Homeless Link

Managing the risk and impact of suicide

Guidance for organisations

EASL

Groundswell
Out of homelessness

pathway
Healthcare for homeless people

VCSE health & wellbeing alliance

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Introduction

People who have survived suicide or who have had suicidal thoughts continually emphasise the importance of compassion and listening in preventing their suicide and in supporting their recovery. This fits well with the concepts of trauma-informed care and strengths-based practice which are approaches many homelessness organisations are adopting. Taking time to build trusting relationships, actively listening, building on peoples' strengths, and ensuring people have control over their own lives are important elements for service delivery, and for minimising the risk of suicide.

This guidance outlines what organisations might want to include in a suicide prevention protocol. It includes information and signposts to other sources that may be useful. It is intended to support organisations to have a suitable approach, and relevant and appropriate policies and procedures in place, to support people at risk of suicide. Having protocols in place will ensure a consistent and appropriate response, however having a compassionate, trauma-informed and strengths-based approach is also a priority.

It is important to be clear from the outset that not all suicides are preventable – many occur impulsively and rapidly in response to sudden distressing situations. Organisations and their staff can, and should, try to prevent a death by suicide but many people who end their lives make sudden decisions to do so without telling anyone. This guidance includes information on how best to try and prevent suicide with an acknowledgement that, sadly, this will not always be possible.

Policy context

In 2021 13.4% of deaths of people experiencing homelessness in England and Wales were deaths by suicide. By comparison, 1% of registered deaths in the general population were deaths by suicide.

An even greater number of people try to take their life and/or experience suicidal thoughts or feelings. Suicidal thoughts or feelings can range from someone having thoughts that life is not worth living, through to clear intentions and plans to end their life.

While people from all sections of the population experience suicidal thoughts and feelings and die by suicide, people who experience homelessness are at particular risk. There is a high prevalence of suicide risk factors in those who are experiencing homelessness: high levels of mental ill health, previous episodes of self-harm, current poverty and debt, concurrent drug and alcohol issues, and physical and emotional isolation.[1]

The commitment to developing local suicide prevention strategies is set out in the government's 2012 national strategy for England, Preventing suicide in England: a cross-government outcomes strategy to save lives. It is also a key recommendation in the Mental Health Taskforce's report to NHS England, The five year forward view for mental health. This report outlines the increased risk of suicide amongst people who are facing social issues including homelessness, unemployment, involvement in the criminal justice system, and exposure to violence and abuse. The NHS Long Term Plan (2019)[2] reaffirmed the NHS's commitment to prioritising suicide prevention over the next 10 years.

The 2012 strategy recognises that a range of organisations need to play a role in preventing suicide, including Housing Associations and the voluntary and community sector. Most areas should have developed a local suicide action plan led by the local authority Health and Wellbeing Board. Guidance can be found here.

In 2016, the Health Select Committee (HSC) conducted an inquiry into suicide prevention, with the final report published in March 2017. The HSC made several recommendations one of which was the need for a "clear implementation strategy, with strong national leadership, clear accountability, and regular and transparent external scrutiny." As a result, Government published the Cross-Government Suicide Prevention Workplan with more detailed information on each area of the strategy and how it should be delivered.

1. Mental Health UK, Suicide https://mentalhealth-uk.org/suicide/
2. NHS Long Term Plan 2019 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Developing an organisational Suicide Prevention Protocol

Having a Suicide Prevention Protocol in place can help to ensure that everyone within the organisation is clear about their role in preventing suicide and the steps they need to take. Each organisation will need to develop a protocol that meets their specific needs. However, there are some general points that all organisations should consider when developing a protocol. These are discussed in detail in this guidance.

