors were collected through a chart review of routine data collected in the SSF. Similar data were collected for clients by the North Dublin SATS.

This analysis includes all participants who received the CAMS intervention, with analysis focusing on those who received more than one session (where a difference between time one and time 2 could be calculated).

Where one group is being compared over time the Wilcoxon signed ranks test was used (e.g., SATS time 1 compared to SATS time 2, or female clients time 1 compared to female clients time 2). Where two groups were compared at one time point the Wilcoxon-Mann Whitney test was used (e.g., SATS service users compared to Dublin Simon clients at time 1). The significance level was set at $p < 0.05$.

2.2.4 Participants

Dublin Simon Community: The data relate to 61 clients who were referred to the CAMS intervention team by the Dublin Simon Community between 2016 (1 case) and November 2019.

North Dublin SATS: The data relate to 182 service users who received CAMS treatment between 2012 and 2019. Both pre- and post-intervention data were available for between 136 and 138 of service users for each of the 5 domains of the SSF. As this was a review of collected data, no other specific inclusion or exclusion criteria were employed.

2.2.5 Instrument

The SSF was used for the clinical assessment and tracking of suicidal clients form the initial to the final intervention session. The SSF provides a means to record the nature of someone's current suicidality informed by their initial self-assessment. The current analyses concerns the SSF ratings and the supplementary qualitative responses, and the Reasons for Living (RFL) and Reasons for Dying (RFD) indicated by clients.

2.2.6 Procedure

Clients from both Dublin Simon Community and the North Dublin SATS received the CAMS intervention. Initial sessions included the completion of pre-session SSF forms as well as the construction of stabilisation and treatment plans for

each client.

Successful completion of the intervention and the resolution of suicidal risk is indicated by three consecutive sessions of no suicidal thoughts, feelings, or behaviours. This was done through collaborative assessment, tracking and judgement by both counsellors and clients throughout the course of their respective interventions. The analysis is primarily concerned with changes over time, and looks at differences for all clients, regardless of whether or not they resolved their suicidality.

There were no statistically significant differences in the numbers of CAMS sessions attended by clients. Sure Steps clients attended an average of 4.90 sessions (M = 4.90, SD = 5.05), while SATS service users attended an average of 5.84 sessions (M = 5.84, SD = 4.52), (t(241) = 1.354, p = 0.177).

When looking at the risk profile of service users over time[2], a reversal in the proportion of clients in the high risk category (according to self-rated risk) can be observed among Dublin Simon clients. Among SATS users (N = 33), there is initially an almost even spread of service users across risk categories at the initial session, and at the final recorded session over 80% are in the low risk category (N = 136).

Figure 2.2.1 Percentage of Self-Reported Low, Medium and High Risk Clients at First and Final CAMS Session - Dublin Simon

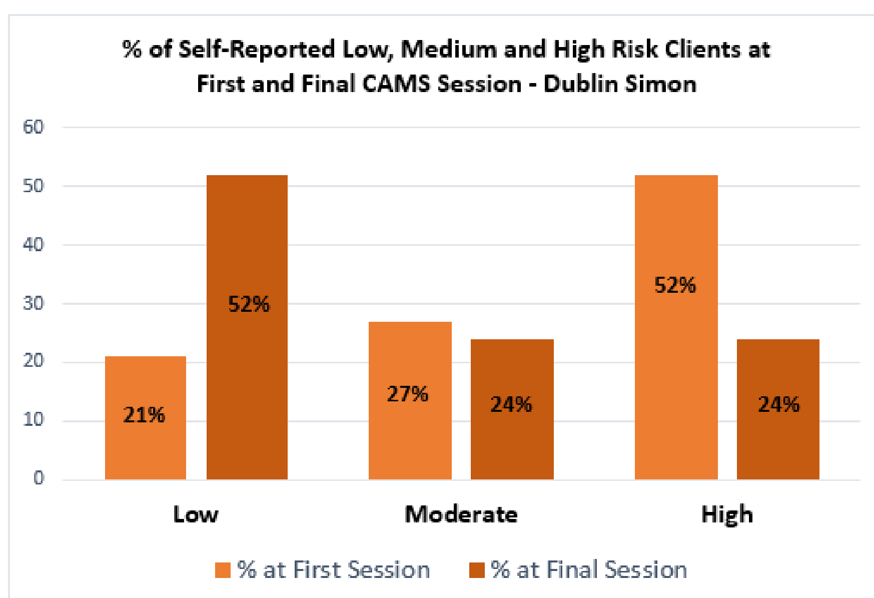
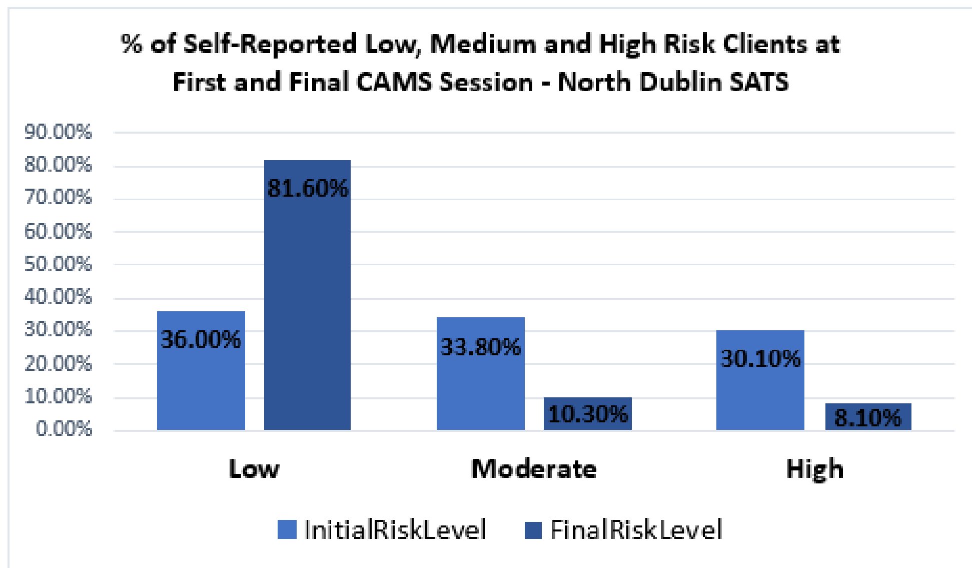


Figure 2.2.2 Percentage of Self-Reported Low, Medium and High Risk Clients at First and Final CAMS Session - North Dublin SATS



2.2.7 Findings

<u>**Differences over time on SSF domains and risk self-ratings**</u>

<u>Overview of findings</u>

Both Dublin Simon clients and SATS service users demonstrated significant differences over time on all 6 SSF domains (Risk included) between first and last session (in the desired direction). At their first recorded session Dublin Simon clients reported significantly more pain, stress and agitation than SATS service users. At the final recorded session Dublin Simon clients reported more pain, stress and risk than SATS service users. With regard to the magnitude of change over time, no statistically significant differences emerged.

<u>Dublin Simon Community</u>

Dublin Simon Community: 61 clients received the CAMS intervention between 2016 and November 2019 (23 Female and 38 Male, aged between 21 and 78 years). 48 of these cases were identified as closed, 9 were open and 4 were noted as other or unknown. Clients had attended on average 4.90 sessions. 21 clients had attended one CAMS session only.

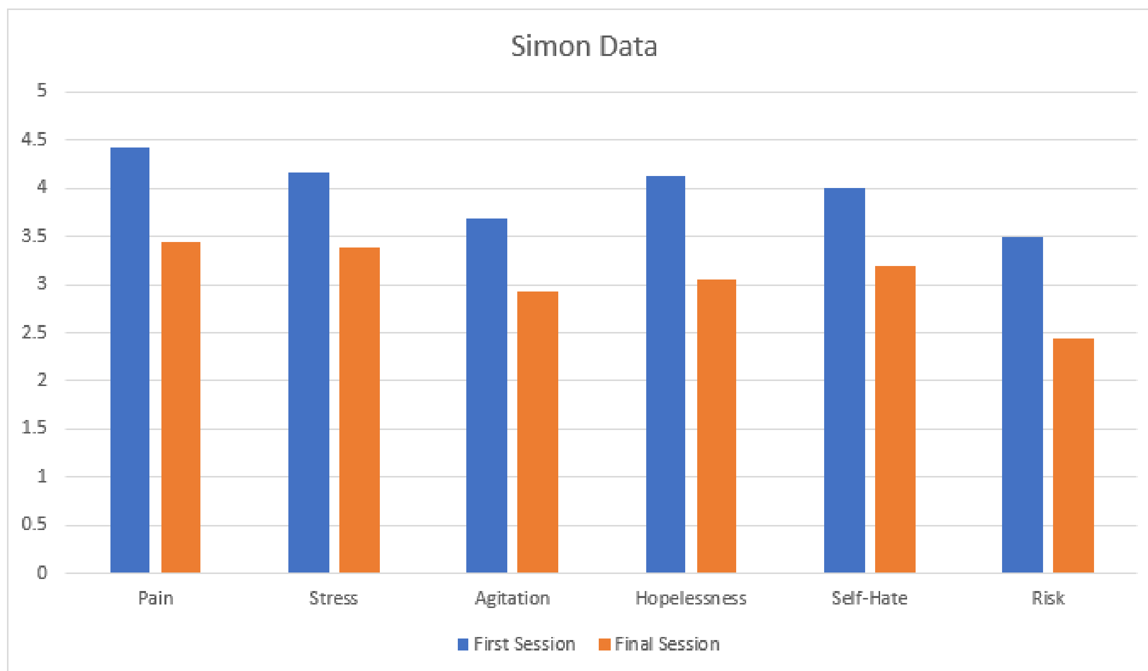
Wilcoxon Signs Tests as shown in Table 7 found statistically significant

reductions for all five core SSF ratings and for self-rated risk among clients where there were data from more than one CAMS session.

Table 2.2.1 Differences over time on SSF domains and self-rated risk for Dublin Simon clients

SSF Rating	Session	Mean	N	Std. Deviation	Z-Score	p
Pain score	First session	4.42	36	0.80623	-4.101	0.000**
	Final session	3.44	36	1.22927		
Stress score	First session	4.17	36	1.18322	-2.808	0.005**
	Final session	3.39	36	1.47895		
Agitation score	First session	3.68	34	1.38653	-2.717	0.007*
	Final session	2.94	34	1.34708		
Hopelessness score	First session	4.12	33	1.11124	-3.374	0.001**
	Final session	3.05	33	1.42721		
Self-Hate score	First session	4.01	36	1.29000	-2.923	0.003**
	Final session	3.19	36	1.48938		
Risk score	First session	3.50	34	1.33144	-3.376	0.001**
	Final session	2.44	34	1.41830		

Figure 2.2.3 Simon Data



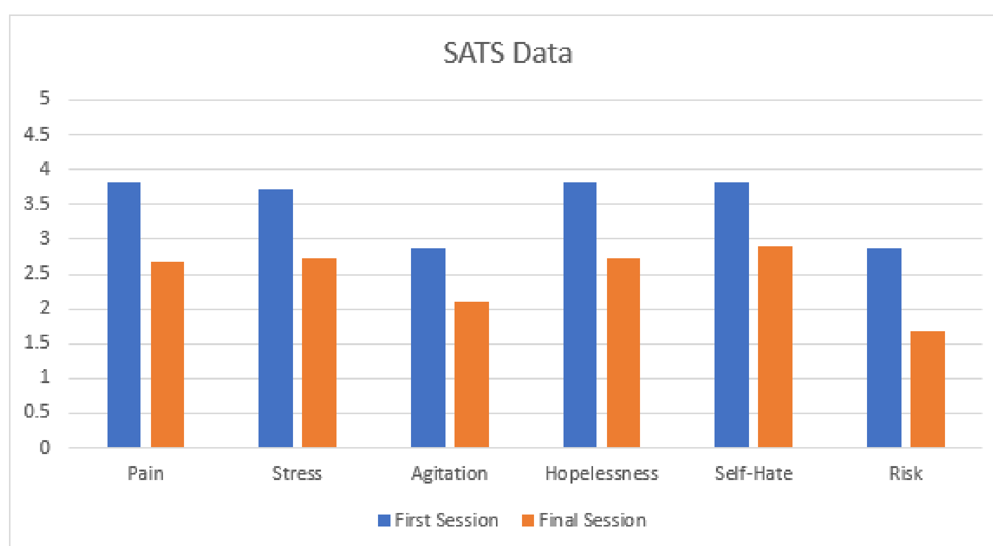
North Dublin SATS

These findings are based on the data available for 182 service users who received CAMS treatment between 2012 and 2019. Both pre- and post-intervention data were available for between 136 and 138 of service users for the 5 elements of the SSF, indicating notable missing data. Information on Gender was available for 113 of the service users, of whom 54 were recorded as female and 79 as male. Information on gender was redacted from the more recent records available to the researchers.

