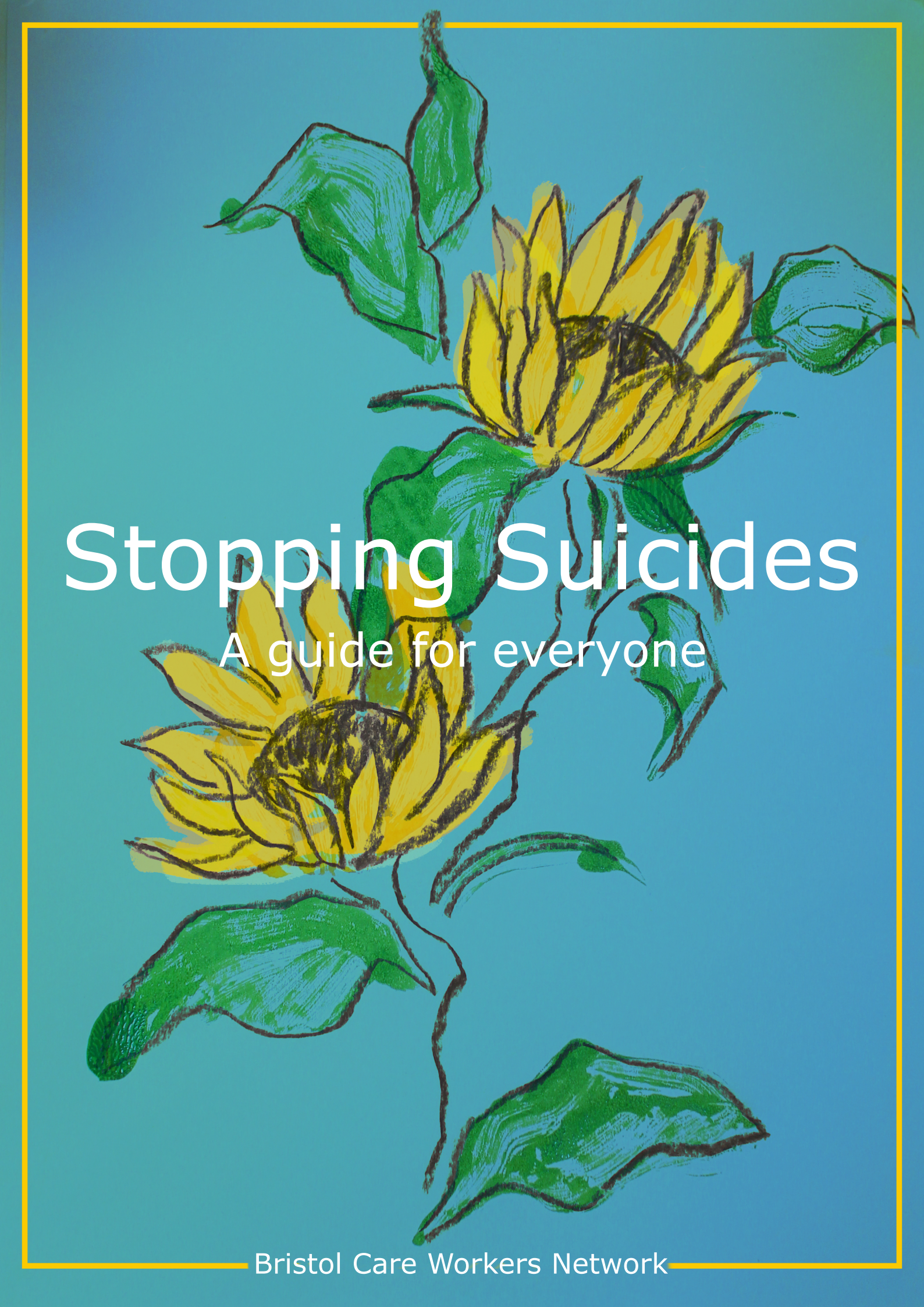

Stopping Suicides

A guide for everyone

Bristol Care Workers Network

In an emergency

If someone is hurt, or is about to hurt themselves, **call 999**

If you are worried about someone,
call Bristol Mental Health Line on **0300 555 0334**

If you are thinking about hurting yourself,
call the Samaritans on **116 123**

If you are having suicidal thoughts, or you are talking to someone who is having suicidal thoughts, then **read these points first**.

You can read the rest of the pamphlet later.

1) If you are feeling suicidal right now, then contact someone you trust. **Try not to be alone**. Try not to think about the future. Try not to use drugs and alcohol. Try to do something you usually enjoy. You do not need to fix your problems now if they seem overwhelming, just keep yourself safe. You can fix things later.

2) If you are talking to someone else about their suicidal feelings, **be sensitive** but also **be clear**. Use the word 'suicide'; do not use euphemisms. If you're worried about someone, then be honest with them and ask directly if they are feeling suicidal.

3) Anyone can be affected by suicide but some people are at **higher risk** than others. A history or a family history of deliberate self harm or suicide, and bereavement (especially bereavement by suicide), all increase a person's risk of suicide. People from marginalised groups, including people who are poor or unemployed, are at a higher risk of suicide.

4) Not everyone who is feeling suicidal wants to die.
Lots of people who seem to want to die actually feel **ambivalent** about death; part of them wants to die and part of them wants to live. If you are talking to someone who is feeling suicidal, try and find out what is making them ambivalent, and talk about their ambivalence.

5) If you are talking to someone who has planned how to end their life, try to **break up their plan**. If they are planning to attempt suicide at a particular time, offer to **be with them** at that time so they do not attempt suicide.

If they are planning to attempt suicide using a particular means, try to **remove their access** to these means, for example by offering to take away medication, weapons, nooses or car keys.

6) If you are regularly caring for someone who is feeling suicidal, try to **share the care out** with other trusted people. Ideally you want a caring 'team' who all work together to support the suicidal person.

7) If you are caring for someone who is feeling suicidal, try to **care for yourself** too. Make time to do things you enjoy and make sure you have someone who you can talk to about what is happening.

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Introduction

This pamphlet is for anyone who wants to know more about how to **prevent suicide**. This pamphlet is mostly aimed at friends, family and carers, who are supporting people experiencing suicidality.

However, this pamphlet will also be useful to people who are experiencing suicidality themselves.

This pamphlet will help you to spot people who might be **at risk** of suicide. This pamphlet will give you the skills to **talk** about suicide and, if you want to, to **help** the people you care about to stay safe.

Bristol Care Workers Network 2019
www.bristolcareworkersnetwork.org

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Language

“Suicidality”

Suicidality means suicidal **thoughts**, suicidal **behaviours** and para-suicidal behaviour. Suicidality is a broad spectrum, from fleeting suicidal thoughts to deliberate and planned suicidal acts.

Most people probably experience suicidality at some point in their lives without ever acting on their suicidal thoughts. However, suicidal thoughts that are not dealt with may escalate into suicidal behaviours, so it is important that all suicidality is taken seriously.

“Para-suicide”

Para-suicide means deliberate **self-harming behaviours** where the person doesn’t actually want to die. Making shallow cuts and taking non-lethal overdoses might be examples of para-suicidal behaviours.

Para-suicidal behaviours are sometimes called ‘cries for help’, but this is not always a helpful way of thinking about para-suicide, and people can have many different reasons for para-suicidal behaviours. If para-suicidal behaviours are not addressed then they can escalate into suicidal behaviours, and some para-suicidal behaviours are very dangerous and might lead to an accidental death or injury, so it is important to take para-suicidality seriously.

“Health workers”

In this pamphlet, we have used the term health worker to mean healthcare professionals, support staff, volunteers, and anyone else who **cares for others** on behalf of an agency which is **recognised by the State**.

This could include mental health workers but also social workers, teachers, support workers, care assistants, paramedics, hospital staff, volunteers, and maybe even the police in some circumstances.

“Carer”

When we say ‘carer’, we mean **anyone** who is **supporting** another person who is experiencing suicidality. A carer can be a friend, a partner or a relative of the person experiencing suicidality.

The State defines these carers as **‘informal’** carers, to distinguish them from care workers or other paid staff or volunteers. There are no clear rules about what counts as ‘caring’ and what doesn’t; lots of the things that carers do are things that they would be doing anyway as friends, partners or family of the person experiencing suicidality.

Caring doesn’t have to be dramatic or a **big deal**; taking someone to an appointment, letting them stay at your house when they are feeling low, or just talking to them about their feelings, can all be caring, so if you are a friend or relative of a person who is experiencing suicidality, then you are probably also a carer. Some people do not like the term carer, and the carer or the cared-for person might feel stigmatised or devalued by that term. You don’t have to use the word ‘carer’ if you don’t want to.

“ ‘Commit’ suicide?”

‘Committing’ suicide is a common phrase. The use of the word ‘commit’ goes back to the time when suicide was illegal. We think that using the word ‘commit’ in relation to suicide is **unhelpful**, and reinforces the bogus idea that suicide is sinful, criminal or taboo.