Suicide Prevention and Postvention Protocol checklist

Below is a checklist of topics that could be included in a suicide prevention and postvention protocol:

- [ ] Clear aims and objectives
- [ ] Approach
  - Trauma-informed and strengths-based approaches to suicide
  - Principles of suicide prevention and postvention
- [ ] Terminology and language
- [ ] Roles of management and staff
- [ ] How to respond
  - Responding to people at risk of suicide or expressing suicidal thoughts
  - Responding to an immediate risk of suicide
- [ ] Policies and procedures
  - Serious Incidents Policy and Procedure
  - Suicide Prevention Policy and Procedure
  - Unexpected deaths Policy and Procedure
- [ ] Risk awareness
- [ ] Staff competencies, training and support
- [ ] Co-production and involvement of people accessing services
- [ ] Working with other agencies
- [ ] Responding after a suicide

Clear aims and objectives

The aim of a Suicide Prevention Protocol is to provide guidance and direction to staff about the interventions and care required to increase the safety of people who are at risk of experiencing suicidal thoughts/feelings.

The objectives of a protocol are:

- To ensure that the organisation approaches suicide prevention in accordance with key principles including trauma-informed and strengths-based practices
- To promote good practice in suicide prevention across the organisation
- To be aware of the wider causes of suicidal thoughts and feelings, including mental ill health and, therefore, to provide a safe and welcoming environment for all people who are working, volunteering, or accessing services
- To provide a framework to enable staff to feel empowered to talk to individuals and colleagues about how they feel and then develop an appropriate safety plan
- To provide people accessing services with the appropriate tools, resources, and access to support services, that are researched and contacted in advance of an emergency
- To provide guidance to staff on referrals for specialist assessment and intervention as part of the safety plan
- To ensure that all team members and people accessing services are proactively engaged in suicide prevention
- To ensure that all staff where appropriate, record details of discussions, and serious incidents (such as self-harm or attempted suicide), to promote organisational learning

Approach

Organisations and individual staff members should prioritise the approach that is taken to engagement and support. How things are approached is equally as important as the delivery of policies and procedures. This is outlined by experts with direct experience as well as existing guidance. For example, the Adult Safeguarding and Homelessness briefing by the Local Government Association emphasises the importance of person-centred practice:

> "Person-centred practice is key, core components of which are being human, compassionately persistent, open, and transparent, respectful use of language, listening and giving time and commitment. Effective practice involves hearing the voice of lived experience, identifying what is important to the individual, sharing reflections about possibilities and demonstrating professional curiosity about history, about the 'there and then' and the 'here and now' of their human story. It involves going at the pace of the person – it is their journey, in their time. Working toward change, which involves them fully, proceeds from this foundation."[3]

This corresponds with trauma-informed and strengths-based approaches which place the individual at the heart of their own journey and stress the significance of giving control and agency to the individual.

3. LGA (2020) Adult safeguarding and homelessness A briefing on positive practice. https://www.local.gov.uk/sites/default/files/documents/25.158%20Briefing%20on%20Adult%20Safeguarding%20and%20Homelessness_03_1.pdf

Trauma-informed and strengths-based approaches to suicide prevention

It is now well-established that a disproportionate amount of people experiencing chronic homelessness have also experienced trauma. Research has shown that 85% of people in contact with criminal justice, substance use, and homelessness services have experienced trauma in childhood.[4] People experience additional trauma whilst they are homeless. Research from Crisis in 2016 revealed the extent of violence and abuse faced by people living on the streets, with 77% reporting anti-social behaviour or crime against them in the past year. The report also details the impact that this has on physical and mental health including suicidality. In addition, homelessness in itself is a traumatic experience.[6]

People who attempt, or die by, suicide and those who engage in self-harm have elevated rates of trauma exposure, evidencing the importance of a trauma-informed approach when focusing on suicide prevention and postvention.[7]

An organisation that is trauma-informed **realises** the widespread impact of trauma and **recognises** the signs of trauma. The organisation **responds** by applying the principles of trauma-informed care and actively seeks to **resist re-traumatisation**.[8]

A consensus-based definition of trauma-informed care is that:

> "Trauma informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."[9]

The four themes of trauma-informed care identified alongside this definition are trauma awareness, emphasis on safety, opportunities to rebuild control and a strengths-based approach. A recent review of relevant research on trauma-informed suicide prevention found that the essential components were an emphasis on safety, personal strengths, and interpersonal relationships.[10]

To engage successfully in suicide prevention, organisations need to apply these principles throughout their services, ensuring that staff understand the impact of trauma and build safe trusting relationships with people. It is important to ensure people are listened to, are given ownership over their own support and that services work in a strengths-based way. You can read more about strengths-based working and trauma-informed care in Homeless Link's knowledge bank.