Table 2.2.2 Differences over time on SSF domains and self-related risk for SATS service users

SSF Rating		Mean	N	Std. Deviation	Z-Score	p
Pain score	First session	3.8080	138	1.17194	-7.181	0.000**
	Final session	2.6812	138	1.26857		
Stress score	First session	3.7283	138	1.24853	-6.333	0.000**
	Final session	2.7319	138	1.29310		
Agitation score	First session	2.8686	137	1.29800	-5.413	0.000**
	Final session	2.1095	137	1.20311		
Hopelessness score	First session	3.8285	137	1.18265	-6.562	0.000**
	Final session	2.7336	137	1.31598		
Self-Hate score	First session	3.8088	136	1.29823	-5.746	0.000**
	Final session	2.9007	136	1.35239		
Risk score	First session	2.8768	138	1.22744	-7.819	0.000**
	Final session	1.6739	138	.98835		

Figure 2.2.4 Simon Data



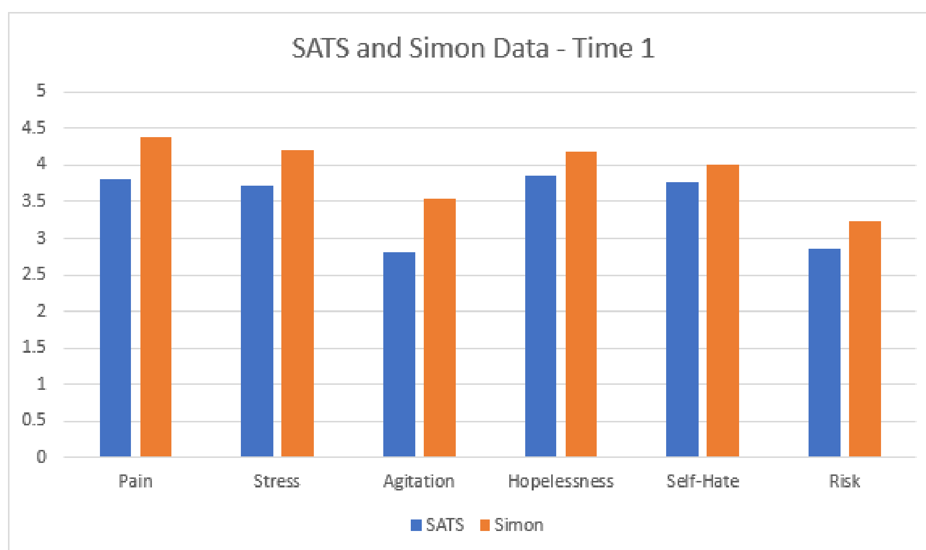
SSF ratings at first recorded session

At their initial session Dublin Simon clients reported significantly more self-rated pain, stress, and agitation when compared to North Dublin SATS service users. The average score on hopelessness, self-hate and risk among Dublin Simon community clients was also higher, but not significantly so. The analysis includes all participants for whom there is data (rather than those for whom there is more than one session).

Table 2.2.3 Differences by service provider in SSF ratings and self-rated risk at the first recorded session

SSF Rating	Source	Mean	N	Std. Deviation	Z-Score	p
Pain score	SATS	3.8075	161	1.18462	-3.404	0.001**
	Simon	4.3814	59	0.85772		
Stress score	SATS	3.7143	161	1.23708	-2.923	0.003**
	Simon	4.2167	60	1.07501		
Agitation score	SATS	2.8094	160	1.31018	-3.464	0.001**
	Simon	3.5439	57	1.40242		
Hopelessness score	SATS	3.8634	161	1.15784	-1.894	0.058
	Simon	4.1818	55	1.03800		
Self-Hate score	SATS	3.7671	161	1.36477	-1.014	0.311
	Simon	4.0085	59	1.23348		
Risk score	SATS	2.8500	160	1.21288	-1.802	0.072
	Simon	3.2321	56	1.38815		

Table 2.2.5 Simon Data



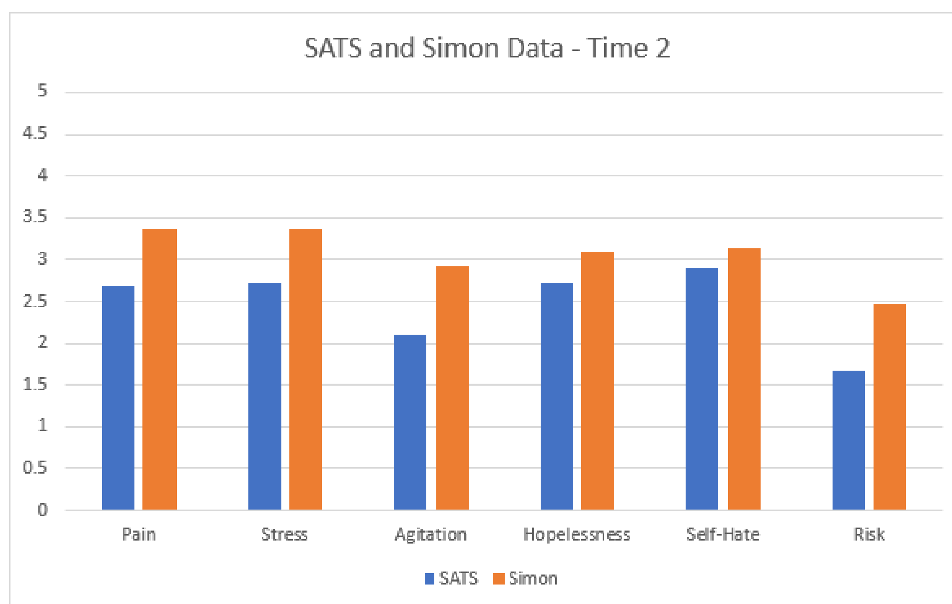
SSF ratings at final recorded session

At their final session, Dublin Simon service users reported significantly more pain, stress, agitation and risk than SATS service users.

Table 2.2.4 Differences by service provider in SSF ratings and self-rated risk at the final recorded session

SSF Rating	Source	Mean	N	Std. Deviation	Z-Score	p
Pain score	SATS	2.6812	138	1.26857	-2.888	0.004**
	Simon	3.3784	37	1.27696		
Stress score	SATS	2.7319	138	1.29310	-2.483	0.013**
	Simon	3.3784	37	1.45967		
Agitation score	SATS	2.1014	138	1.20243	-3.375	0.001**
	Simon	2.9167	36	1.31747		
Hopelessness score	SATS	2.7336	137	1.31598	-1.416	0.157
	Simon	3.0972	36	1.38264		
Self-Hate score	SATS	2.9007	136	1.35239	-.925	0.355
	Simon	3.1351	37	1.51221		
Risk score	SATS	1.6739	138	.98835	-2.994	0.003**
	Simon	2.4722	36	1.46358		

Figure 2.2.6 Simon Data



Magnitude of change

While North Dublin SATS service users reported a marginally higher change in

Overall gender differences

Overview of findings

When Dublin Simon clients and SATS service users are combines, both males and females report significant differences on all 6 SSF domains (self-rated risk included) between first and last session (in the desired direction). At the first recorded session females reported more pain, stress and self-hate than males, at the last recorded session females reported more pain, stress, hopelessness and self-hate than males. Male service users report a significantly greater reduction in hopelessness over time than female service users.

Table 2.2.6 Differences by gender in SSF ratings and self-rated risk at the first recorded session

	Gender	N	Mean	SD	Z-Score	p
Pain score at initial session	Females	71	4.2324	1.04482	-2.235	0.025*
	Males	102	3.8725	1.17668		
Stress score at initial session	Females	72	4.0833	1.12275	-2.045	0.041*
	Males	102	3.6912	1.28403		
Agitation score at initial session	Females	72	3.0972	1.40582	-0.926	0.355
	Males	99	2.8889	1.41522		
Hopelessness score at initial session	Females	69	3.9130	1.19729	-0.099	0.921
	Males	100	3.9650	1.11974		
Self-Hate score at initial session	Females	72	4.1667	1.26991	-3.154	0.002**
	Males	101	3.5891	1.36820		
Risk score at initial session	Females	70	3.0643	1.33493	-1.470	0.142
	Males	99	2.7778	1.29012		

Figure 2.2.8 Simon Data

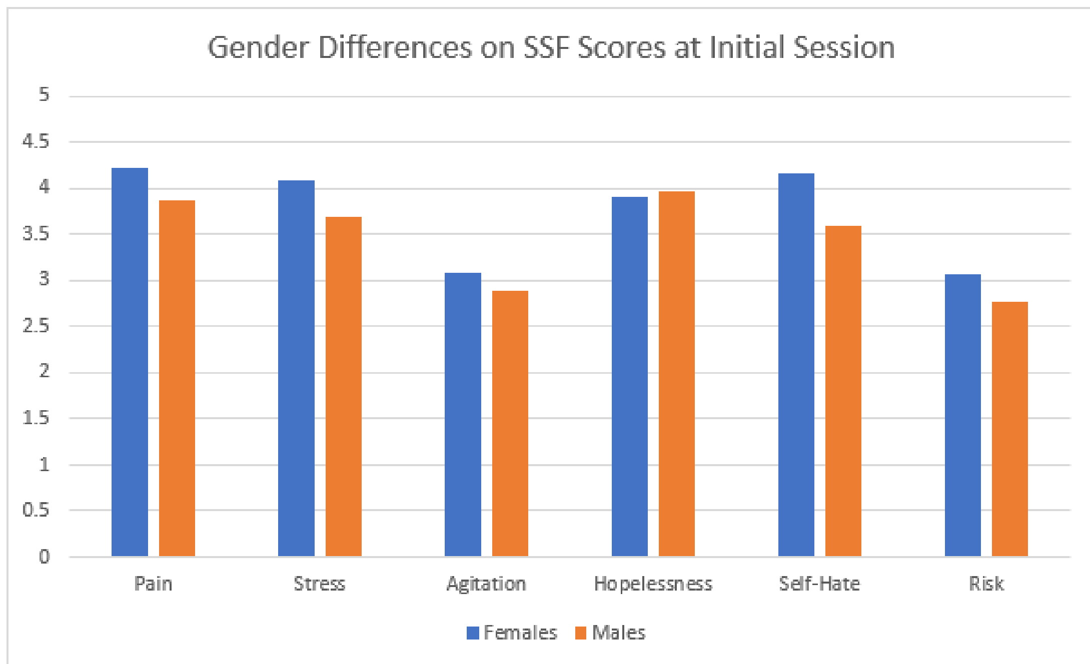


Table 2.2.7 Differences by gender in SSF ratings and self-rated risk at the final recorded session

	Gender	N	Mean	SD	Z-Score	p
Pain score at final session	Females	51	3.2157	1.39016	-2.878	0.004**
	Males	80	2.5125	1.21169		
Stress score at final session	Females	51	3.1961	1.49692	-2.600	0.009*
	Males	80	2.5125	1.24264		
Agitation score at final session	Females	51	2.0784	1.29373	-0.650	0.516
	Males	79	2.1772	1.23786		
Hopelessness score at final session	Females	50	3.1100	1.36011	-2.478	.013*
	Males	79	2.5063	1.28974		
Self-Hate score at final session	Females	50	3.3800	1.44123	-3.725	0.000**
	Males	79	2.4051	1.28621		
Risk score at final session	Females	51	1.7941	1.26561	-0.405	0.686
	Males	79	1.7848	1.10559		