In this pamphlet, when we talk about suicidal behaviours that result in death, we use the word **‘suicided’** or the phrase **‘completed suicide’** rather than ‘committed suicide’. We would encourage people to use the same language. However, the most important thing is that that people **feel comfortable** talking about suicide, so it’s OK to use whatever language is most comfortable to you and the person you are talking to.

Talking about Suicidality

Suicidality is difficult to talk about, and starting a conversation about suicide can seem frightening and uncomfortable for both the carer and the person they are caring for. In this section we will give some tips on how to have these conversations.

Clarity

Do not use euphemisms. Suicide is obviously a difficult thing to talk about and it needs to be discussed sensitively, but it is also literally a life and death issue and you need to be **clear** and **specific**.

Use the word **'suicide'** as much as possible.

Euphemisms like 'ending it all' are unhelpfully vague. Saying things like "topping yourself" belittle the person's feelings, and phrases like "doing something stupid" enforce suicide stigma.
Using euphemisms also enforces social taboos around suicide.

Be **confident**, and use direct and clear language. At the end of the day, if you don't seem comfortable talking about suicide, why would anyone want to talk to you about it?

Some people think that talking about suicide can put ideas in people's heads and make them think about suicide when they would not have done before. There is no evidence to back this view up, and clear evidence showing that **talking openly** and frankly about suicide **reduces the risks** and encourages people to seek help.

Don't be uncomfortable with suicide. Say the word suicide repeatedly until it stops sounding scary and becomes as **normal** as talking about eczema or the flu. If you are a carer, try to show the person at risk that you are happy and **comfortable** talking about suicidality.

If you have the wrong end of the stick and the person you are talking to is not experiencing suicidality, then you can all have a good laugh about it and there is no harm done, and even if a person is not having suicidal thoughts, then asking them about suicide still shows that you care.

Honesty

Be honest with people. If someone tells you they are experiencing suicidality and you want to find out whether they really want to die, it's OK to **ask them directly**. Questions like "do you think you would ever go through with it?" are important. There is no need to beat around the bush, and the person at risk will become resentful if they feel you are being disingenuous or trying to manipulate them.

Be honest about **your own feelings** too; say things like "when you talked about not having any hope and wanting to disappear, that made me really worried about you". Recognising your own feelings will help level the playing field between the carer and the cared-for person, and help build a connection between the two which will make future conversations easier.

Validation

Validation means **acknowledging people's feelings** as valid, appropriate and important. If you are caring for a person who tells you about a very negative experience, you should validate the feelings they express as a result of this.

For example, if someone says "I've felt really low since my friend died", you should respond with something like "that must have been really hard for you".
Responding like this makes people feel OK with their feelings and helps them see that you **understand** and are **listening**.

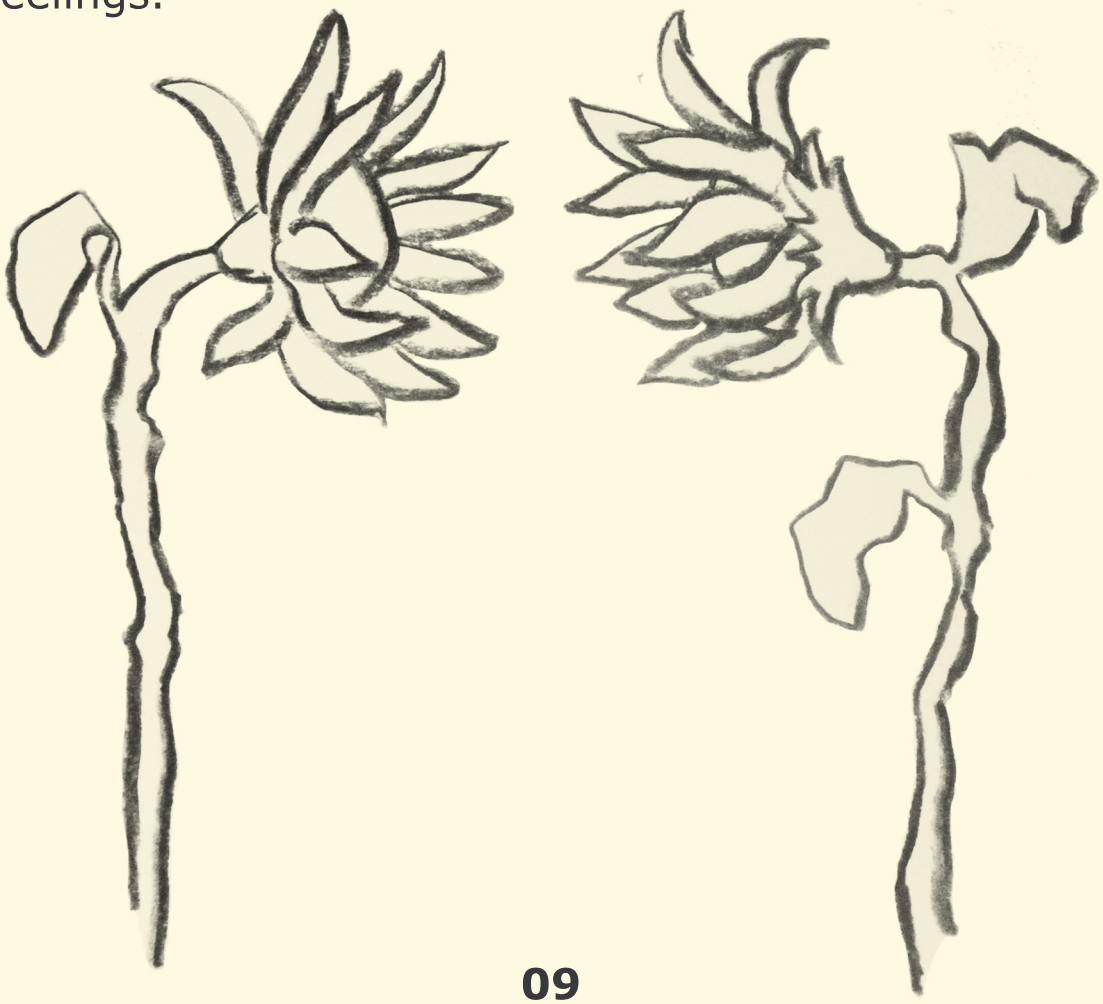
Don’t force it

If you are caring for someone, even if you think you know all the answers to their problems, you should **avoid** being directive or **telling them what to do**. You can’t fix people, and you might hurt them by trying to. The idea is to ask the right questions to lead the person you’re caring for to come up with their own solutions.

If you find that you are doing most of the talking and they are passively agreeing then you are doing it wrong. Shut up for a second and think about what to say to **get them talking**.

Avoid leading the conversation; you might think a person’s partner is a protective factor but statements like “how would your partner feel if you suicided?” are unhelpful. A better question to ask might be “how are things with your partner?”

Don’t get into arguments. If they feel like they have to defend their suicidality to you then you will end up strengthening their suicidal feelings.



Risk

All suicidality should be treated seriously. However, some people are more **likely** to experience suicidality than others, and some people will experience suicidality more **severely** or more **dangerously** than others. This is what we mean when we use the word 'risk'.

This section covers some of the ways to identify **who** is at risk and **how high** the risk is.

You can never guarantee that a person does not have genuine intent, and, again, any expression of suicidality should be taken seriously. But the points above may give an indication of what the person you are caring for is thinking and this may give you a better idea of what they need.

Suicidality and 'Genuine Intent'.

Genuine intent simply means a **wanting to die**. As we said, not everyone who is experiencing suicidality wants to die and it is important to know the difference between para-suicidality and suicidality with genuine intent.

If you have a good relationship with the person and you can do so without being judgemental, then you can **ask** them this question **directly**. It is OK to say to someone "do you want to die?" and in fact, asking this question in such a direct way may help to clear the air and de-stigmatise the issue for the person.

As stated above, most people who have suicidality will feel **ambivalent** about suicide; they will not be certain whether they want to live or die and they will probably feel torn between the two, or part of them will want to die while another part of them will want to live. It's really important to talk about this ambivalence.
See **'keeping someone safe'** below.

Sometimes you may not be able to ask this question directly and you will need to take a **subtler approach** to see if the person has genuine intent; some things to think about might be:

- How many **risk factors** does the person have?
(see the section on risk factors, below)

- Have they had **previous** suicide attempts?
If so, what means did they use? How likely to be lethal were these?

- Did they take steps to make themselves **safe** during previous suicidal actions? (for example making sure there were others nearby or notifying/warning people before the attempt)

Or did they take steps to make it **less likely** that anyone would help them? (e.g. isolating themselves, locking the door, telling others they were out of town so they wouldn't be looked for etc).

- Have their suicidal acts been **impulsive**, or planned?