4. Lankelly Chase Foundation, (2015) Hard Edges: Mapping severe and multiple disadvantage, England, accessed at: http://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf
5. Crisis (2016). It's no life at all. London: Crisis.
6. Goodman, L.A., Saxe, L. and Harvey, M. (1991) Homelessness as psychological trauma. Broadening perspectives. In: American Psychologist, Vol 46(11), Nov 1991, 1219-1225.
7. Asarnow, J.R., Goldston, D.B., Tunno, A.M., Inscoe, A.B., and Pynoos, R. (2023) Suicide, self-harm, & traumatic stress exposure: A trauma-informed approach to the evaluation and management of suicide risk Evidence-Based Practice in Child and Adolescent Mental Health, 5:4, 483-500
8. SAMSHA (2014) SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf
9. Hopper, E.K., Bassuk, E.L. and Olivet, J. (2010) Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings The Open Health Services and Policy Journal 3: 80-100
10. Proctor, N., Othman, S., Jayasekara, R., Proctor, A. and McIntyre, H. (2023) 'The impact of a trauma-informed approach intervention or strategies for suicide prevention across the lifespan: A rapid review of the evidence' in International Journal of Mental Health Nursing 32 (1) 3-13.

Key principles of suicide prevention and postvention

Based on a review of existing evidence and consultation with Experts by Experience, Homeless Link has collated seven key principles that organisations should place at the heart of their approach to suicide prevention:

1. Everyone's job

Everyone in the organisation has a responsibility to meet the needs of people who may be experiencing self-harm or suicidal thoughts.[11]

2. No wrong door

There should be an open-door policy for individuals at risk of self-harm or suicidal thoughts, and a make every contact count approach. A compassionate and appropriate response should be available at every contact point. If signposting to another member of staff is required, continued support should be provided to the individual until the appropriate staff member has made contact and initiated support.[12]

3. Trauma-informed approach

Ensure that staff, volunteers, and organisations place self-harm and suicidal behaviour within the context of trauma-informed care.

4. Strengths-based approach

Ensure people are leading their own support and base any action around their own strengths and resilience.

5. Active listening

Listening in an open, non-judgemental way can make a significant difference and should be prioritised.

6. Collaboration

To ensure that everything the organisation does is **with**, and **not for**, people.

7. Be person-centred not protocol centred

Policies and procedures are used to offer better support as needed by the individual but are not rigidly followed at the expense of a human response.[13]

11. Adapted from Public Health England (date) Better care for people with co-occurring mental health and alcohol/drug use conditions A guide for commissioners and service providers
12. Ibid
13. National Collaborating Centre for Mental Health (2018) Self-harm and Suicide Prevention Competence Framework: Community and public health. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/self-harm-and-suicide-prevention-competence-framework/nccmh-self-harm-and-suicide-prevention-competence-framework-public-health.pdf?sfvrsn=341fb3cd_6

Terminology and language

When talking about suicide, it is important to be mindful about language used. Avoid using language that stigmatises or glorifies death by suicide. The following information has been taken from a guide written by an organisation called Shining a light on suicide.[14]