Figure 2.2.9 Simon Data

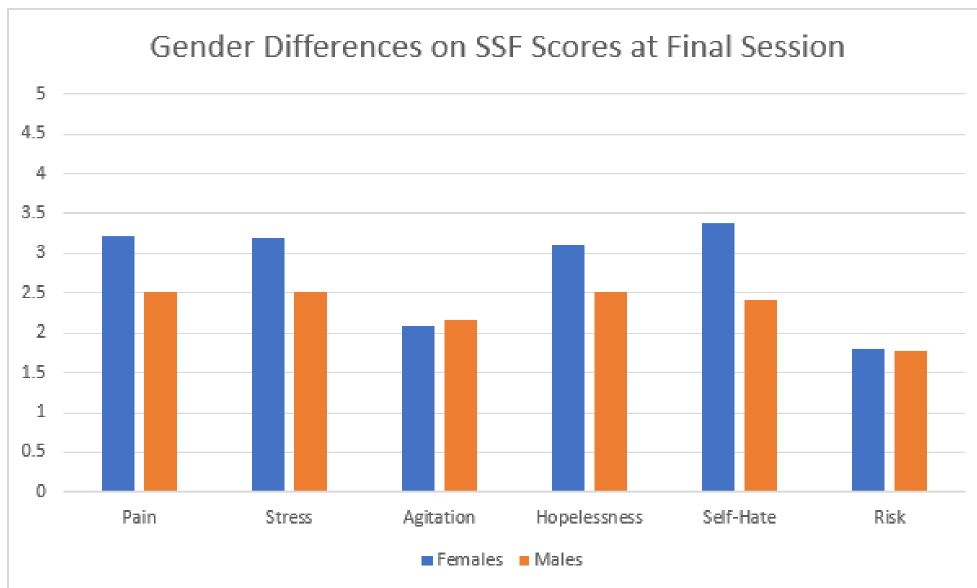
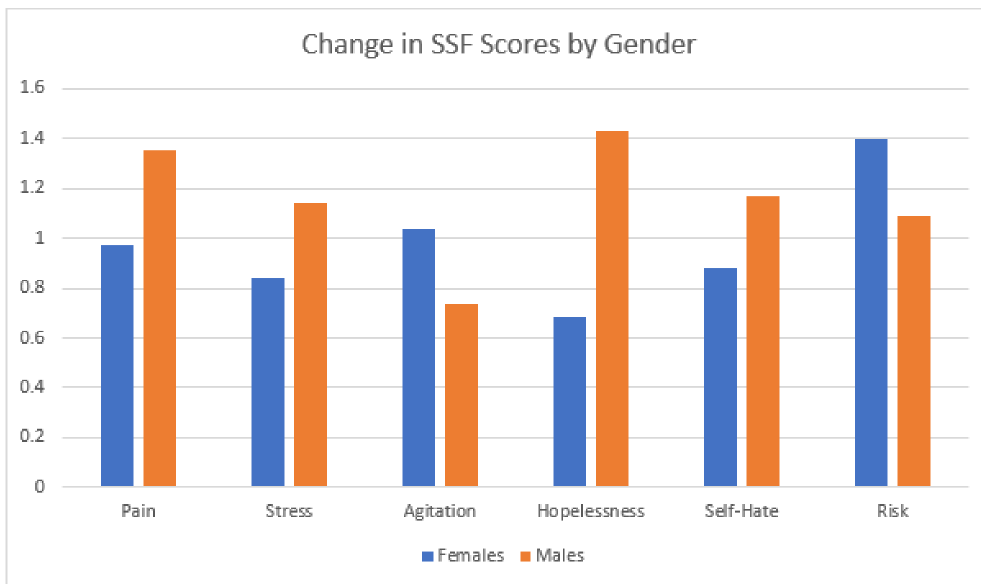


Table 2.2.8 Differences by gender in magnitude on SSF ratings and self-rated risk over time

	Gender	N	Mean	SD	Z-Score	p
Change in pain score	Females	51	0.9706	1.47109	-1.834	0.067
	Males	79	1.3544	1.29137		
Change in stress score	Females	51	0.8431	1.67777	-1.017	0.309
	Males	79	1.1456	1.43927		
Change in agitation score	Females	51	1.0392	1.67285	-1.272	0.203
	Males	77	0.7338	1.39450		
Change in hopelessness score	Females	49	0.6837	1.82201	-2.308	0.021*
	Males	77	1.4351	1.53329		
Change in self-hate score	Females	50	0.8800	1.70102	-0.953	0.341
	Males	78	1.1667	1.49820		
Change in risk score	Females	50	1.4000	1.44279	-1.302	0.193
	Males	77	1.0909	1.25846		

Figure 2.2.10 Simon Data



Gender differences among Dublin Simon clients

Overview of findings

At the first session recorded, no significant differences between genders emerged. At the last session recorded, females reported significantly more pain, stress, hopelessness and self-hate than males. Male service users reported a significantly higher change in pain, hopelessness and self-hate than their female counterparts. A slight increase in reported self-hate was noted for female clients over time, but this difference was not statistically significant.

Figure 2.2.11 SSF Self-Ratings by Gender - First Session - Simon

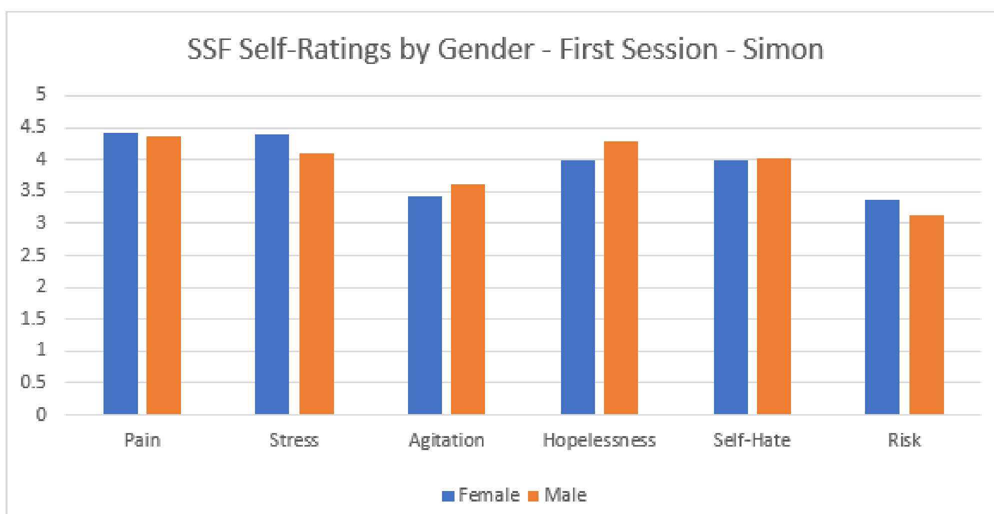


Table 2.2.9 Differences by gender in SSF ratings and self-related risk at the first recorded session for Dublin Simon clients

	Gender	N	Mean	SD	Z-Score	p
Pain score at initial session	Female	22	4.4091	0.95912	-0.595	0.552
	Male	37	4.3649	0.80492		
Stress score at initial session	Female	23	4.3913	0.94094	-1.042	0.297
	Male	37	4.1081	1.14949		
Agitation score at initial session	Female	23	3.4348	1.59049	-0.193	0.847
	Male	34	3.6176	1.27955		
Hopelessness score at initial session	Female	20	4.0000	1.07606	-1.037	0.300
	Male	35	4.2857	1.01667		
Self-Hate score at initial session	Female	23	3.9783	1.30103	-0.008	0.993
	Male	36	4.0278	1.20679		
Risk score at initial session	Female	21	3.3810	1.49921	-0.713	0.476
	Male	35	3.1429	1.33158		

Figure 2.2.12 SSF Self-Ratings by Gender - Final Session - Simon

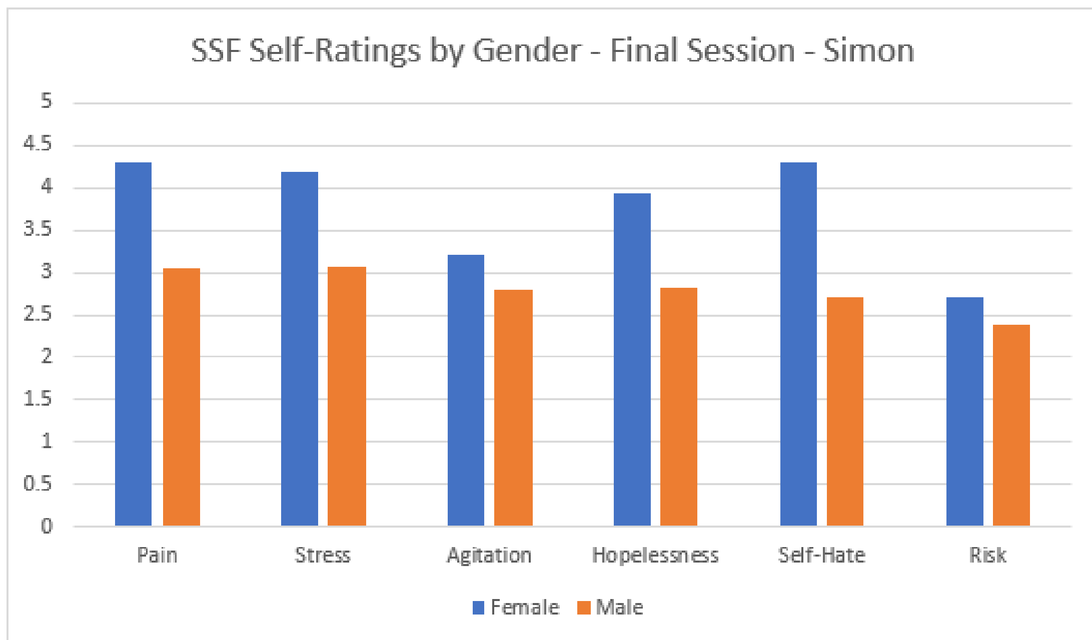


Table 2.2.10 Differences by gender in SSF ratings and self-rated risk at the final recorded session for Dublin Simon clients

	Gender	N	Mean	SD	Z-Score	p
Pain score at final session	Female	10	4.3000	0.82327	-2.725	0.006*
	Male	27	3.0370	1.25519		
Stress score at final session	Female	10	4.2000	1.31656	-2.162	0.031*
	Male	27	3.0741	1.41220		
Agitation score at final session	Female	10	3.2000	1.13529	-.679	0.497
	Male	26	2.8077	1.38620		
Hopelessness score at final session	Female	9	3.9444	0.88192	-2.185	0.029*
	Male	27	2.8148	1.41522		
Self-Hate score at final session	Female	10	4.3000	1.33749	-3.051	0.002**
	Male	27	2.7037	1.35348		

Figure 2.2.13 Overall Change in SSF Ratings by Gender - Dublin Simon

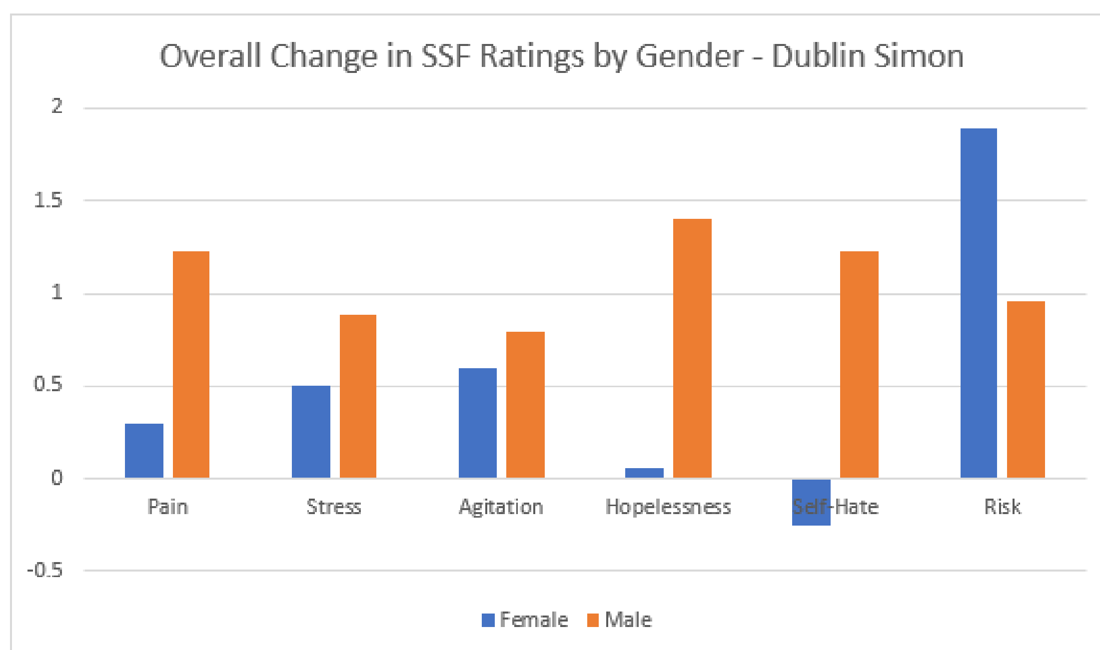


Table 2.2.11 Differences by gender in magnitude of change on SSF ratings and self-rated risk over time for Dublin Simon clients

	Gender	N	Mean	SD	Z-Score	p
Change in pain score	Female	10	0.3000	0.67495	-2.617	0.009*
	Male	26	1.2308	1.06987		
Change in stress score	Female	10	0.5000	1.50923	-1.109	0.267
	Male	26	0.8846	1.45126		
Change in agitation score	Female	10	0.6000	2.06559	-0.155	0.877
	Male	24	0.7917	1.38247		
Change in hopelessness score	Female	8	0.0625	1.01550	-2.072	0.038*
	Male	25	1.4000	1.58114		
Change in self-hate score	Female	10	-0.2500	1.13652	-3.016	0.003**
	Male	26	1.2308	1.36551		
Change in risk score	Female	9	1.8889	1.26930	-1.738	0.082
	Male	24	0.9583	1.33447		

Gender differences among SATS Service Users

Overview of findings

When looking at SATS service users only, females reported greater pain, stress, agitation and self-hate at the first recorded session. Females reported significantly greater pain, stress, hopelessness and self-hate at the final session. Males reported a significantly greater reduction in hopelessness over time.