- Have they been **open** about their feelings?
Have they reached out and asked for help?

- How do they **feel** about their **previous** suicidal acts?
Do they feel embarrassed, ashamed, or wish they hadn't acted suicidally, or do they regret not doing more, and wish their attempts had been successful?

- Have they made any **preparations** for suicide?
(e.g. deliberately stockpiling medication or putting lots of effort into getting the means, writing a note etc).

Risk factors

Anyone can be at risk of suicide, but evidence shows that some people are at **higher risk** than others, depending on social and demographic factors, behaviours, and life experiences.
These are called risk factors.

Some risk factors to look out for are:

- People with a diagnosed **mental illness** are at a higher risk of suicide than the general population.

- People who have been **bereaved** by suicide, with a **family history** of suicide, or who have been **caring** for or supporting a person who has completed suicide, are at an increased risk of suicide compared to the general population.

  This risk is especially high in the first four years after bereavement by suicide, and if the cared-for person was the carer's parent.

- People who are **isolated** or lonely are at an increased risk of suicide.

- People who use **drugs** (including alcohol and prescription medication) heavily or erratically, are at an increased risk of suicide.

- People who **self-harm** or have a history of self-harm are at an increased risk of suicide.

- People with a long-term, **life-limiting illnesses**, people who experience **chronic pain**, and especially people with a **terminal illness**, are at increased risk of suicide.

  The risk is highest shortly after diagnosis.

• People who have experienced a lot of **violence** are at an increased risk of suicide compared with the general population.

This includes people who have **witnessed** or **perpetrated** violence to others as well as people who have **survived** violence; soldiers, for example, are at an increased risk of suicide compared with the general population.

• People who have recently experienced **loss** are at increased risk of suicide. This can include things like relationship breakdowns or the loss of things that were important to the person such as a skill or a job, not just a bereavement or a death.

• People who are on **low incomes**, unemployed, in precarious work or struggling with debt, are at an increased risk of suicide.

Workers in some industries are at an increased risk of suicide compared to the general population. This includes **healthcare** and **social care** workers (including in the veterinary industry), and **emergency services** workers.

Workers in jobs that are considered **'unskilled'** or jobs that have low social status are at an increased risk compared to the general population.

Workers whose jobs give them **easy access** to means (like guns, stockpiles of medication, or harmful chemicals) are at an increased risk of suicide compared to the general population.

• There are several studies which link suicide to **age**, but this is complicated. Suicide is the one of the biggest killers of people under the age of 35, however suicides are actually more common in middle-aged people than younger people.

• **Men** are at an increased risk of suicide compared to the general population, but the links between gender and suicide are **complicated**.

Even though men complete suicide more frequently than women, women actually experience suicidality, including para-suicidality and 'suicide attempts', more frequently than men. Men and women tend to undertake suicidal behaviours using different means, and men who behave suicidally tend to use more violent and more lethal means, which partially explains this.

Trans and **gender non-conforming** people are believed to be at a significantly higher risk of suicide compared to the general population, especially trans people under the age of 25, but this is an under-researched area.

• **Queer** and **LGBT+** people are at a higher risk of suicide compared to the general population, especially queer and LGBT+ people under the age of 25.

• **Disabled** people are at a higher risk of suicide compared to the general population.

Remember that disability is not the same as illness. Many disabled people have chronic illnesses but all disabled people experience stigma, oppression and **discrimination** as well as the effects of their impairments.

• There is some evidence to suggest that **people of colour** and people from **ethnic minority** backgrounds are at an increased risk of suicide compared with the general population, but this is an under-researched area and the evidence for this is not conclusive.

- People who have experienced **migration** are at an increased risk of suicide compared with the general population.

Suicide rates vary significantly between countries but there is a lack of evidence as to whether people born outside the UK from a country with a higher suicide rate remain at a higher risk after moving to the UK.

All of these factors are **linked**.

For example, a person may become socially isolated if they work unsociable hours. A person who has migrated to the UK from a conflict zone is more likely to have experienced violence.

Risk factors can be either **static** (e.g. life-long) or **dynamic** (something that happens or fluctuates throughout a person's life).

These risk factors alone are **not enough** to predict whether a person will develop suicidal behaviours.
Lots of people have one or several of these factors without ever being at risk of suicide. Not every queer, migrant, low-income worker is necessarily at risk of suicide.

However, people who have **one or more** risk factors may always be prone to poor mental health and this can include suicidality.

The people at the **highest** risk are people with **both** static and dynamic risk factors.

If you care for someone who has one or more static risk factors, and who then suddenly **acquires** a dynamic risk factor (e.g. through losing a job, experiencing a trauma, being diagnosed with a chronic illness etc.), you should think seriously about **talking** to them about suicidality.

History

If someone seems to be suicidal and you want to know how risky they are, try and find out the **history** of their suicidality, and how this fits in with the rest of their life story.

Some useful things to know would be:

- Have they experienced any recent **life events**, that may have caused them to become suicidal?
- Have they experienced suicidality or para-suicidality **before**? Were these just thoughts, or did this escalate into suicidal behaviours? What did they do? Is there a pattern?
- What **led** to their previous suicidality? What else was going on in their life at the time?
- What **stopped** their suicidality? Are there any times in their life when they did not experience suicidality? What else was happening in their life at this time?
- When they experienced suicidality before, what **support** did they get? What worked well for them, and what did not work well?
- Have they **lost** any protective factors recently? (see below)

Protective factors

Protective factors are the **things** in people's lives that mitigate, reduce or prevent suicidality and help **keep them safe**.

A protective factor could be any positive thing in someone's life; anything they take **pleasure** from, that helps them **manage** their mood or symptoms, or that gives them a sense of **pride** and self-esteem.

This could be a hobby/interest, a project which gives them a sense of achievement, a significant relationship, or something else.

For example, a person who is experiencing suicidality might say something like "part of me really wants to die but part of me really wants to spend more time with my best friend, and I know if I die I won't be able to do this".

It is important to find out what these things are and, if possible, get the person **talking about them**.

If you are planning how to care for a suicidal person, you should **use** and **build on** their protective factors as far as possible.

In the above example, you could ask the person for permission to contact the best friend, and agree with the friend that next time the person is experiencing suicidality then you will take them to their best friend's house.
(More on care and safety planning below).

Again, if you have a close enough relationship with the person you are caring for, you can **ask** them **directly** about their protective factors.

Sometimes being direct and saying "you said that you're having thoughts of killing yourself. What's stopped you from going through with it?" is a good approach to take.

A softer way of wording this is "What keeps you safe?"

If you do not feel able to ask this question directly, other questions you could ask to try and **find out** about a person's protective factors are:

- When was the last time you **felt OK**? (followed up with-where were you, what were you doing, who were you with etc.)
- What do you do for **fun**?
- What's **going well** for you?
- If you were feeling low, what would you do to **feel better**?
- Who do you **care about** most?
- Who do you **admire** or look up to?

Warning Signs

Even if someone does not say they are feeling suicidal, there are some signs to look out for that might indicate a person's mental health is getting worse.

- Changes in **sleep** pattern (under-sleeping or over-sleeping)
- Changes in **diet** (under-eating or over-eating)
- Self **isolation**
- Escalating **drug**/alcohol/medication use
- Escalating **self-harm**,
- Changes in **behaviour**
- Neglect of **self-care** and personal hygiene
- **Tiredness**/fatigue, poor **concentration**

- Becoming **quieter** or more withdrawn, poor **eye contact**
- Anhedonia (not being able to **enjoy** anything)
- **Unusual** thoughts, beliefs or behaviours

could all be symptoms of worsening mental health.
This could lead to suicidality if not addressed.

Other warning signs that indicate that a person is experiencing suicidality might be:

- Feelings of hopelessness, guilt, worthlessness or of being a burden
- Feeling that life has become very difficult or not worth the effort
- Feeling that things will never get better, being unable to see or imagine the future, and especially if the person says things like "I can't go on" or "I just want this all to end".

Sometimes, if a person says things like this, they are inviting you to help them. Comments like this should always be explored and discussed if possible, and should never be dismissed or brushed off.

For more information, see below.

Sometimes a person who is experiencing suicidality will not feel able to talk about their feelings even when they have genuine intent or they are actually planning a suicidal act.

Non-verbal warning signs that a suicidal act is imminent might be that a person has started **'settling their affairs'** (i.e. paying off debts, giving away possessions, rehoming pets, closing bank accounts, quitting their job, looking at life insurance or funeral plans etc), or has **severed ties** with friends and family.

Keeping someone safe:
The Pathway to Assisting Life (PAL).

The information above should give you an idea of who might be at risk of suicidality, when the risk is highest, and how to start a conversation about suicidality.

The next section of the pamphlet is designed to give you instructions for how to have a **conversation** about suicide that reduces the person's risk and helps them **keep safe**.