Avoid	Use	Why
Commit / committed suicide	Died by suicide Lost their life to suicide Took their own life	Using the word 'commit' implies suicide is a sin or crime, reinforcing stigma that it is a selfish act and personal choice. Suicide was decriminalised in England in 1961. Using neutral phrasing like 'died by suicide' helps remove shame or blame
Successful suicide Completed suicide	Died by suicide Fatal suicide attempt	Saying 'successful' or 'completed' is inappropriate because it frames a very tragic outcome as an achievement or positive circumstance
Failed suicide attempt Unsuccessful suicide attempt	Suicide attempt Survived a suicide attempt Non-fatal suicide attempt	Saying 'failed' or 'unsuccessful' is inappropriate because it implies that the opposite would be a positive outcome
[Name] is suicidal	[Name] is thinking of suicide [Name] is feeling suicidal [Name] is experiencing suicidal thoughts or feelings	Try not to define someone by their experience with suicide. They are more than their suicidal thoughts

14. Shining a Light on Suicide. Language guidelines. https://shiningalightonsuicide.org.uk/wp-content/uploads/2021/04/Language-guide-for-talking-about-suicide.pdf

Avoid	Use	Why
Cry for help		Suicide attempts must be taken seriously. Describing an attempt as a 'cry for help' dismisses the intense emotional distress that someone may be experiencing
You are not going to do anything silly are you? Are you thinking of ending it all? You are not going to top yourself, are you?	Are you having thoughts of suicide? Are you feeling suicidal? Have you been thinking about killing yourself?	Showing that you will not dismiss or make fun of the person, but instead that you are prepared to talk about it and take it seriously. Ask open questions and not ones that require yes or no answers. It is important to be direct. Using the word suicide shows others that you are ok with them talking about suicidal feelings and that you are there to listen
[Name] is feeling suicidal because of... They took their own life because...		Do not speculate on the reason someone may be experiencing suicidal thoughts or the reason they took their own life. The reasons for someone thinking about suicide, or taking their own life, are usually complex.

Roles of management and staff

It may be helpful for a protocol to explicitly set out the key roles staff can play in relation to suicide prevention, for example:

Management is responsible for:

- Ensuring staff are aware of the contents of the organisational Suicide Prevention Protocol
- Ensuring suitable training is provided about how to structure discussions on mental health and self- harm, and producing a Safety Plan for people accessing services:
    - All staff should listen compassionately, and have a low threshold before seeking advice from managers/more experienced staff when concerns about mental health or self-harm are identified in routine discussions
    - Ideally, all staff should have face-to-face training (see the Further Resources' document on our website)
    - As a minimum, all staff should undertake on-line training, such as free training from the zero suicide alliance: https://www.zerosuicidealliance.com/
- Ensuring good quality supervision structures are in place, including clinical supervision where required
- Reviewing and auditing all incidents and enabling reflective discussions to encourage and embed learning

Frontline staff are responsible for:

- Being aware of the Suicide Prevention Protocol
- Undertaking training in mental health and discussions about self-harm, ideally face-to-face (see the Further Resources' document on our website)
- Engaging with supervision
- Making time and space for discussions with people accessing services. Exercising 'professional curiosity' about mental health symptoms and thoughts of self-harm in a supportive manner
- Working with people experiencing suicidal thoughts to develop and implement personalised Safety Plans that can be accessed by them when required
- Proactively escalating concerns about mental health and self-harm to senior staff/management, and feeling empowered to approach health services with appropriate supervision when required
- Contributing to a safe and welcoming environment where people can disclose suicidal thoughts and feel these are taken seriously

How to respond

Responding to people at risk of suicide or expressing suicidal thoughts

Although training in suicide prevention is advisable, all staff can use transferable trauma-informed and strengths-based skills to talk to someone who has expressed suicidal thoughts.[15] Managers should support staff to feel confident using these relational skills, emphasising the importance of this for suicide prevention.

There are a number of key points emphasised by charities with expertise in supporting people at risk of suicide. The following have been adapted from recommendations by Campaign Against Living Miserably (CALM).[16]

1. Listen

People most often say that they value being listened to. It is important to listen without judgment and without focussing on trying to 'fix' someone. Listening can enable staff to get a better sense of whether someone is having suicidal thoughts or is actively preparing to take their life. Ask open questions that encourage the person to talk further about their feelings.