Figure 2.2.14 SATS Gender Differences - First Session

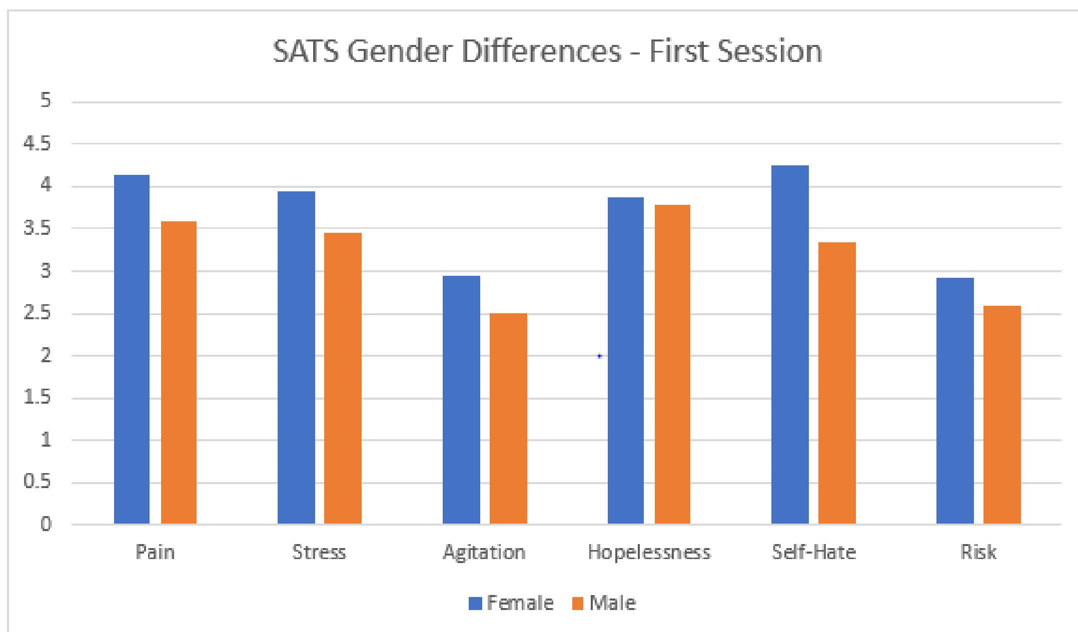


Table 2.2.12 Differences by gender in SSF ratings and self-rated risk at the first recorded session for SATS service users

	Gender	N	Mean	SD	Z-Score	p
Pain score at initial session	Female	49	4.1531	1.08111	-2.571	0.010*
	Male	65	3.5923	1.26520		
Stress score at initial session	Female	49	3.9388	1.17983	-2.030	0.042*
	Male	65	3.4538	1.30421		
Agitation score at initial session	Female	49	2.9388	1.29756	-1.795	0.073
	Male	65	2.5077	1.33900		
Hopelessness score at initial session	Female	49	3.8776	1.25221	-.655	0.513
	Male	65	3.7923	1.14186		
Self-Hate score at initial session	Female	49	4.2551	1.25881	-3.743	0.000**
	Male	65	3.3462	1.40012		
Risk score at initial session	Female	49	2.9286	1.25000	-1.542	0.123
	Male	64	2.5781	1.23191		

Figure 2.2.15 SATS Gender Differences - Final Session

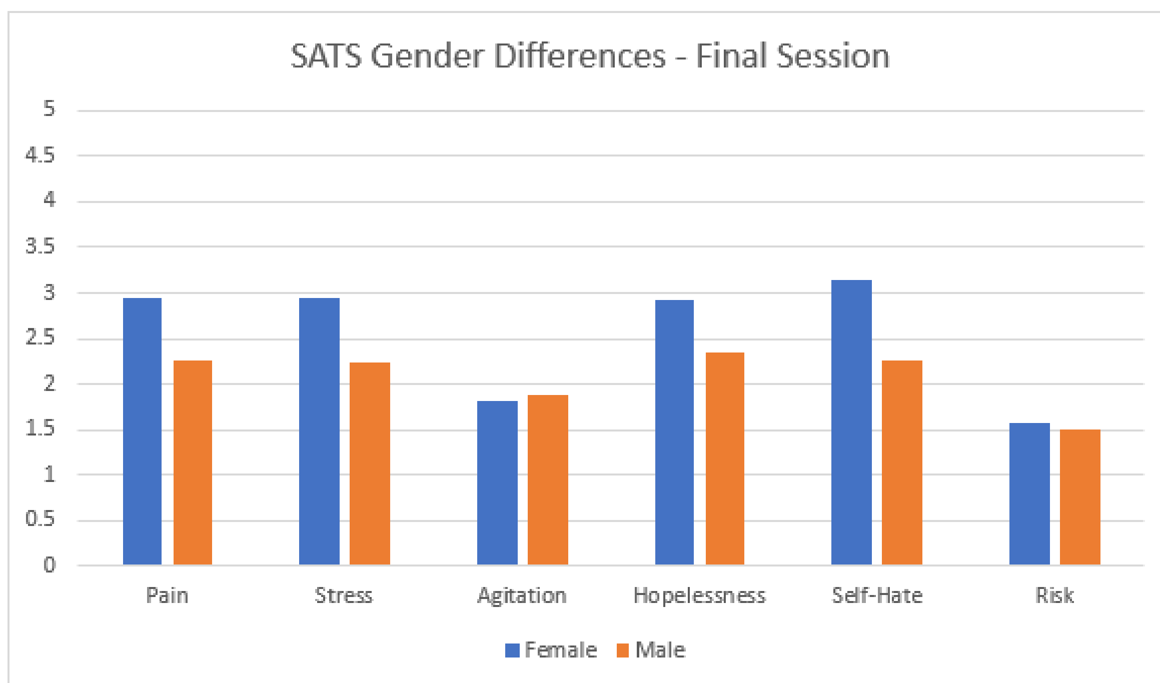


Table 2.2.13 Differences by gender in SSF ratings and self-rated risk at the final recorded session for SATS service users

	Gender	N	Mean	SD	Z-Score	p
Pain score at final session	Female	41	2.9512	1.37752	-2.521	0.012*
	Male	53	2.2453	1.10776		
Stress score at final session	Female	41	2.9512	1.44830	-2.422	0.015*
	Male	53	2.2264	1.04957		
Agitation score at final session	Female	41	1.8049	1.18784	-0.817	0.414
	Male	53	1.8679	1.03845		
Hopelessness score at final session	Female	41	2.9268	1.38546	-2.041	0.041*
	Male	52	2.3462	1.20269		
Self-Hate score at final session	Female	40	3.1500	1.38767	-3.057	0.002**
	Male	52	2.2500	1.23471		
Risk score at final session	Female	41	1.5732	1.04619	-0.176	0.860
	Male	53	1.4906	0.79958		

Figure 2.2.16 SATS Gender Differences - Magnitude of Change

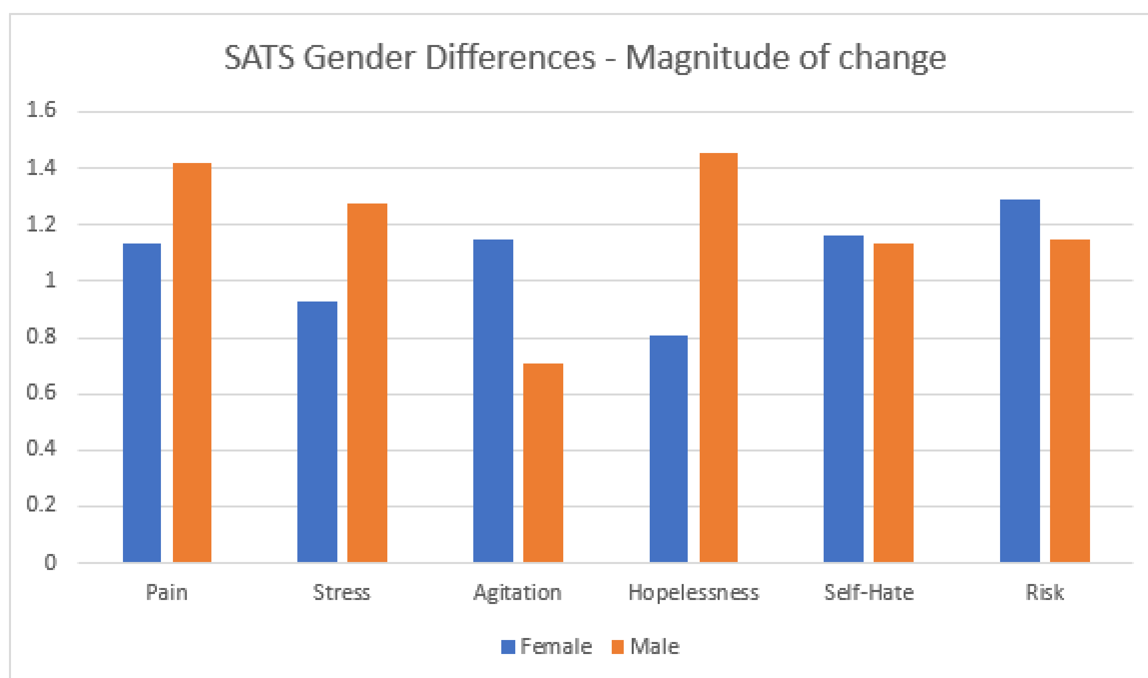


Table 2.2.14 Differences by gender in magnitude of change on SSF ratings and self-rated risk over time for SATS service users

	Gender	N	Mean	SD	Z-Score	p
Change in pain score	Female	41	1.1341	1.56933	-1.106	0.269
	Male	53	1.4151	1.39276		
Change in stress score	Female	41	0.9268	1.72323	-0.829	0.407
	Male	53	1.2736	1.42965		
Change in agitation score	Female	41	1.1463	1.57418	-1.284	0.199
	Male	53	0.7075	1.41229		
Change in hopelessness score	Female	41	0.8049	1.92639	-1.658	0.097
	Male	52	1.4519	1.52515		
Change in self-hate score	Female	40	1.1625	1.71115	-0.196	0.844
	Male	52	1.1346	1.57217		
Change in risk score	Female	41	1.2927	1.47044	-0.541	0.589
	Male	53	1.1509	1.23095		

Differences across service providers for females

Overview of findings

At the first recorded session there were no significant differences between self-ratings on any of the SSF scales among female Dublin Simon clients compared to female SATS service users. However, at the final session, female Dublin Simon clients reported significantly higher ratings on all the SSF constructs than their counterparts in the SATS group; it should be noted that there were only data for 9 and 10 females from the Simon group for the final session, compared to 40 and 41 females for the SATS group.

Figure 2.2.17 Female SSF Ratings by Service Provider - First Session

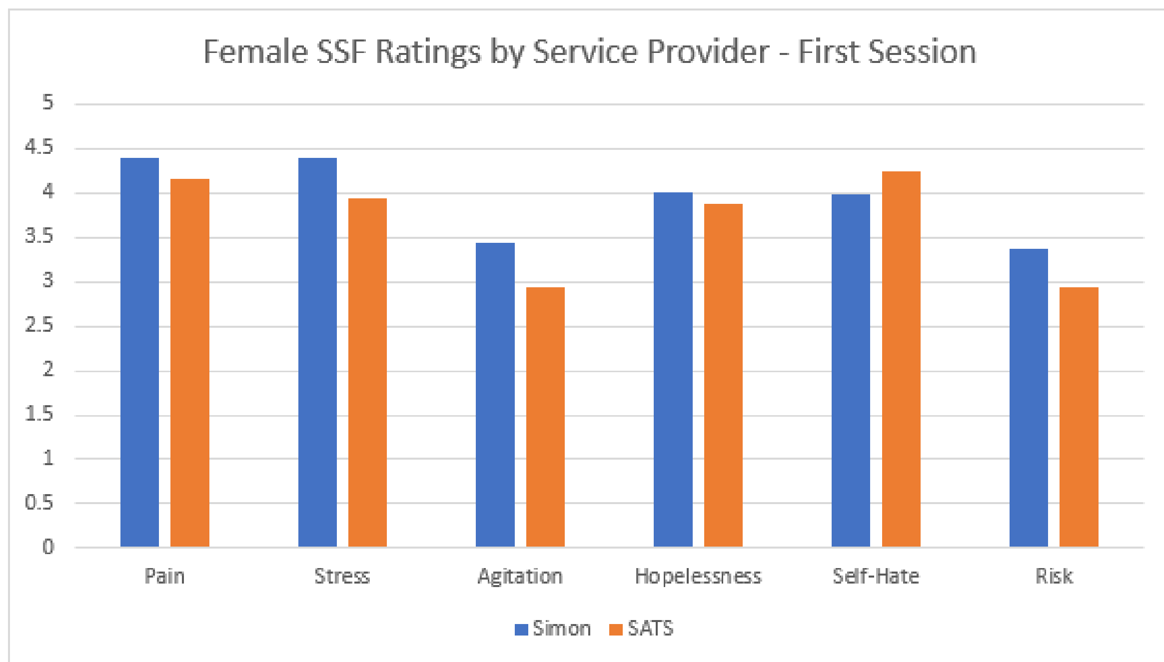


Table 2.2.16 Differences by service provider in SSF ratings and self-rated risk at the first recorded session for females