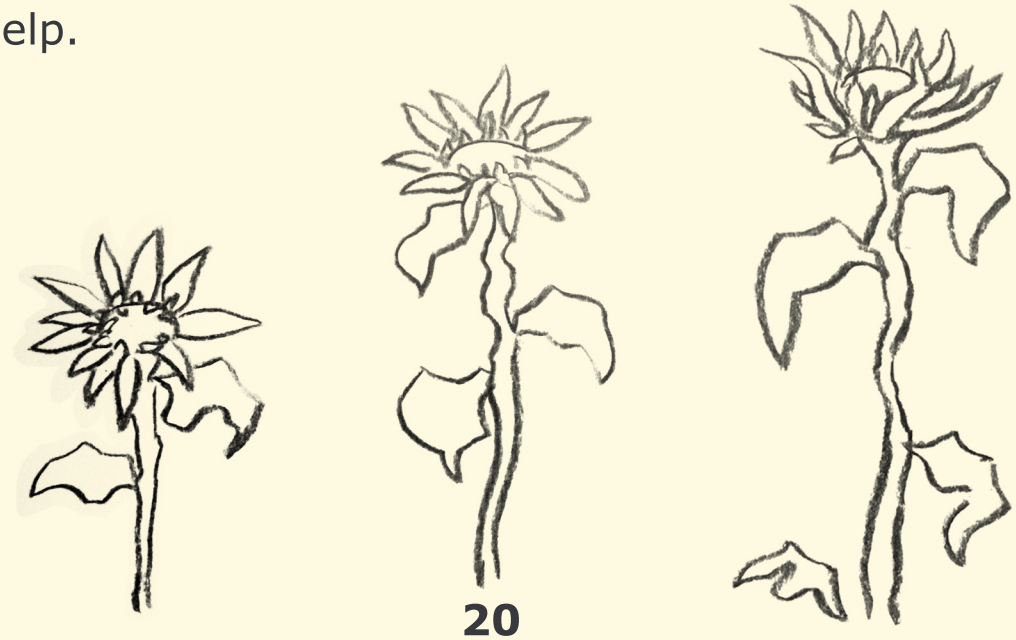
This type of conversation is sometimes called a brief intervention, or suicide first aid. We have based our brief intervention around a specific model called the **Pathway for Assisting Life**, or PAL.

PAL is a model to use when caring for someone who is experiencing suicidality and who is **at risk** of attempting suicide.

It is a semi-structured conversation in **three parts**.

A PAL-style conversation is **not** designed to **solve** all the person's problems and it doesn't need to be therapeutic or a 'cure'.

Instead, a PAL conversation aims to keep the person **safe** in the short term, and point the person in the right direction to get more long term help.



PAL was invented by an organisation called LivingWorks as part of their Applied Suicide Intervention skills (ASIST) training program. LivingWork's aim is to create 'suicide safer communities' by offering ASIST training to a range of different workers; not just health workers but teachers, social services, emergency services workers and so on.

You don't have to be a health worker and you don't need any formal mental health experience to use this model.
The idea is to up-skill the population so that communities can take responsibility for their own mental health.

However, LivingWorks are a for-profit company and are very precious about their copyright. They strongly advise that this model isn't used by people unless they've had the official ASIST training.

For most people, this training isn't an option, and we aim to give you the next best thing by giving you easy-read, **step-by-step** instructions for **using PAL**.

We've tried to make these instructions as simple as possible but this is a lot of information to remember, and in the real world conversations rarely follow a plan, so if you can't do every part of the PAL conversation with someone then **don't worry** too much. Try and see it more as a **guideline** than a set of rules.

If you can, **get together** with a trusted friend or another carer, read this together, and talk about how you could use it.
You could even **role play** this conversation, with one of you playing the role of the carer and the other playing the role of the person who is experiencing suicidality.

If you are caring for someone alongside **other carers**, then try and read through and talk about this together as a team.

A PAL conversation should have **three steps.**

Step 1- **'Connecting with suicide'** and looking for invitations.

The goal of step 1 is to **establish** whether the person you are talking to is experiencing **suicidality**.

As we said, the best way to do this is to **ask** them **directly**.
To get started, read the above sections on risk and talking about suicide. If you are worried about someone then try to sit down and ask them, calmly and assertively, whether they are feeling suicidal.

If you don't feel able to ask straight away, then you should look for **invitations** to ask about suicide.

Invitations are just what they sound like. The person experiencing suicidality **wants to talk** about their feelings, but they, like you, don't feel comfortable bringing it up, so they drop hints to encourage you to ask them about suicide.

Statements that express **hopelessness** and helplessness, like "I can't take it any more", "I give up", "I don't know how to make it better", "I'll never be good enough" could be invitations to ask about suicide.

Invitations might be **subtle**, like "I don't want to be here any more", "I want to go away and never come back", or they might be **explicit**, like "I want to die".

If you get an invitation to talk about suicide then take the invitation; ask the person to **tell you more** about how they're feeling.

If the conversation is leading towards suicide then you need to ask, clearly, whether the person has been thinking about suicide.
Be **sensitive** but also try to be **clear**, and do not use euphemisms.

If someone tells you that they are experiencing suicidality, then it's time to move on to the **next stage** of the conversation.

Before you do, make sure the person knows you heard them, **validate** their feelings, and if possible, check in with the person and get their **permission** to talk more.

Some **useful phrases** are:
"that's a huge thing to have to deal with. Do you want to talk about it?" or "it must have been really hard to say that. Can I ask you about it?", or "It sounds like you're having a difficult time at the moment. You told me you're having suicidal thoughts. Do you mind if I ask a bit more about that?", or something similar.

If they say **no**, then don't panic, let them know you **respect** their right to refuse, and see if you can talk about something else instead.

If you can't complete the whole PAL but you can still reach out, have a chat and make a connection with the person, then you have still done a good thing, and they might come back to you later.

Ending Step 1 - Step 1 ends when the person you are speaking to tells you that they are experiencing suicidality.

After you have clarified this and dispelled any ambiguity, validated the person's feelings, and tried to get consent, then move on to step two of the PAL.

Step 2 - **'Understanding choices'**, engaging with ambivalence, and looking for a turning point.

It is important not to jump straight from talking about suicidality to talking about safety. If the person you are talking to is not ready to be safe, then they are likely to resist this and you might just end up arguing with them.

It can be tempting to jump straight in with **solutions** and to try and 'fix' the problem, but this will **not work**. You need to meet the person where they are and take them with you.
This is the goal of step 2.

Step 2 should be an **open-ended** conversation where you encourage the person to talk about their **feelings,** their **life**, and what has **led** to them feeling the way they are.

In the PAL model, this is called Understanding Choices, and the purpose of the conversation is to understand more the person's life and their situation.

Try not to talk too much, ask **open questions**, and **listen** actively. You can direct this conversation to an extent by asking them about different parts of their life; try and start the conversation with really open questions like "what's been happening recently?" or "how did it get like this?", then later in the conversation you can ask more specific questions like "how's work?" or "have you seen your family recently?", depending on what issues come up.

The **goal** of stage 2 is to find the person's **ambivalence** and engage with it. By ambivalence, we mean the part of the person that **wants to live**, or is having second thoughts about dying. Find the part of them that does not want to die, **validate** that part of them, and try to **steer** the conversation towards it.

Once you have them talking about the things that stop them from wanting to die, you should look for **turning points**.

Turning points are moments where the person begins to turn away from suicidal thoughts and starts to consider the possibility of **wanting to live**.

These can be **obvious**, for example "what was I thinking?" or "I'd never go through with it", but usually they are more **subtle**.

If you cannot find ambivalence and there is no turning point, do not worry. There is **no rush**. Just keep the conversation going, keep asking open questions, and wait.

At the end of the day, the person you're talking to is still alive and is willing to talk to you, so something has **stopped** them from completing suicide up until this point and something is making them give you a chance to help.

You just need to find out what that is.

You can even ask this question; if all else fails, say something like "What's keeping you alive right now?"

Ending step 2 - Step 2 ends when you find a turning point.
A turning point is a verbal cue which tells you that the suicidal person's ambivalence is getting stronger, and they are willing to put dying on hold for the time being.

The different types of **turning points**, and how to respond to them, are:

- A **rejection** of suicide

(e.g. "I don't want to kill myself!" "What was I thinking?")

You can respond to this by validating what they have said and then offering to make a **safety plan** with the person.

Say something like "I'm really glad you've said that. Do you want to think of some ways that we can keep you safe if this happens again?"

- A **hope** for something to happen

(e.g. "I'd be alright if I could sort out my housing",
or "if only I had a way to talk to my partner about this").

Respond to this by validating the feelings, and offering to help the person **work towards** this (in stage 3 we look at safety plans, and these goals should be part of the plan).

Say something like "That must be really important to you. Do you want to talk about how we can do that?"