2. Ask

Ask the person directly if they are having suicidal thoughts or have thought about ending their life. Asking about suicide will not encourage someone to make a suicide attempt. It will give the person an opportunity to talk about their feelings. Many people feel a sense of relief. Ask if the person has made any plans to take their own life.

3. Create a safety plan

Risk assessments, or more generalised safety plans, are standardly created in services. However, a specific suicide Risk assessments, or more generalised safety plans, are often completed in services. However, a specific suicide safety plan is different and should be developed with the person when they are felt to be at risk of suicide. Safety Plans build on strengths, are collaborative and are an effective way to have conversations about future harm, in advance of any crisis. Good quality relationshipsare fundamental to the development of safety planning and staff need to be given sufficient time to get to build trusting relationships. Time to build these.

15. https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/supporting-someone-suicidal-thoughts/
16. Adapted from CALM https://www.thecalmzone.net/guides/worried-about-someone

Safety Plans need to be developed in collaboration with the individual and the process should enable reflection and identification about what works for them. If relevant, other professionals can be consulted, however the main priority is to develop something that works for the person in question.

Many suicide support organisations offer a template Safety Plan, so we recommend that you identify one that works for your organisation and the individuals supported. Beside is an example based on a template from the Samaritans.

To watch an example of how an organisation makes use of safety planning, you can access this good practice example from Landworks.

A Safety Plan could include the following areas:

Samaritans Safety Plan	
What I need to do to reduce the risk of me acting on the suicidal thoughts?	
What warning signs or triggers are there that make me feel more out of control?	
What have I done in the past that helped? What ways of coping do I have?	
What I will do to help calm and soothe myself?	
What I will tell myself (as alternatives to the dark thoughts)?	
What would I say to a close friend who was feeling this way?	
What could others do that would help?	
Who can I call: • Friend or relative: Another? • Health professional: Other? • Telephone helpline: Other?	
A safe place I can go to:	
If I still feel suicidal and out of control: • I will go to the A& E department • If I cannot get there safely, I will call 999 (112, 911 etc.)	

Responding to an immediate risk of suicide

A Suicide Prevention and Postvention Protocol should set out procedures for what to do when staff are concerned about an individual's level of mental health distress or crisis. This may include having frequent or constant suicidal thoughts, having a specific plan and intention to act, and/or being unable to identify protective factors.

If staff feel that someone is at immediate risk of harm, they should:

Stay with the person or arrange for a colleague to be with them.

Talk to them and continue to **listen** using the skills outlined above.

Contact their GP Practice or the Community Mental Health Team, who may have a duty worker.

- This may result in people being advised to attend the Accident & Emergency department at hospital for psychiatric assessment, or it might trigger a Crisis Response or Home Treatment Team visit.
- Discuss this onward referral with the person at risk of suicide, gain consent where possible and follow procedures for overriding consent when there is significant risk of harm.

In the event of immediate risk of suicide, **call Emergency Services**. An ambulance can take someone to hospital for assessment or the police might use their legal powers granted under the 1983 Mental Health Act to escort the person at risk to a place of safety with a view to being assessed.

Any incidents, including your intervention, should be documented in the individual's **notes**, and shared with other relevant staff and partner agencies in accordance with your organisation's confidentiality and safeguarding policies.

Regular observation or monitoring to reduce the risk of suicide. Your protocol should include information on when additional monitoring may be appropriate.

- This should be undertaken for time-limited periods and in collaboration with the person being supported.
- The nature of the observation should ideally be agreed with the person being supported. Depending on their wishes, observation can take the form of regular chats or conversations or be as non-intrusive as possible. This should be seen as an opportunity to engage with the person rather than a tick box check. Some people
- may prefer to 'check in' at set times rather than have staff knock on their door.
- Adequate staffing needs to be provided for this intervention to be consistent and effective.