	Site	N	Mean	SD	Z-Score	p
Pain score at initial session	SATS	49	4.1531	1.08111	-1.173	0.241
	SIMON	22	4.4091	0.95912		
Stress score at initial session	SATS	49	3.9388	1.17983	-1.695	0.090
	SIMON	23	4.3913	0.94094		
Agitation score at initial session	SATS	49	2.9388	1.29756	-1.352	0.176
	SIMON	23	3.4348	1.59049		
Hopelessness score at initial session	SATS	49	3.8776	1.25221	-0.203	0.839
	SIMON	20	4.0000	1.07606		
Self-Hate score at initial session	SATS	49	4.2551	1.25881	-1.187	0.235
	SIMON	23	3.9783	1.30103		
Risk score at initial session	SATS	49	2.9286	1.25000	-1.351	0.177
	SIMON	21	3.3810	1.49921		

Figure 2.2.18 Female SSF Ratings by Service Provider - Final Session

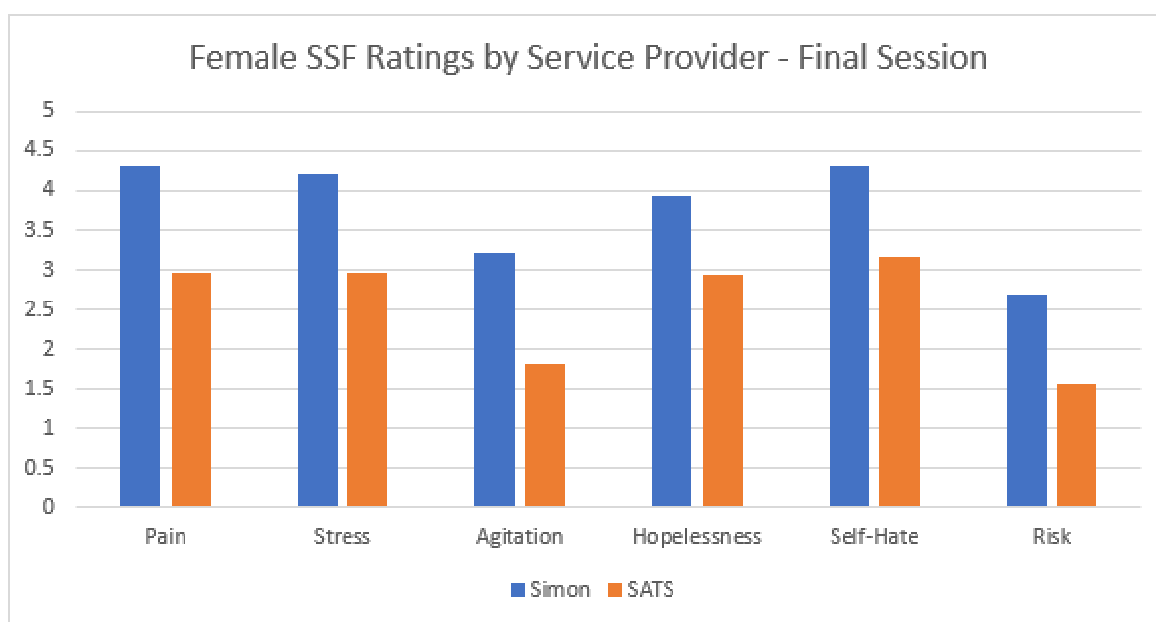


Table 2.2.17 Differences by service provider in SSF ratings and self-related risk at the final recorded session for females

	Site	N	Mean	SD	Z-Score	P
Pain score at final session	SATS	41	2.9512	1.37752	-2.777	0.005**
	SIMON	10	4.3000	0.82327		
Stress score at final session	SATS	41	2.9512	1.44830	-2.440	0.015*
	SIMON	10	4.2000	1.31656		
Agitation score at final session	SATS	41	1.8049	1.18784	-3.349	0.001**
	SIMON	10	3.2000	1.13529		
Hopelessness score at final session	SATS	41	2.9268	1.38546	-2.110	0.035*
	SIMON	9	3.9444	0.88192		
Self-Hate score at final session	SATS	40	3.1500	1.38767	-2.490	0.013*
	SIMON	10	4.3000	1.33749		
Risk score at final session	SATS	41	1.5732	1.04619	-2.199	0.028**
	SIMON	10	2.7000	1.70294		

Figure 2.2.19 Change in Female SSF Ratings by Service Provider

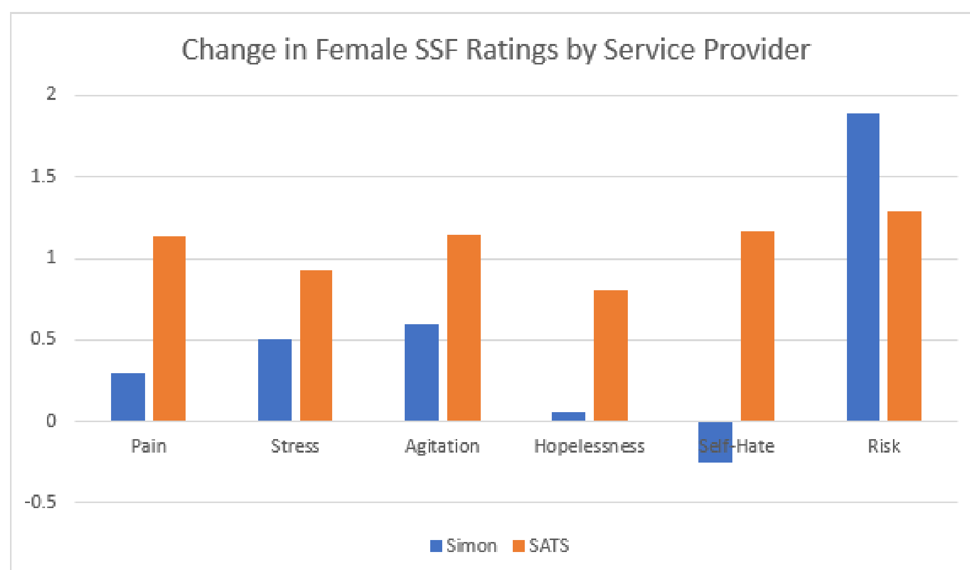


Table 2.2.18 Differences by service provider in magnitude of change on SSF ratings and self-related risk over time for females

	Site	N	Mean	SD	Z-Score	p
Change in pain score	SATS	41	1.1341	1.56933	-1.874	0.061
	SIMON	10	0.3000	0.67495		
Change in stress score	SATS	41	0.9268	1.72323	-1.160	0.246
	SIMON	10	0.5000	1.50923		
Change in agitation score	SATS	41	1.1463	1.57418	-.533	0.594
	SIMON	10	0.6000	2.06559		
Change in hopelessness score	SATS	41	0.8049	1.92639	-1.358	0.175
	SIMON	8	0.0625	1.01550		
Change in self-hate score	SATS	40	1.1625	1.71115	-2.706	0.007*
	SIMON	10	-0.2500	1.13652		
Change in risk score	SATS	41	1.2927	1.47044	-1.128	0.259
	SIMON	9	1.8889	1.26930		

Differences across service providers for males

Overview of findings

Among males at their initial session, male Dublin Simon clients reported significantly higher self-ratings on all constructs in the SSF. At the final session, males in Simon group reported significantly more pain, stress, agitation and risk

than males in the SATS group. There were no significant differences in terms of the magnitude of change over time.

Figure 2.2.20 SSF Ratings at Time 1 by Service Provider

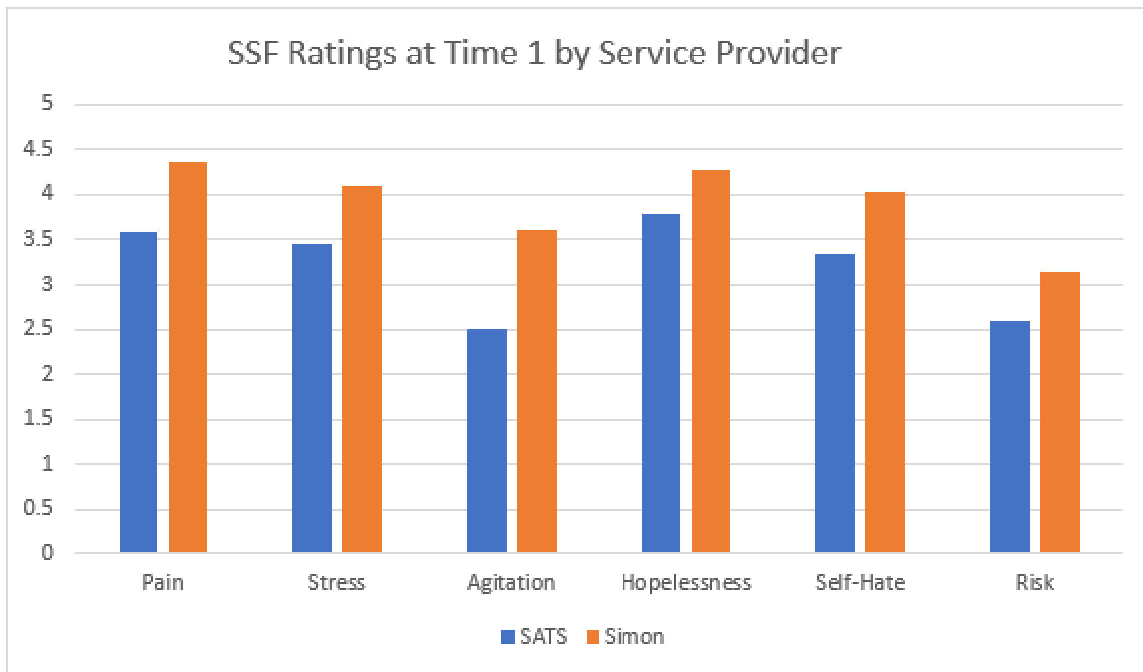


Table 2.2.19 Differences by service provider in SSF ratings and self-rated risk at the first recorded sessions for males

	Site	N	Mean	SD	Z-Score	p
Pain score at initial session	SATS	65	3.5923	1.26520	-3.107	0.002**
	SIMON	37	4.3649	0.80492		
Stress score at initial session	SATS	65	3.4538	1.30421	-2.560	0.010*
	SIMON	37	4.1081	1.14949		
Agitation score at initial session	SATS	65	2.5077	1.33900	-3.746	0.000**
	SIMON	34	3.6176	1.27955		
Hopelessness score at initial session	SATS	65	3.7923	1.14186	-2.403	0.016*
	SIMON	35	4.2857	1.01667		
Self-Hate score at initial session	SATS	65	3.3462	1.40012	-2.426	0.015*
	SIMON	36	4.0278	1.20679		
Risk score at initial session	SATS	64	2.5781	1.23191	-1.989	0.047*
	SIMON	35	3.1429	1.33158		

Figure 2.2.21 SSF Ratings at Time 2 by Service Provider

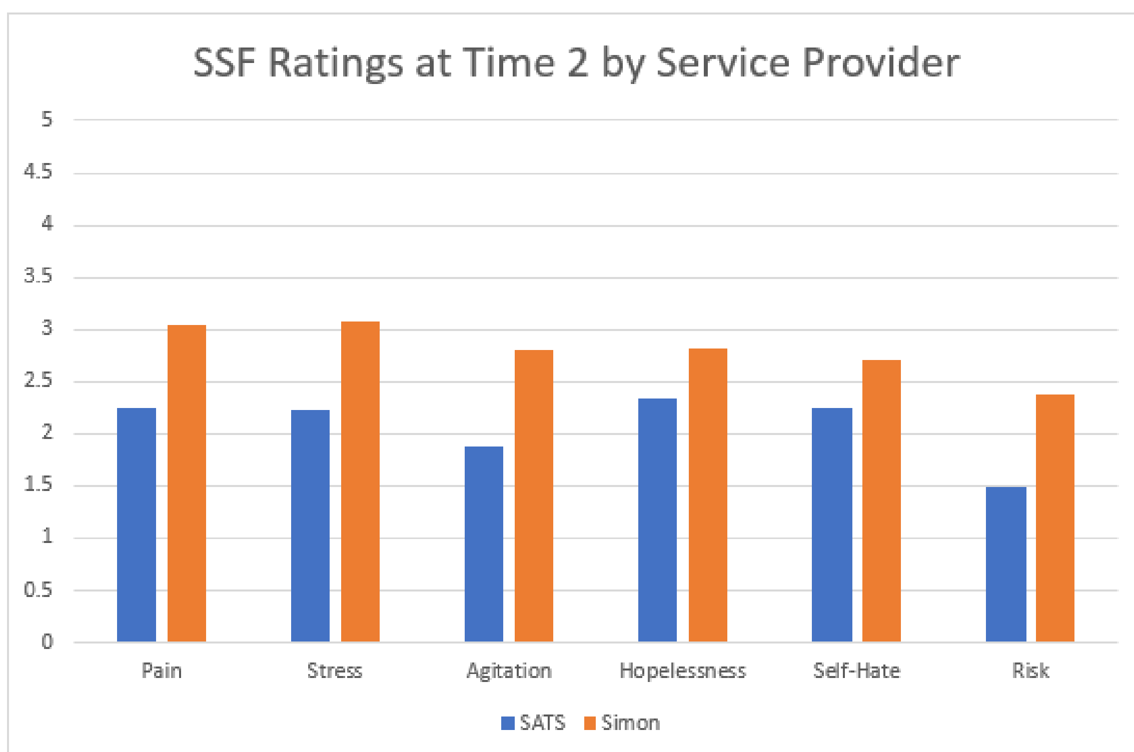


Table 2.2.20 Differences by service provider in SSF ratings and self-rated risk at the final recorded session for males