- **Uncertainty**

(e.g. "I don't know how I feel". "This is all so confusing").

Respond to this by validating the person's feelings and suggesting that, if they are not sure what they want, then they should think about staying **'safe-for-now'** until they are more clear.

Say something like "This is such a huge decision to make, it's understandable that you're not certain how you feel. Maybe If you are not sure whether suicide is the right thing or not, we should talk about a way to stay safe for the time being?"

- At least being willing to **try**.

(e.g. "so if I do want help, what could I do?"
or "I don't know but I've got nothing to lose").

Respond to this by validating the person's feelings and suggesting that you can help them look at their **options**.

Say something like "It's great that you're willing to try. Do you want to look into some options?"

If you have the person's agreement, move on to step three.

Step three - **'Assisting Life'**, assessing the risks and planning for safety.

The goal of Step 3 is to make a **safety plan**.

A safety plan should be a few, **practical steps**, that the carer and the cared-for person can take together, to keep the person **safe** in the **short term**.

As stated, the end goal of the PAL is not to solve all the person's problems. It is about finding short-term solutions to help a person stay safe until the bigger issues in their life can be addressed.

What the plan involves will depend on how **immediate** the **risk** is. In PAL, there are **three levels** of a safety plan. These are:

- **Safety Aids** - for anyone experiencing suicidality.

- **Safety Guards** - for people with more concrete suicidal thoughts, who may have a suicide plan

- **Safety First** - for people who are about to carry out a suicidal act, or who have already started.

Safety Aids

This is for everyone who has expressed **suicidal feelings** and who has gone through the first two steps with you.

This is aimed at short-to-medium term support, and designed to put the person on the **right track** to getting more long-term help.

A safety aids plan should be **led** by the **cared-for person**; the carer's role is to prompt, offer suggestions, and make sure the plan is **clear** and **feasible**.

If the person identified specific **issues** that need addressing, the safety aids plan should address these issues (or at least get the ball rolling.)

If the person identified specific **protective factors** or positives about their life in step 2, these should be part of the safety plan.

If the person has **other carers** or a support network, involve them in the plan. Make sure both of you are clear about the plan and you know who is doing what (and that the cared for person has something to do. The carer should not do all of it!).

If it helps, **write** the plan down, and agree to talk about it again later to see what worked and what still needs to be done.

Safety Guards

This is for people who are willing to talk to you, but are at a more **immediate risk**.

They might have a suicide plan, or have access to dangerous means, or they might have had previous suicide attempts in the past, which have led to significant harm.

Safety Guards are designed to be an **extra level** of protection on top of a safety aids plan. The carer will need to take a more **active** role here in assessing how much danger there is and trying to address it.

At this point it is important to find out how **high** or how **immediate** the risk to the person is. Read the section above on risk for some pointers.
If a person has genuine intent or has several risk factors, then you will probably need to use safety guards as well as safety aids.

If possible, find out:

- Has the person experienced suicidality **before**? Did this result in suicidal or para-suicidal behaviours? What means did they use? What stopped them from completing suicide?

- Have they harmed themselves **recently**? When, and why? How dangerous was this?

- If they are planning a suicidal act, have they decided what **means** they would use? Do they have **access** to these means or have they taken steps to get access to them? (i.e. have they been buying or stockpiling tablets or weapons? Have they made a noose, or practiced making one?)

• If they are planning a suicidal act, have they decided **when** they will do this? How soon is it? Why then?

• Have they made any other **preparations** (like writing a note, paying off their debts, rehoming their pets, contacting or severing contact with loved ones, things like that)?

• If you are not with the person, find out **where** they are and **who** they are with.

If the person is planning to attempt suicide by using a specific **means** then, if possible and if the person consents, you should remove, disable or destroy the means - i.e. by taking away excess medication, dangerous chemicals, ropes or weapons.
(but do not push for this if they or you are not comfortable with it and don't panic if they say no).

If the person is thinking about a suicidal act at a specific **time**, offer to be with them at that time or schedule something for you both to do together so they are not alone.

Safety First

If there is **immediate danger**, if the person is actually harming themself (i.e they have already taken an overdose, or made a noose), or they are about to hurt themself, then you need to use a safety first plan.

If you think they have genuine intent, and they are **not willing** or **not able** to go through the **steps** with you (i.e. if they are very drunk or high, or unconscious, or they have gone missing and won't tell you where they are), then you need to use a safety first plan.

The first step in a safety first plan should be to contact **emergency services** (see 'the police' and 'guide to services' for more info on this).

During this time, the cared-for person should **not be left alone**, and ideally should have more than one carer with them.

Ideally, the carers should have working **mobile phones**, and at least one of them should have a car or access to **transport** (and be sober enough to drive it).

The carers present should also let **other people** know what is happening and where they are, and try and keep in contact fairly regularly with others, to help keep themselves safe.

A safety first plan is **instead** of the safety guards and safety aids. You might need to do a more thorough plan at a later stage, but this is not the time.

The carer will need to **direct** this and, in many situations, it will not be possible to get the cared-for person's consent.

Example of the PAL in action

Charlie is 27 years old and lives in a shared house with three housemates.

Charlie is in an on-and-off relationship with their partner.

Charlie has a part-time job with a cleaning agency.

Charlie is involved in activist groups and goes to regular demos and protests.

Charlie recently moved to Bristol from Brighton, and does not know many people, but they are likeable and have started making friends.

Charlie is still in touch with their friends in Brighton.

They have been estranged from their family since coming out as gay.

They have a sibling who also struggles with their mental health.

Jay and Charlie are part of an animal rights group that meet twice a month. At the group's last demo, Charlie was arrested, and they have a court date next week.

Charlie was originally very enthusiastic about the group but since their arrest they have stopped coming to meetings.

Jay is worried because Charlie has some **static risk factors** (they are LGBT+, they have a low pay, 'low-status' job, and a family history of mental illness).

They also have some **dynamic risk factors** (the imminent court date, the stress of being arrested and the fact they lost a lot of their support network when they left Brighton).

Jay decides to phone Charlie and check they are OK.

Step 1

Charlie is quite guarded at first. Jay is **honest** with Charlie and says that they are worried about them because they haven't been to meetings and they have a court date soon.

Charlie tells Jay that they have been feeling really crap since the arrest, and Charlie says that they **don't know how to carry on**. Jay asks Charlie what they mean by this, and Charlie tries to change the subject, which worries Jay.

Jay decides to ask Charlie **directly** if they have been experiencing suicidality.

Jay says to Charlie: "Charlie, you've got a lot to think about at the moment and I think anyone would be struggling in your situation." (**validating** Charlie's feelings)."You just told me you don't know how to carry on. Are you thinking about suicide?" (exploring an invitation)

Jay asks this **sensitively** but is also **clear**, doesn't use any euphemisms or leave any space for uncertainty.

After hesitating, Charlie says "yeah, I have thought about it to be honest".

Moving on to step 2

Charlie has given Jay an invitation to talk about suicide, so now it is time to move on to step 2. Jay says, "I'm sorry that you're feeling like that" (again, **validating** Charlie's feelings) and then says, "do you want to talk more about it?" (Asking for **permission**).

Step 2

To start step 2, Jay asks an open question in a **relaxed**, informal manner, saying, "I know we've not known each other for very long. How did you end up in Bristol?"

Charlie starts talking about all their friends in Brighton and how much fun they used to have and how much they miss their friends. Charlie has some phone and Facebook contact with Brighton and sometimes goes back for a night out, but has not been back recently.

Jay then asks Charlie how they have found living in Bristol, and Charlie tells them more about what has happened recently.

Charlie is not enjoying their job at all, as they are working very long hours for low pay. Charlie has recently started to get back pain from all the hoovering. Charlie does not get on well with their housemates and feels bullied by them.

Charlie does not know many people in Bristol but they have one friend, Sam, who Charlie and Jay both know from the animal rights group.

Charlie's relationship with their partner is very important to them, but their partner can sometimes be critical of them and they argue a lot.

Charlie has not told their partner how low they have been feeling recently. At this point Charlie says, "I really care about my partner. I wish we could just stop fighting all the time. If only I could tell them how I feel, we might get on better".

Jay thinks that this might be a **turning point**. Jay says, "If you could talk to them, do you think life would be a bit easier?"

Charlie thinks about this and says "maybe" but then pulls back, saying "It's pointless. It won't work". Jay realises that this was not the turning point that they were looking for.

Jay does **not** try to **force** this issue, and instead of trying to move on to step three, Jay **goes back** and carries on with step two.

Jay asks Charlie more about their family and their sister, and Charlie tells Jay how upset they are with their parents and how worried they are about their sister.

Jay tries steering the conversation back to talking about Charlie's friends in Brighton but Charlie is becoming more negative and is struggling to identify any positives.