Removing the potential means of suicide. Staff should remove items that can be dangerous. However, staff should try to do this in a collaborative way by including the person in this decision whilst also being clear about why this is something that staff feel is necessary. Items may include:

- Sharp objects such as razor blades and knives,
- Cleaning products
- Drugs or medication
- Belts, cords, wires, and rope

Policies and procedures

Serious Incidents Policy and Procedure

Every organisation should have a Serious Incidents Policy which may also be combined with Serious Incidents Procedures. You can see an example from Evolve here.

A Serious Incidents Policy and Procedure will usually cover a range of incident types, including fire, inter-personal violence and injury, and death. The Policy should include the organisation's approach to:

- Assessing and responding to risk
- Responding to an incident
- Incident reporting and investigation
- Principles and approaches underpinning the policy

Suicide Prevention Policy and Procedure

Organisations should develop a policy that covers key principles as well as clear procedures that staff can refer to when needed. You can view an exampe of a Suicide Safety Policy by Landworks as part of the accompanying resources. This should include information on:

- Responding to people who may be at risk or suicide or who are expressing suicidal thoughts
- Responding to an immediate risk of suicide
- Responding after a death by suicide

Unexpected Deaths Policy and Procedure

Some organisations find it useful to have a separate policy on unexpected deaths in addition to a Serious Incidents Policy and Procedure. This may include a section on suicide.

A policy on unexpected deaths or suicide should include:

- Purpose and scope
- Guiding principles
- Procedure to follow on discovering an unexpected death
- Information recording
- Funeral arrangements
- Medication
- Media
- Possessions
- Supporting others using the service
- Supporting other staff

Postvention

The protocol should include a procedure for how to respond when a suicide takes place. For more information, please see our separate guide on Postvention After a Death by Suicide.

Risk awareness

It is essential that organisations work in a way that is 'risk aware' rather than 'risk averse.' Staff should be conscious that people may be at risk but not to use this assessment to exclude people or close opportunities. Any activity or intervention aimed at reducing the risk to the individual should place their welfare first and should apply the key principles to suicide prevention and postvention discussed above.

Risk factors for suicidality

Certain groups are at higher risk of suicide and many of these are over-represented amongst people experiencing homelessness. This includes men (discussed in more detail below), people within the lowest socio-economic group as well as those with histories of self-harm, mental illness, and substance misuse. Alongside risk factors, individuals may also have protective factors that mitigate any specific risks.

However, it must be emphasised that risk factors do not predict the likelihood of any one person attempting suicide and many people that make attempts on their life do not have any risk factors.[17] Risk assessment tools based on demographic factors have been found to be poor predictors of suicide and should not be relied upon.[18] It is essential to work with each person as an individual.

Men

Men are at greater risk of suicide than women with 74% of suicide deaths being men. Suicide in the general population occurs most frequently in men aged 50-54 and is the biggest killer of men under 50.

Many of the factors that are associated with suicide are common in men and in those experiencing homelessness. These include depression especially when undiagnosed or untreated, alcohol and substance misuse, unemployment, family and relationship issues, social isolation, and low self-esteem.[19]

Initiatives aimed at reducing the risk of suicide in men often focus on addressing underlying needs and on encouraging men to seek help. These include the following:

- Using peer support so that men receive information and support from people they trust
- Meeting men within the community or in spaces of their choice, rather than clinical settings
- Providing places for safe conversations such as 'men's sheds' or other spaces for informal conversation.[20]

17. Royal College of Pyschiatrists (2020) Self-harm and suicide in adults Final report of the Patient Safety Group https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b-6fdf395_10
18. Bolton J.M., Gunnell D. and Turecki G (2015) Suicide risk assessment and intervention in people with mental illness. BMJ, 351: http://dx.doi.org/10.1136/bmj.h4978
19. PHE Local Suicide Prevention Planning: a practice resource https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/939479/PHE_LA_Guidance_25_Nov.pdf
20. Ibid

People who are using substances

Substance misuse is also associated with a higher risk of suicide, and dual diagnosis presents a further increased risk.

LGBTQ

People who identify as LGBTQ are more likely to experience poor mental health, including suicidal thoughts. This may be a result of abuse and trauma experienced.