	Site	N	Mean	SD	Z-Score	P
Pain score at final session	SATS	53	2.2453	1.10776	-2.722	0.006*
	SIMON	27	3.0370	1.25519		
Stress score at final session	SATS	53	2.2264	1.04957	-2.582	0.010*
	SIMON	27	3.0741	1.41220		
Agitation score at final session	SATS	53	1.8679	1.03845	-2.992	0.003**
	SIMON	26	2.8077	1.38620		
Hopelessness score at final session	SATS	52	2.3462	1.20269	-1.411	0.158
	SIMON	27	2.8148	1.41522		
Self-Hate score at final session	SATS	52	2.2500	1.23471	-1.406	0.160
	SIMON	27	2.7037	1.35348		
Risk score at final session	SATS	53	1.4906	0.79958	-2.839	0.005**
	SIMON	26	2.3846	1.38786		

Figure 2.2.22 Magnitude of Change for Males by Service Provider

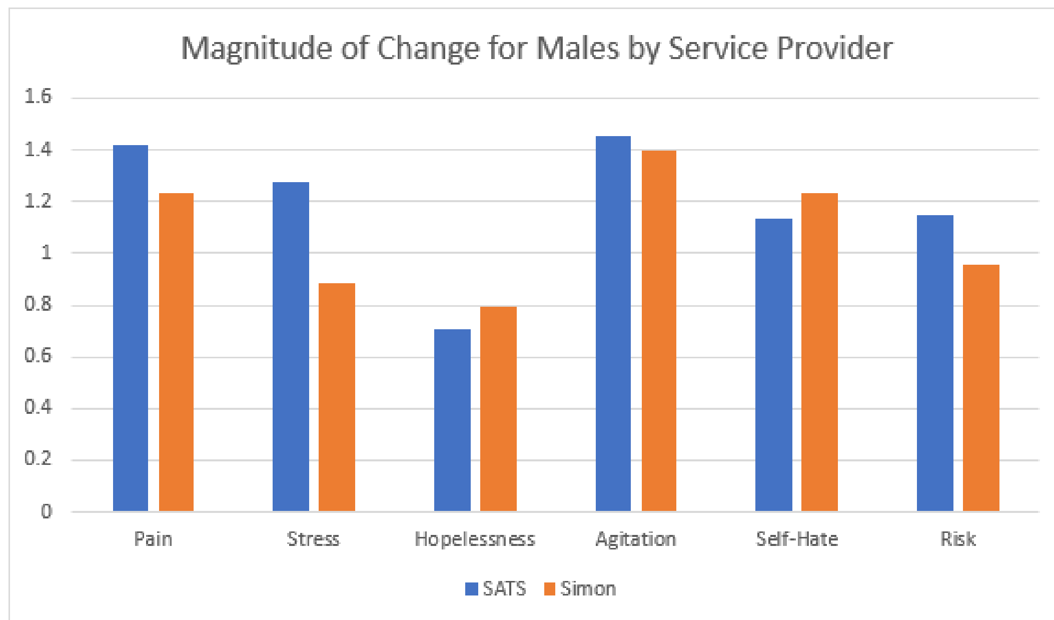


Table 2.2.21 Differences by service provider in magnitude of change on SSF ratings and self-rated risk over time for males

	Site	N	Mean	SD	Z-Score	p
Change in pain score	SATS	53	1.4151	1.39276	-1.222	0.222
	SIMON	26	1.2308	1.06987		
Change in stress score	SATS	53	1.2736	1.42965	-1.174	0.241
	SIMON	26	0.8846	1.45126		
Change in agitation score	SATS	53	0.7075	1.41229	-0.124	0.901
	SIMON	24	0.7917	1.38247		
Change in hopelessness score	SATS	52	1.4519	1.52515	-0.227	0.820
	SIMON	25	1.4000	1.58114		
Change in self-hate score	SATS	52	1.1346	1.57217	-0.136	0.892
	SIMON	26	1.2308	1.36551		
Change in risk score	SATS	53	1.1509	1.23095	-0.614	0.539
	SIMON	24	0.9583	1.33447		

Qualitative findings

Qualitative data reported on each of the SSF domains from both Sure Steps and SATS were coded. For data from Sure Steps clients, responses were coded into the 12 categories used in the 2018 ‘Opening the door to Hope’ report. For data from the SATS, responses were coded into the categories for each domain as identified in Jobes et al (2004). A small number of responses were uninterpretable, because either the handwriting or the intended meaning could not be determined. These were coded as ‘could not interpret’. The findings therefore not directly comparable, but some interesting similarities emerged (see appendix 2 for frequency of codes applied according to service provider).

- For 'psychological pain', the same top three codes emerged (unpleasant internal states, relational, global/general).
- For 'stress' two of the top three codes were the same (relational and situation specific).
- For 'agitation' two of the top three codes were the same (unpleasant internal states, and situation specific).
- For 'hopelessness' global/general was included in the top three codes for both services.
- For 'self-hate' both internal and external descriptors were included in the top three codes for both services.