In the end, Jay says "You've been through so much recently.
You must be a really strong person to have coped with all of this".
Jay then says "I know you said you were feeling suicidal, but something has helped you get through this up until now.
What keeps you going?"

Moving on to Step 3

Charlie thinks about this. Charlie says "I don't know. I don't really want to be dead, I just don't know how to make life OK and dying seems easier right now".

This is an example of **ambivalence**, and could be a **turning point**. To engage with the ambivalence, Jay says "I think sometimes when people are feeling suicidal, they feel like they're being pulled in two different directions. You've obviously got a lot pulling you towards wanting to die. What's pulling you the other way?"

Charlie then tells Jay some positive things; they have been looking at jobs recently, and although their partner can be critical, they also get regular messages from them which cheer them up.

After talking about this, Charlie says "I don't know what to do. I just want to sort all this out". Charlie has not **explicitly** rejected suicide, but they have indicated they are **willing to try**.

This is the **turning point** that Jay wanted.

Jay says "I might be able to help if you want me to".
Charlie agrees, and they move on to step 3.

Step 3

Jay begins on a positive note and suggests a **safety aids** plan.

They agree straight away that Charlie will ring their friends in Brighton and arrange a day trip. Charlie will do this themselves.

Jay is going to speak to their friend Sam and make sure that Charlie has Sam's number so they have someone they can call if they feel really low. Jay is also going to arrange a night out with Sam and Charlie together.

Charlie is going to speak to their partner and arrange a time to talk where Charlie can tell their partner how they feel.

Jay asks about Charlie's work and housing; Charlie will keep looking for jobs but they don't feel able to look for another room to rent by themselves because they don't know Bristol very well. Jay agrees to help them do this.

They agree a **timescale** for all these actions. This is a good safety aids plan, and Charlie says they feel **positive** and optimistic about this plan.

Next, Jay considers whether they need to make a **safety guards** plan on top of the safety aids plan.

To find out, Jay asks Charlie a few questions about **risk**.

Charlie has a diagnosis of depression but has been well for the last few years up until now. Charlie previously had counselling, and they found this helpful. Jay knows the local counselling agency takes self-referrals and offers to help Charlie refer themselves for more counselling.

Charlie has had suicidal thoughts before but has never acted on them.

Charlie hasn't got a clear suicide plan but they have thought about taking a medication overdose. Charlie has not been stockpiling medication but they do have a supply of codeine left over from a recent operation and they have been thinking about taking all of the codeine.

Charlie does not have a specific date and time planned but they said they had thought about taking the codeine on the morning of their court date, which is next month.

Jay asks Charlie where they are and Charlie says they are at home. They say they are feeling OK at the moment but their housemates will be back soon and they are worried that this will make them feel worse.

Based on this information, Jay thinks that Charlie is quite risky. They are experiencing suicidality and they have begun to make a suicide plan, although at the moment Charlie has not started to act on their plan. Because of this, Jay thinks a safety guards plan would be helpful.

There is no **imminent danger** (Charlie hasn't taken any tablets yet, is at home, is conscious, and agreeing to help), so there is no need for a safety first plan.

Jay takes the **lead** here and suggests some **safety guards** on top of the safety aids.

Jay suggests that Jay, Sam, Charlie's partner and some other friends from the animal rights group can all go to Charlie's house in the morning of the court date and go with Charlie to court. So they are not alone.

Charlie agrees to this and Jay offers to arrange it.

Jay also suggests that Charlie goes back to Brighton for the weekend before their court date, which Charlie agrees to.

Jay offers to take away Charlie's codeine stash. Charlie refuses this but does tell Jay that they are feeling better and not planning on taking the codeine any time soon.

Jay is conscious that they are trying to keep Charlie safe-for-now, not safe-for-ever, and decides not to force the issue about the medication.

Jay also writes down some useful phone numbers.

Jay offers to **meet** Charlie next week for a coffee so they can **go over** the plan together.

So the plan looks like this:

What will we do?	Who will do it?	When?
Ringing friends in Brighton and going for a day trip (safety aid)	Charlie	Now!
Speak to Sam, tell them what's going on, make sure Charlie's got their number and make sure Sam is happy to be called (safety aid)	Jay	Tonight
Go for a night out together (safety aid)	Charlie, Sam, Jay. Jay to arrange.	Jay to arrange tonight, go out next weekend.
Speak to Charlie's partner about how Charlie feels (safety aid)	Charlie	Tuesday night after work
Look for jobs (safety aid)	Charlie	Wednesday on Charlie's day off
Look for a room to rent (safety aid)	Charlie and Jay	Saturday
Referring to a counselling agency (safety aid)	Charlie and Jay	Saturday
Going to court to support Charlie (safety guard)	Jay, Sam, Charlie's partner, other friends	The court date; Jay to arrange this week.
Meet up for coffee.	Charlie and Jay	Next week

Useful Numbers:		
• Samaritans • Bristol mental health line • Charlie's GP • Brighton friends • Jay • Sam • Charlie's partner		

After recapping the plan and **checking** Charlie is happy with it, Jay ends the conversation.

Before doing anything else, Jay does some **self care** by running a relaxing bath, listening to music, and phoning a friend to talk about the conversation with Charlie.

This is the end of the section on PAL.

We've tried to make this as simple as possible but this is still a lot of information to take onboard.

We recommend you **stop reading** now and go and do something else for a few hours, to give this information time to sink in.

PAL quick reference sheet

Step 1 - Connecting with suicide and looking for invitations

Is someone at **risk** of suicide?

Can you ask them **directly**?

Are they **inviting** you to ask them about suicide?
Listen out for things like "I can't go on", "I don't want to be here", "It's all pointless".

Once you get an invitation, **ask clearly** whether the person is talking about suicide.

If they say yes, **validate** their feelings, then move on to step two.

Step 2 - Look for ambivalence

Ask **open questions** and let the suicidal person do most of the talking

Try and find out as much as you can about their **life**, their **problems**, and what led them to be suicidal.

Try and find out what is making them **ambivalent** about dying, or what has stopped them from attempting suicide up until now.

Once you've found something, **steer** the conversation in this direction.

Look for **turning points**; signs that the person no longer wants to die, is willing to make changes, or is at least willing to put off suicide and give living a chance.

Step 3 - Safety Plans

Are they trying to die? Are they at immediate risk?

Take steps to keep them, you, and others **safe**.

Think about calling **999** or another service.

You may have to **take charge** of the situation and act without the person's consent or knowledge.

Have **two** or more carers if possible.

Have a working **mobile phone**.

Let someone know **where you are** and what you are doing.

Do they want to die? Have they got a suicide plan?

Ask if you can disable the plan by **removing** dangerous items (e.g. medication stockpiles, ropes, car keys, weapons)

If they're planning a **time** to attempt suicide then offer to be with them at that time to keep them safe.

You will need to be assertive but you should try and ask their consent to do this.

Do they want to live? Do they want your help?

Think of a plan **together** that addresses some of their problems and builds on the things that are keeping them safe.

You should be collaborative and supportive; help them come up with a plan, don't do it for them.

Self Care

Carers need to look after themselves.

Carers who support someone who completes suicide are at a significantly **increased risk** of suicide themselves.

Some studies show this increased risk lasts for four years after the suicide, but there is lots of evidence to show that losing a loved one to suicide can put you at an increased risk of suicidality for your whole life.

If you are caring for someone who is experiencing suicidality, you will often have to make **difficult** judgement calls in very highly emotional situations. To do this, you need to be **reflective** and **aware** of your own thoughts, feelings and values.

Talking about feelings (either with other carers or health workers), or writing a **diary**, are both good ways of doing this.

The single best thing you can do is **share** the caring role with others. Stopping suicides should be a **community** effort, and the cared-for person should feel like they have a lot of different people they can turn to for support.

Carers should also be talking to each other, with the consent of the cared-for person, to share **concerns**, divide up **tasks** and **support** each other.

By working together with the cared-for person, you can build up a care network or a '**care team**' of trusted people who share out the caring role between them and support each other to care.

You may be caring for someone who is experiencing suicidality and who does not want **anyone else** involved in their care.

This should be a **negotiation**; it is important that the cared-for person has some control over who is involved in their care, but you should be **realistic** with the cared-for person about your own **limits**, and how much risk and responsibility you are prepared to hold on your own before you need to get others to help.

Even if the cared-for person does not want other people involved, you should try and **share** your feelings as much as possible.

Talk to your own **friends** and your own support network, or talk to a **health worker** if you need to speak to someone confidentially.

You can self-refer for **talking therapies**, your **GP** can prescribe medication and write fit notes if you need time off work, or if you need to talk to someone out of hours, think about using the **Samaritans** line.