Figure 2.2.23 Psychological Pain - North Dublin SATS - 172

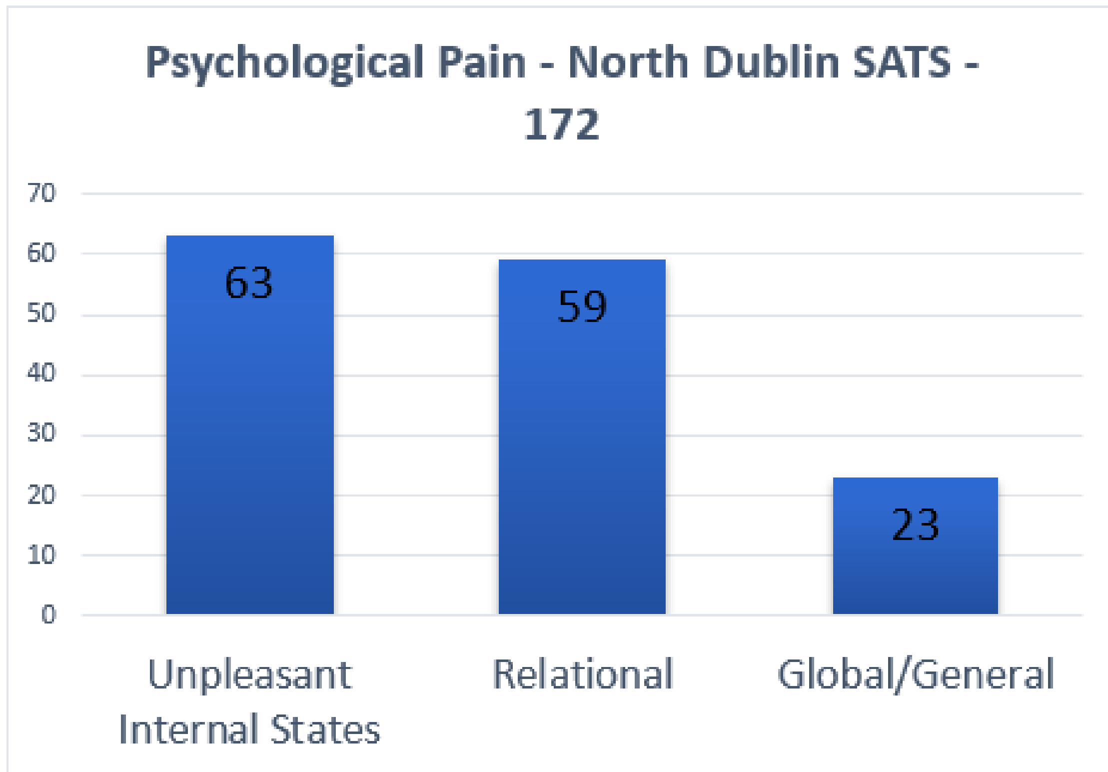


Figure 2.2.24 Psychological Pain - Sure Steps - 37

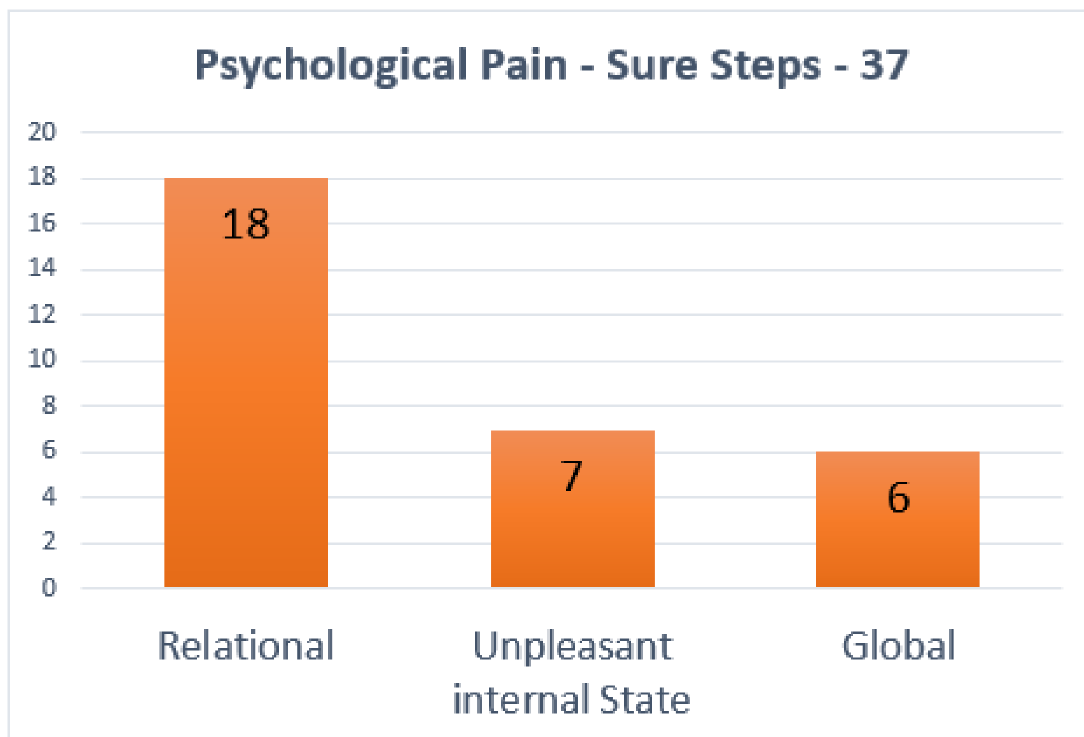


Figure 2.2.25 Stress - North Dublin SATS - 172

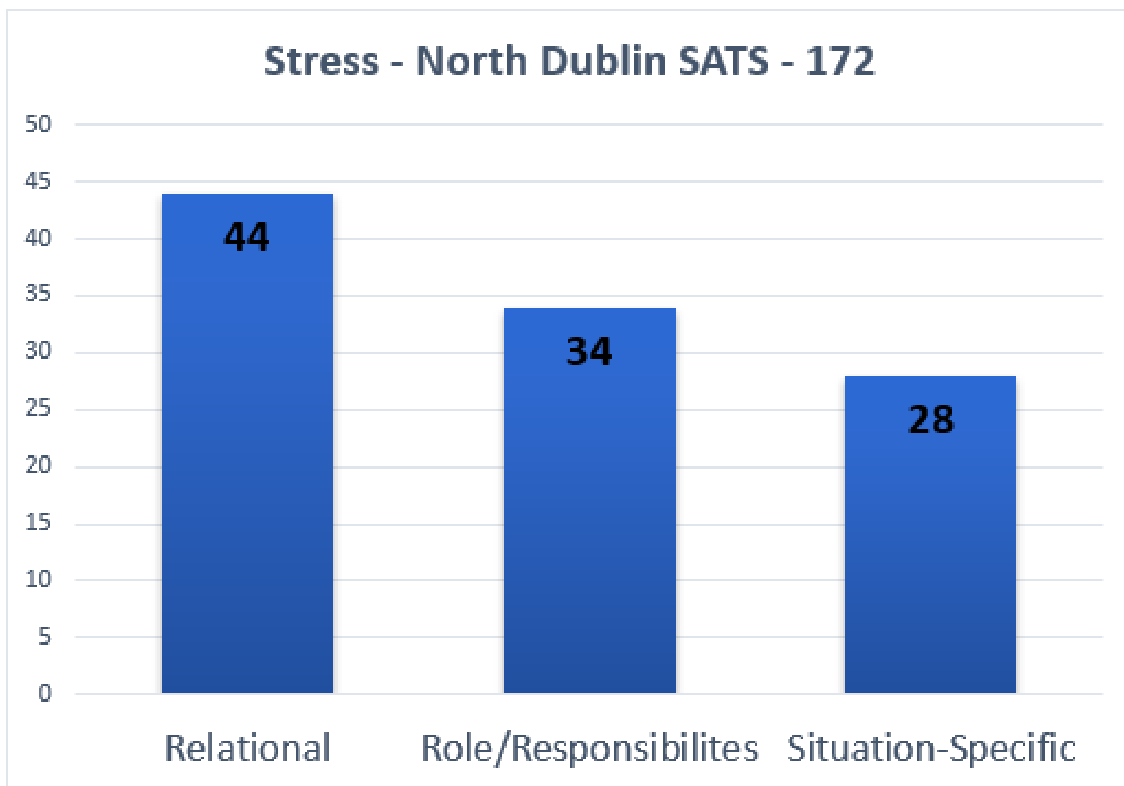


Figure 2.2.26 Stress - Sure Steps - 36

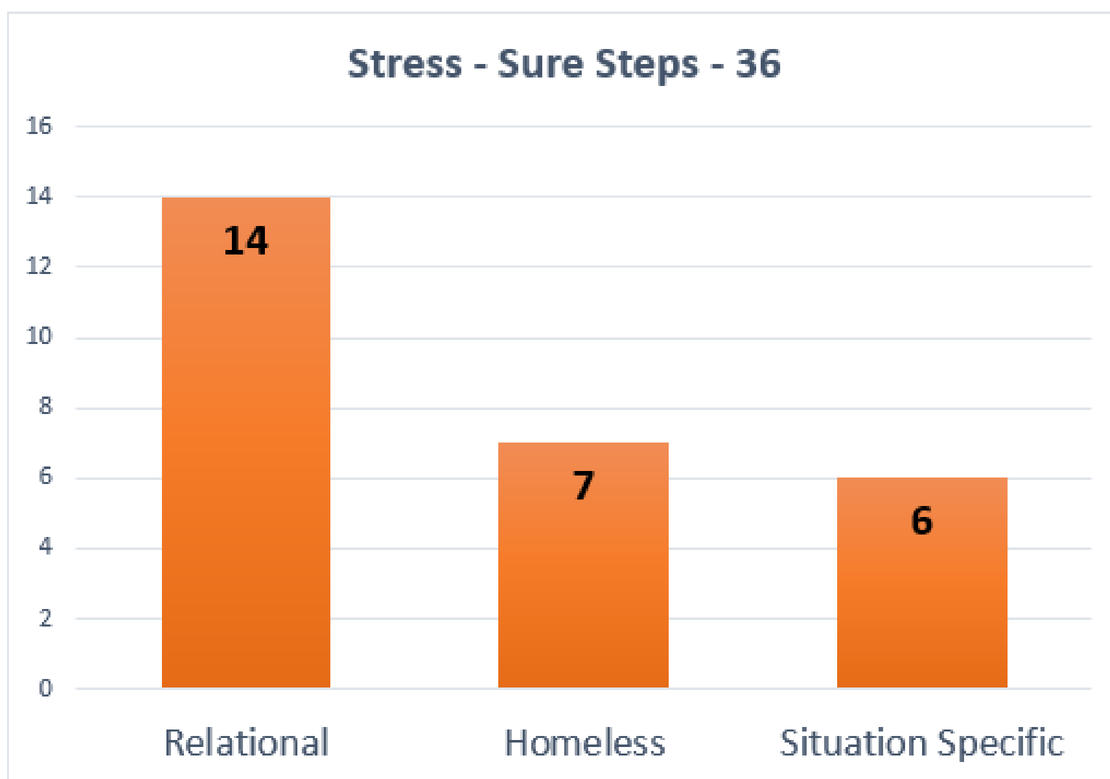


Figure 2.2.27 Agitation - North Dublin SATS - 164

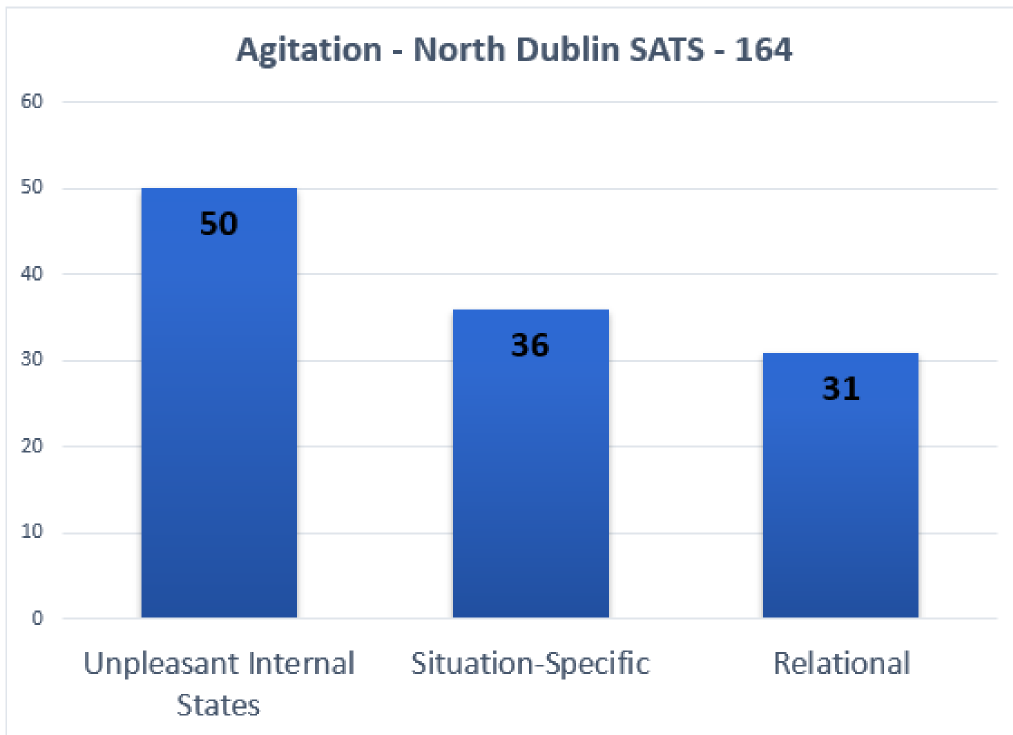


Figure 2.2.28 Agitation - Sure Steps - 35

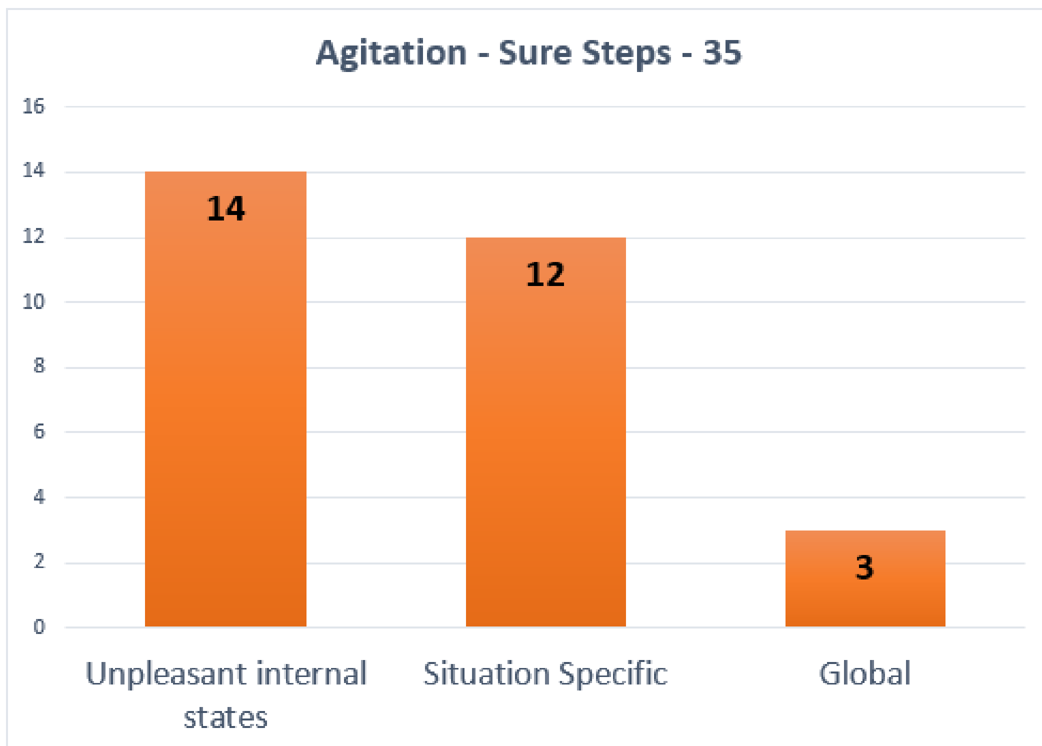


Figure 2.2.29 Hopelessness - North Dublin SATS - 172

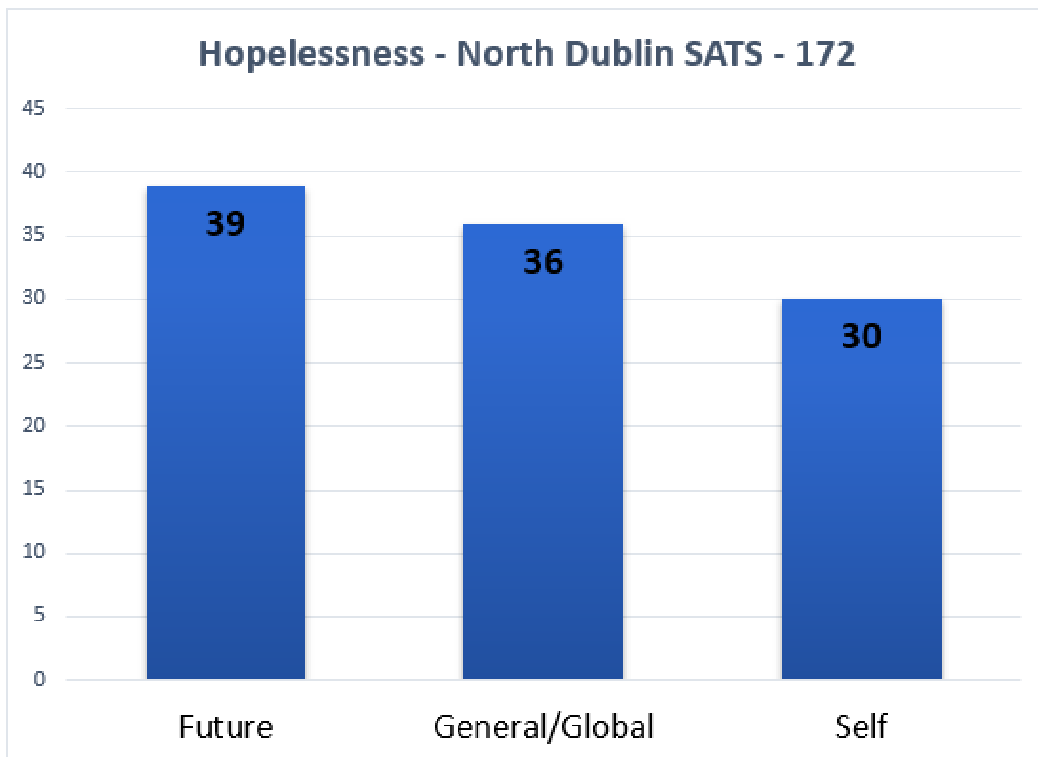


Figure 2.2.30 Hopelessness - Sure Steps - 36

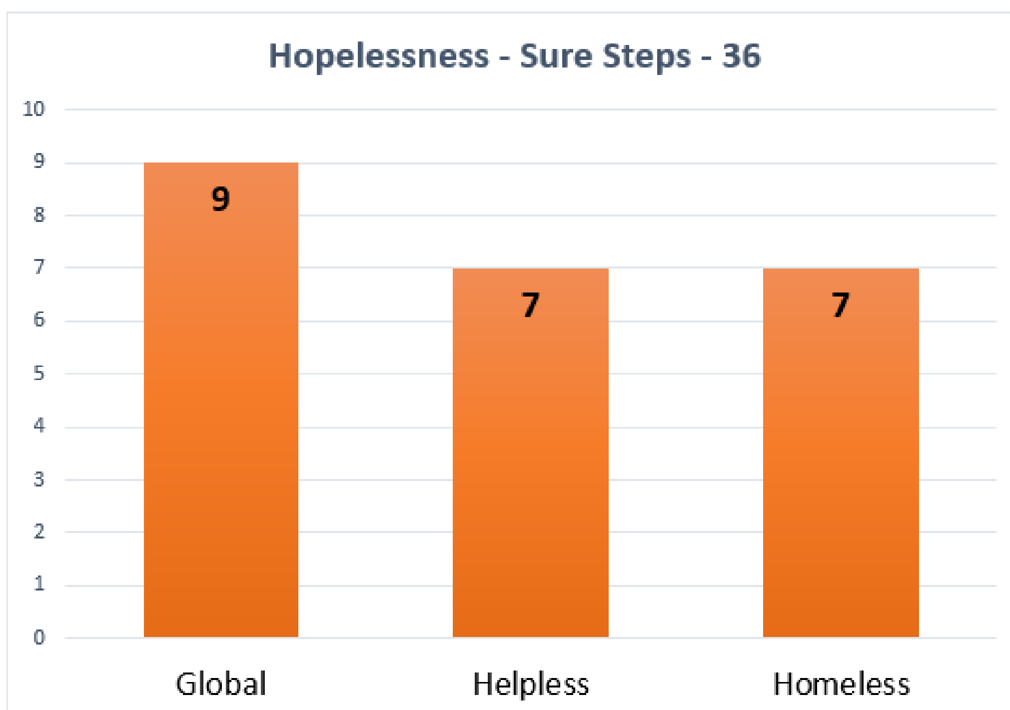


Figure 2.2.31 Self-Hate - North Dublin SATS - 167

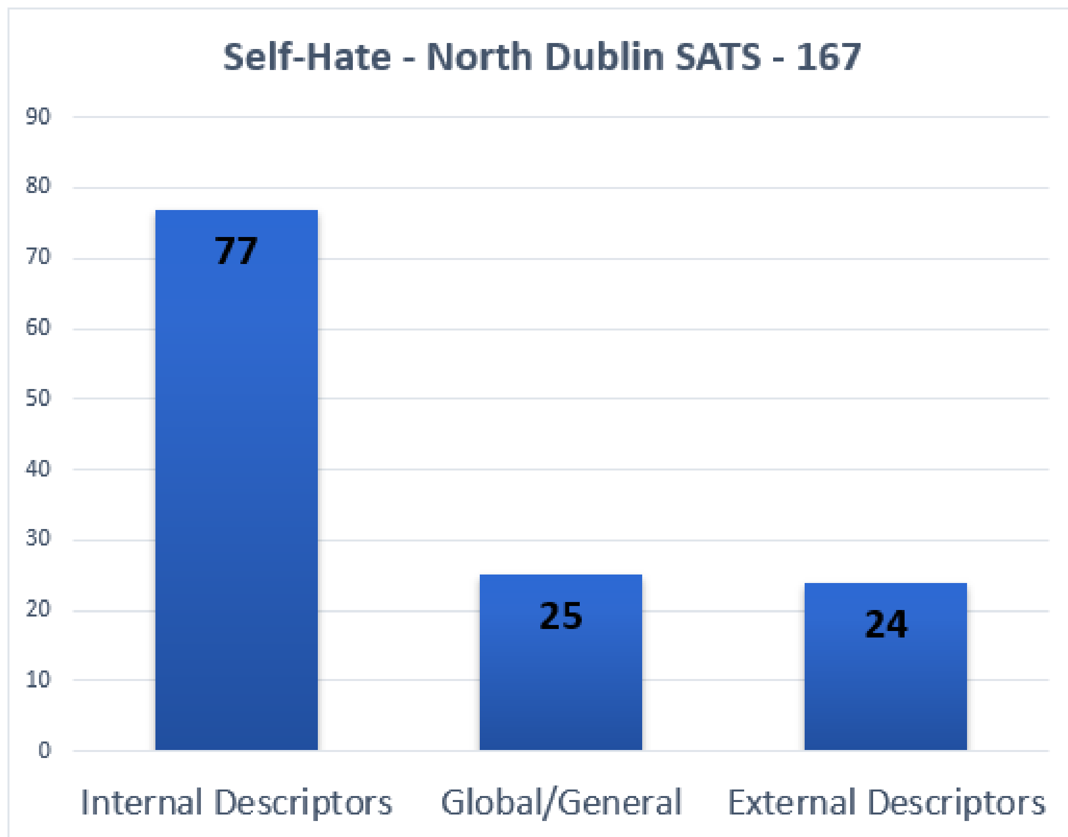


Figure 2.2.32 Self-Hate - Sure Steps - 31

Part Three: Qualitative Research Project

An Exploration into Counsellors' Experiences of Using the Collaborative Assessment and Management of Suicidality Approach in the Homeless Sector

3.1 Research Aim

The aim of this qualitative research study was to explore counsellors' experiences of using the Collaborative Assessment and Management of Suicidality (CAMS) approach and the Suicide Specific Treatment Track (SSTT) in the homeless sector. The specific objectives of the research were to explore the beneficial aspects and limitations of the training the counsellors have received for CAMS and the SSTT, and to explore the advantages and barriers of using CAMS and the SSTT in the homeless sector.

3.2 Methodology

There were 6 counsellors who took part in this research. The interviews were in-depth and semi-structured. All interviews were transcribed verbatim and thematic analysis was conducted on the data (Braun & Clarke, 2006). Informed consent was sought from each participant and full ethical approval was gained from Dublin City University and the Dublin Simon Community.

3.3 Results

Seven main themes emerged through the analysis of the interviews with the counsellors which include:

"Seeing it live in action" - The lasting impact of in-person training on counsellor practice

The in-person training the counsellors received for CAMS had a significant lasting impact on counsellors' practice both in providing the theoretical and practical element of using CAMS and also on the way in which the counsellors subsequently engaged with their practice and interacted with their clients. The roleplay during the in-person training resonated with all of the counsellors. They noted it to be the most critical aspect during training which facilitated the transition of CAMS from a theoretical approach to how it could be practically applied.

"I don't see it now as a barrier" - Approaching the CAMS paperwork

Many of the counsellors admitted that they had initially resisted the paperwork associated with CAMS, viewing it as a barrier to the psychotherapeutic process. The SSTT was subsequently developed which enabled counsellors to implement CAMS without the SSF. The SSTT was noted to be useful in crisis situations or when working over the telephone.

"... now I feel more confident" - CAMS and the SSTT as a psychological resource for the counsellors

Supporting a client who is suicidal can be a traumatic experience, evoking feelings of distress. It became clear that CAMS and the SSTT provides the counsellors with confidence in assessing suicidal risk, for structuring sessions and using the forms as reassurance, to reaffirm their practice in the event that a client did commit suicide. The counsellors came to view the paperwork as a source of reassurance particularly if a client committed suicide as it reaffirmed the counsellor's practice.

"They want to know they can trust you" - Building a trusting relationship

Trust was a theme which emerged both as a major issue for the clients and an essential element in building a strong therapeutic relationship for meaningful work between the counsellor and the client. Given the isolation of the homeless clients, taking a collaborative approach in addressing their suicidal ideation was seen as a necessity for the counsellors. Furthermore, as CAMS main focus is to work collaboratively and to build a strong therapeutic alliance, it was conveyed that the framework fit very well with the needs of the clients.

"The client is coming in affected and there's that level of mental illness..." - Challenges in implementing CAMS

Due to the chaotic lifestyle of the homeless clients, there are a number of challenges that the counsellors described when using CAMS and the SSTT among this population. As the Sure Steps counselling service is low threshold, many of the clients coming to sessions can be under the influence of drugs or alcohol. Engaging a client who is intoxicated in meaningful therapeutic work did pose a challenge to counsellors. Furthermore, if a client had a dual-diagnosis and did not have access to a psychiatrist, the counsellors found offering the necessary support was difficult. This caused the counsellors to feel limited in their ability in using CAMS to provide the necessary care that they believed the client required.

"Use the tool to enhance who you are, use the tool to make you more proficient" - Flexibility of integrating CAMS into counsellor practice

The counsellors spoke extensively about their ability to integrate CAMS and the SSTT into their own psychotherapeutic approach and utilise their individual areas of competency. When asked what the counsellors would recommend for another clinician using CAMS, one counsellor captured the essence of the theme in their emphasis of how important it is for CAMS to be a tool which is integrated into the counsellor's individual style of practicing.

"For the support, just the comradery support" - The importance of colleague support

One benefit of having CAMS as a standardised tool used by all of the counsellors

was the fact that the counsellors could seek advice from other CAMS trained counsellors. This provided them with insight on how their colleagues were using CAMS. The counsellors also noted that having an out of hours team did alleviate some stress when they went off shift, as they were confident in the knowledge that their clients had someone to call if they needed support. However, the out-of-hours team felt that more support was needed for the service to run optimally. As there are generally more than two people on shift during the day compared to out of hours, where at times it is only one person on shift, there is naturally more support available from other counsellors. Two workers was seen as a minimum in order for a counsellor to feel supported.

3.4 Discussion

From the findings, there were seven main themes which were captured from the research. It was evident that the counsellors had adopted CAMS and the SSTT as part of their general counselling practice when working with suicidal clients. The counsellors conveyed that CAMS and the SSTT was beneficial, as it provided them with confidence when working with suicidal clients. However, the SSTT was used primarily when working with clients over the telephone, as the counsellors preferred using the CAMS paperwork in sessions.

Barriers did exist which posed particular challenges for the counsellors when implementing CAMS, such as clients being under the influence of drugs and alcohol or having a dual diagnosis. Furthermore, recording a role-play which has been adapted to the homeless populations, in addition to the in-person training could provide much more relevant insight for counsellors when beginning CAMS training and could be a resourceful tool when wanting to revisit and revise the training session. The counsellors did note that the SSTT is a beneficial resource in a crisis situation, when the CAMS paperwork is not available to a clinician or when working over the telephone. Gaining the client’s trust and forming a therapeutic alliance should be a priority before introducing the CAMS forms.

Finally, having an out of hours service is important for providing round the clock care for suicidal homeless clients. However, given the importance of colleague support, organisations must ensure there is sufficient support for staff working in the area of suicide prevention.

Working with clients who are suicidal and who are homeless can be a traumatic and challenging experience, therefore gaining insight from counsellors who are using a suicide specific intervention which can be adapted for the needs of this population offers an important contribution to the current literature.

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Appendix: Frequency of qualitative response codes applied to SSF domains by service provider

Dublin Simon - Pain

Total	37
External Descriptor	1
Future	1
Global	6
Homeless	3
Relational	18
Situation Specific	1
Unpleasant internal State	7

Dublin Simon - Stress

Total	36
Not Coded	1
Future	1
Homeless	7
Relational	14
Situation Specific	6
Unpleasant Internal State	4

Dublin Simon - Agitation

Total	35
Compelled to Act	1
Global	3
Helpless	2
Relational	2
Situation Specific	12
Unpleasant internal states	14
Unsure	1

SATS Hopelessness

Total	172
Future	39
General/Global	36
Self	30
Unpleasant Internal States	24
Role/Responsibilities	23
Relational	20
Unsure/Unable to Articulate	0

SATS Self Hate

Total	31
External Descriptor	7
Global	3
Helpless	3
Internal Descriptor	9
Relational	4
Role Responsibilities	2
Self	3

SATS Stress

Total	172
Relational	44
Role/Responsibilities	34
Situation-Specific	28
Self	22
Unpleasant Internal States	22
Global/General	17
Helpless	4
Unsure/Unable to Articulate	0

SATS Agitation

Total	164
Unpleasant Internal States	50
Situation-Specific	36
Relational	31
Global/General	22
Self	10
Helpless	8
Compelled to Act	5
Role/Responsibilities	2
Unsure/Unable to Articulate	0

SATS Hopelessness

Total	172
Future	39
General/Global	36
Self	30
Unpleasant Internal States	24
Role/Responsibilities	23
Relational	20
Unsure/Unable to Articulate	0

SATS Self-Hate

Total	167
Internal Descriptors	77
Global/General	25
External Descriptors	24
Relational	21
Helpless	13
Unsure/Unable to Articulate	5
Role/Responsibilities	2

Dublin Simon - Hopelessness

Total	36
Not Coded	1
Future	4
Global	9
Helpless	7
Homeless	7
Relational	4
Self	1
Situation Specific	2
Unpleasant	1

Dublin Simon - Self Hate

Total	31
External Descriptor	7
Global	3
Helpless	3
Internal Descriptor	9
Relational	4
Role Responsibilities	2
Self	3

SATS Pain

Total	172
Unpleasant Internal States	63
Relational	59
Global/General	23
Self	18
Helpless	4
Role/Responsibilities	2
Unsure/Unable to Articulate	2

Seirbhís Sláinte
Níos Fearr
á Forbairt

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