Some general tips for self care are:

- Make **time** for yourself. Make a list of easy, achievable and fun things you can do to cheer yourself up, and try to do one a day.
- Keep a **diary** of your thoughts and feelings. You can use this to 'scale' your mood (write a number between one and ten, with one being the worst you've ever felt and ten being the best you've ever felt). Do this every day, and compare over time.
- Don't spend too much time **alone**
- **Talk** about what's going on
- Try and **eat** regularly

- Try and get regular **sleep**
- It is OK to **distract** yourself. You do not have to feel everything all the time.
- Be careful with **drugs** (including alcohol, caffeine and prescribed medication). Be aware if you are using more than you would normally, using alone, using erratically or dangerously.
  If you use medication for your mental health, try to use as it's prescribed and talk to a health worker if you want to make changes to your medication.
- **Exercise**.
- Do not beat yourself up if you cannot do any of these things. Care for yourself for **yourself**, not for anyone else.

Ultimately, preventing suicide is a **collaborative** process between the carer and the cared-for person.

If the cared-for person will not talk to you, won't be honest with you, or doesn't want to be cared for, the amount of support you can give will be limited.

Even if a person wants help, sometimes what they need will be **too much** for any carer to give them.

Do not feel guilty for trying and failing to help someone when the majority of people out there wouldn't even try.

Suicidality, Control and Abuse

In some circumstances, people will threaten suicide or self harm as a way of **manipulating** and **controlling** others.

This sometimes happens in **abusive relationships**, where the abused partner tries to leave the relationship or stand up for themselves, and the abuser threatens self harm or suicide as a way of making them stay.

There is no easy way of telling whether a person is talking about suicide because they genuinely experience suicidality or because they want to assert control over a situation.

Sometimes the person themselves will not know, and sometimes there will be elements of both. Reading the information above on **risk** might shed some light onto how likely the person is to attempt suicide.

As in any caring role, it is really important to be aware and reflective of your **own feelings** in this situation.

For example, if you are in an abusive relationship with the person you are trying to care for then you may feel angry with them or frightened of them.

If you are angry or frightened by the person you are caring for, does this make the **risk** seem more or less **real**?

Are you the **best person** to care for someone if they make you feel scared, or weak, or helpless, or angry?

Are they more likely to **hurt you** or hurt someone you care about than to hurt themselves?

Do they **only** talk about suicide when you try to stand up to them, or do they have other suicidal feelings that aren't linked to what you do?

Do their suicidal feelings effect any **other** aspect of their lives (i.e. their work, hobbies, or other relationships), or are they only suicidal when around you?

Suicide and domestic abuse are both incredibly difficult and complex issues. When suicide and domestic abuse intersect, the people affected will be faced by a myriad of different seemingly impossible dilemmas.

If you are in either situation, it is vital that you **share** your feelings with someone who is **removed** from the situation.

Think about calling an **advice line** and talking to a **health worker** or **volunteer**.

Ultimately, you should never let someone else make you **responsible** for their life.

As we said, Suicide prevention needs to be **collaborative**.

If you are caring for someone who says things like "I'll kill myself unless you..." or "I'll kill myself if you...", you are unlikely to be able to help them, and you are likely to hurt yourself by trying.

It's OK to say when you **can't do any more**, and it's OK to protect yourself with the same determination that you would protect a loved one.

For Health Workers

If you are likely to be in contact with people that experience suicidality as part of your job, then your employer should **train** you to work with them.

This pamphlet is **not a substitute** for proper training.

If you work with someone who has one or some of the above risk factors, make sure you **ask** them about suicidality.

Make sure you **document** that you have asked this question and **how** they answered.

Clearly document any **risk factors** that you notice and document any **steps** that you undertook to keep the person safe, and what your **reason** for taking these steps was.

Do not make decisions about risky people by yourself. The burden of these decisions should be **shared**.

If you are worried about someone, tell your **line manager**, document what they said and document what their advice was.

Tell your **colleagues** too and make sure you get space to **talk** and reflect on your decision-making.

You should have regular, protected, paid time for **supervision** where you can talk about people who you work with.

Make sure you are getting your **supervision entitlement** and that these supervision sessions are documented.

Always **document** your own supervision sessions and make sure you keep copies; do not trust management to do it.

Remember that the **higher** your workload, the more **dangerous** your job is.

High caseloads (for community teams) or increased pressure for beds (for inpatient workers) put you at risk of **stress** and **burn-out** and put your clients at risk of receiving **poor care.**

There is clear evidence of a correlation between service cuts, rising caseloads and increased risk to patients.

CQC advise that the safe limit for caseload sizes for community mental health teams is **25 clients** per **full time worker**.

If you case work, and your caseload is approaching 25, then talk to your workmates and think about the best way to **challenge** your managers about the size of your workload.

If you find you are routinely working outside your contracted hours, or missing your lunchbreak, then your caseload is **too high**.

Keep on good terms with your colleagues and try to foster a **supportive culture** among your workmates.

If you can, consider setting up informal **peer supervision** sessions with trusted co-workers, to help manage the emotional stress of working with clients who are experiencing suicidality.

This advice will keep you safe from stress, burn-out and, should the worst happen, these steps will ensure that your decision-making is legally defensible and you can't be scapegoated.

A client's suicide is one of the most stressful things that any health worker will have to go through in their working lives, and managers are often quick to dump blame on individual workers for what usually amount to organisational failures. **Protect yourself**.

If you don't feel like your employer is doing what they should, then contact **BCWN** for advice. We can help you stand up for yourself and get what you need.

If you don't live in Bristol, contact your nearest **Solidarity Federation** local or **Industrial Workers of the World** branch.

Guide to Services

Note - This information is correct as of **May 2019**.

Services change very quickly, so some of this information is likely to change.

Services are structured differently in different areas.

If you live outside England, some of this information might not be true.

All of these services are very stretched and under resourced.

They can be frustrating to use, they often don't do what they are supposed to, and people sometimes feel like they have to 'jump through hoops' to get the help they need.

However, they can be life-saving resources for people in need.

The **National Institute for Care Excellence (NICE)** publishes guidelines for how services should run. These guides are available online. If you are using services and they are not doing what the NICE guidelines say they should, then you should tell them about the guidelines, get an advocate, or make a complaint.

Mental health services (AKA 'secondary' care)

By 'mental health services', we mean secondary services like **recovery teams** and **crisis teams**, not primary services (like your GP), IAPT schemes or charity/voluntary sector organisations.

If a person is under the care of mental heath services then they might be being cared for under something called the **Care Program Approach** (CPA).

If they are under CPA then they should have a **care coordinator.**

A care coordinator is a health worker (usually a psychiatric nurse, a social worker or an occupational therapist) who is primarily responsible for the person's care throughout the period of time that they are in services.

A person's care co-ordinator should be the first point of contact if they need help.

A **care coordinator's job** is to:

- Build a relationship with the person and their carers, and keep in regular contact with them,
- Assess how much risk the person is under, and take steps to manage the risk,
- Make sure all the other workers involved in the person's care are working together, and the person is getting all the care they need,
- Check in regularly to see if the care that the person is getting is working.

If you are under CPA you should also see a **psychiatrist**, who can make diagnoses, and prescribe psychiatric medication.

You should have the option to see a **clinical psychologist**, who can provide in-depth talking therapy.

You cannot self-refer to mental health services.
The most common way to get into mental health services is to get **referred** by your **GP,** although other agencies like hospital liaison teams and crisis teams can also refer you (see below).

If you have been referred by your GP, you will usually have to see a **triage liaison team** first.

If the liaison team think you need to be under CPA, they will then refer you on again into **secondary mental health services**.

If they don't think you need to be under secondary services, they should give you advice and information about **other help** that is available instead.

Crisis teams and Intensive Support teams

Crisis teams (sometimes called intensive support or intensive teams) provide 24 hour support to people who are very distressed and who need help at **short notice**.

Anyone can phone the crisis team, you don't need a referral and you don't need to be in services already.

The Bristol Crisis team's number is 0300 555 0334.

If a situation is **dangerous** (i.e. if you are caring for someone who has already harmed themselves, or you think the person you are caring for might hurt you) then you should call **999** NOT the crisis team. The crisis team are not a confidential service and they do talk to police.

GP services (AKA 'primary care')

Your GP should be your first point of contact for **non-emergency** mental health problems.

GPs can **diagnose** common mental health problems like anxiety and depression, although if someone is experiencing **severe** or **complex** mental illness, the GP shouldn't diagnose this and should refer to secondary services instead.

GPs can **prescribe** medication to treat common mental health problems but, again, if someone has severe and complex mental health needs including significant suicidality, the GP should refer them to a **specialist** instead.

GPs are **not** mental health experts, and the amount of traiing and experience they have in working with mental health can **vary** a lot from one GP to the next.

If you want your GP to refer you on to another service, you should ask them explicitly. If they refuse you should ask to see a different GP, and consider making a complaint.

IAPT

IAPT stands for '**Improved Access to Psychological Therapies**'.

IAPT schemes provide free counselling, group work and other talking therapies for people who are **not in secondary services**.

You can **self-refer** to IAPT schemes.
If you self-refer, you will usually have a telephone assessment with a health worker, and they will then tell you what kind of treatment the service can offer you.

The **local IAPTs** are:

- Bristol Wellbeing Therapies
- South Gloucestershire Talking Therapies,
- BANES Therapies
- Positive Step (In North Somerset)

The Bristol IAPT scheme has a very **long waiting list** so if you need support straight away then you should think about other options like charities, private counselling, or asking to be referred to secondary services.

Psychiatric hospitals and the Mental Health Act

If you have a diagnosed or suspected mental illness that is too **severe** or dangerous to treat in the community, you might be admitted to a **psychiatric hospital** for treatment.

If you **refuse** to be admitted voluntarily then you can be **detained** under the Mental Health Act (usually under s.2, for up to 28 days, or s.3, for up to six months).

If you are detained under the Mental Health Act then you can also be given **medication** and other **treatments** without your consent.

Being detained under the Mental Health Act is sometimes called being **'sectioned'**. To be detained under s.2 or 3, you need to be assessed by an Approved Mental Health Practitioner (AMHP) and two doctors.

The AMHP has a responsibility to consider the '**least restrictive** option' i.e. to make sure that **other options** including talking therapies, treatment under CPA and different medications have been tried first before they detain you.

They can only detain you as a **last resort**, if other options have not worked or aren't possible. The AMHP and doctors cannot enter your home without your permission unless they have a **warrant**.

Being detained is quite **unusual** and in reality, health workers tend to do everything they can to avoid sectioning people (partly because it's a violation of someone's human rights and partly because it's expensive and there is a huge shortage of psychiatric beds nationally).

Being detained can be a really **traumatic** experience, but this isn't universally the case and some people actually really **benefit** from spending time in hospital.

If you are detained then the local authority are **responsible** for looking after your **kids**, **pets** and any other dependents, and making sure your home is **secure**, while you are in hospital.

If you agree to go into a psychiatric hospital **voluntarily**, and the AMHP feels that you are mentally well enough to give informed consent to treatment, then you can go to hospital voluntarily (called **'informally'**).

Informal patients are not detained under the Mental Health Act, and they should be free to **leave** hospital at any time.

General hospitals, A&E and Ambulance Services

If you are caring for a person who has deliberately hurt themselves, including cutting themselves, taking an overdose or ingesting a dangerous substance, then you will probably need to use **emergency services** or A&E.

If you are **not sure** whether to do this or not then you can phone NHS direct on **111** for advice.

However, if you are not sure, then it is better to **play it safe** and call **999**. Do not take chances if you don't have to.

Ambulances are crewed by **paramedics**. Paramedics are not mental health specialists but they tend to be very experienced dealing with people in **crisis** situations.

Paramedics do not have any statutory powers under the Mental Health Act so they **cannot detain people**.

However, paramedics often work closely with the **police**, and will sometimes instruct the police to use their s.136 powers (see below).

If you are caring for someone who is experiencing an **acute** mental health crisis, even if they are not physically sick or hurt, then you can take them to **A&E**.

General hospitals usually have **on-site mental health teams** (called liaison psychiatry teams, hospital liaison teams, or something similar), who work with people who are in general hospital but also experiencing mental distress.

This includes people who have hurt themselves as a result of suicidal behaviours. Liaison teams can **assess** people in hospital and can then **refer** them in to secondary services.

Going to A&E and being seen by a hospital liaison team can be the quickest way to get access to secondary **mental health services**, although doing this will often involve sitting in A&E for many hours **waiting** to be seen.

Anecdotally, we have heard of people being left in A&E for up to eighteen hours waiting to be seen by a liaison team.

Health workers tend to advise people **not** to use A&E for mental health problems unless there is also a physical injury or illness, because of the pressure this causes on over-stretched A&E departments.

The Police

Anyone who has first hand experience of the police will know that they can make things **worse** not better, and there legitimate reasons why you or the person you are supporting might want nothing to do with the cops.

If the cared-for person is LGBT+, trans, homeless, substance dependent, or a person of colour, then interactions with the police could be especially **stressful** for them.

Police receive **inconsistent** mental health training and can be **insensitive** and unhelpful in situations where someone is acutely distressed.

On the flip side, the police have **powers** which you, as a carer, probably won't have.

In a life-or-death emergency, they can respond **faster** than other organisations can, and although the police as an institution are not set up to help people, some police officers will have **experience** or training in working with people who are experiencing suicidality.

Police forces usually employ **health workers** to work alongside police officers in situations where a person is very distressed.

Police forces also tend to work closely with **crisis teams** and other statutory mental health agencies, so having contact with the police might be a **quicker** way to access support than waiting for a referral from a GP.

There is no easy answer to the question of whether or not to involve the police in someone's care.

If you care for a person regularly or you think this situation could arise in future, see if you can **agree in advance** with the person you care for whether, and in what circumstances, they would want the police involved.

If you can agree this in advance then it will make it easier to know what to do if a **crisis arises**.

Sometimes, whatever your thoughts are, you will call the police because you are frightened and you do not know what else to do.

Be **realistic** with the cared-for person about your own limits, and how much risk and responsibility you are prepared to hold on your own before you get others involved.

Do not ever let anyone judge you for making difficult decisions in circumstances that are literally life-or-death.

If a person is mentally distressed in a public place, and the police feel they are at a **significant risk** to themselves (or others), police have the power to **detain** the person under **s.136** of the Mental Health Act. Police can hold people under s.136 for **36 hours**, and in that time they will be assessed to see whether or not they will be detained for longer (i.e. being 'sectioned' in a psychiatric hospital).

If the police detain someone under S.136 then they have to hold them in a **'place of safety'** - in Bristol the place of safety is called the Mason Unit at Southmead Hospital.

Police sometimes hold people in **cells** under s.136 although they should not do this if there are other options.

Police will sometimes keep people in their **own homes** or their **carer's homes** under s.136, but only if they think these places are safe.

Police can also **detain** someone under **s.135** of the Mental Health Act. S.135 works like s.136 except the person doesn't have to be in public and the police can **enter their home** to detain them, without the person's consent and including entering by force.

The police need a **warrant** to use s.135.

Advocacy

In Bristol, **MIND** provide advocacy services.

If you are **detained** under the Mental Health Act then have a right to an **advocate** (called an **IMHA**) who will advocate for your human rights and make sure you are not detained without a good reason.

If you are deemed to lack mental capacity to make a **decision** under the Mental Capacity Act, and you have **no-one else** to help you make that decision, then an advocate should be contacted on your behalf to make sure the decision is in your best interests (called an **IMCA**).

This can include decisions about where to live and whether to accept treatment.

Bristol MIND also run an advocacy **drop-in session**, for people who want advice about mental health services.

Email advocacy@bristolmind.org.uk for details.

The national MIND website has lots of useful **factsheets** about mental health, which are free to download.

Carer's services

Local councils have a legal duty to **support carers** under the Care Act 2014.

If you regularly provide care for someone, you can ask for a **carer's assessment**. This will involve an assessor visiting you, usually at home, talking to you about your caring role, and arranging support for you to keep caring.

'Support' usually means referrals to carer's **groups**, clubs and workshops, but sometimes you can have a **'carer's budget'** where the council gives you money towards any expenses.

In Bristol, a charity called the **Carer's Support Centre** are responsible for supporting carers on behalf of the local council.

As well as offering carer's assessments, the Carer's Support Centre provide a helpline, sitting services, counselling, workshops and other support for carers.

The Samaritans

The Samaritans is a **24-hour phone line** for people who are experiencing suicidality and emotional distress.

Samaritans workers are volunteers, but they are **highly skilled** and **trained**.

Unlike other agencies, the Samaritans do not take names and do not record contact information from the people they support, so the service is **completely confidential**.

About BCWN

Bristol Care Workers Network is a revolutionary **union** for health workers in Bristol.

As well as fighting our bosses, we want to build democratic, patient- and worker- controlled **alternatives** to our current **healthcare system**.

We want to build **communities** that have the skills, knowledge and resources to **care** for themselves.

This is why we have written this pamphlet.

You can **contact us** on careworkersnetworkbristol@gmail.com, or find us on **facebook** and **twitter**.

We can't always reply to messages quickly and we won't usually meet up with strangers, so if you need help with yours or someone else's health and care needs, please contact someone else first.

See the back page of this pamphlet for useful **contact numbers**.

Design and Artwork by Holly Summerson

Holly is an illustrator and animator with a particular interest in community art and social/political subjects.

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Useful Numbers

The Samaritans (open 24/7, free)

116123

NHS Direct (open 24/7)

111

Bristol Mental Health Line (open 24/7)

0300 555 0334

Bristol MIND advocacy line (staffed part-time)

01179 800376

Carer's Support Centre hotline

01179 652200