General risk factors

The features listed on the next page have been shown to be risk and protective factors for people at risk of suicide:[21]

21. Centers for Disease Control and Prevention https://www.cdc.gov/suicide/factors/index.html

	Risk Factors	Protective Factors
Individual factors	• Previous suicide attempt and history of self-harm • History of depression and other mental illnesses • Substance use • Serious illness such as chronic pain • Criminal/legal problems • Job/financial problems or loss • Impulsive or aggressive tendencies • Current or prior history of adverse childhood experiences • Sense of hopelessness • Violence victimization and/or perpetration	• Effective coping and problem-solving skills • Reasons for living (for example, family, friends, pets, etc.) • Self-esteem and sense of purpose in life • Strong sense of cultural identity
Relationship factors	• Bullying • Family history of self-harm or suicide • Loss of relationships • High conflict or violent relationships • Social isolation	• Support from partners, friends, and family • Feeling connected to others
Community factors	• Lack of access to healthcare • Suicide cluster in the community • Stress of acculturation • Community violence • Historical trauma • Discrimination	• Feeling connected to school, community, and other social institutions • Availability of consistent and high quality physical and behavioural healthcare
Societal factors	• Stigma associated with help-seeking and mental illness • Easy access to lethal means of suicide among people at risk • Unsafe media portrayals of suicide	• Reduced access to lethal means of suicide among people at risk • Cultural, religious, or moral objections to suicide

Signs that someone may be experiencing suicidal thoughts

People may not actively state that they are thinking of ending their own life. It is important that staff are aware of the signs that someone may be feeling suicidal. If staff notice any of these signs, they should explore this further with the person to better understand how they are feeling and to offer additional support. The signs listed below have been adapted from publications by the Samaritans, Papyrus, and Mersey Care.[22,23,24]

A person may be at high risk of attempting suicide if they:

- Threaten to hurt or take their own life
- Talk or write about death, dying or suicide
- Actively look for ways to take their own life, such as stockpiling tablets

Other signs that someone might be at risk of attempting suicide include:

Things people might say:

- **Talking about suicide** – Any talk about suicide, dying, or self-harm, such as "I wish I hadn't been born," "If I see you again…" and "I'd be better off dead."
- **Words/language being used** - "I can't take it anymore," "Everyone would be better off without me"

Feelings people may have:

- **Feeling aggressive or angry**
- **Feeling restless or agitated**
- **No hope for the future** – Feelings of helplessness, hopelessness, and being trapped. Belief that things will never get better or change.
- **Self-loathing, self-hatred** – Feelings of worthlessness, guilt, shame, and self-hatred. Feeling like a burden.
- **Feeling unable to cope** – this may include feeling unable to cope with everyday things.
- **Feeling low** – feelings of depression or sadness or feeling tearful.
- **Sudden sense of calm** – A sudden sense of calm and happiness after being extremely depressed can mean that the person has decided to attempt suicide

22. Mersey Care NHS Foundation Trust, Warning Signs https://www.merseycare.nhs.uk/health-and-wellbeing/suicide-prevention/worried-about-someone/warning-signs
23. Papyrus UK, How do I know if someone is suicidal https://www.papyrus-uk.org/how-do-i-know-if-someone-is-suicidal/
24. Samaritans, How to support someone you are worried about https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/how-support-someone-youre-worried-about/

Behaviours that you might see:

- **Looking for a way to end their life** – Searching for a method or seeking access to medicines/ other objects that could be used in a suicide attempt.
- **Preoccupation with death** – Unusual focus on death, dying, or violence.
- **Getting affairs in order** – Making out a will. Giving away prized possessions. Making arrangements for family members.
- **A change in routine** – Sleeping or eating more or less than usual.
- **Saying goodbye** – Unusual or unexpected visits or calls to family and friends. Saying goodbye to people as if they will not be seen again.
- **Withdrawing from others** – Withdrawing from friends and family. Increasing social isolation. Desire to be left alone.
- **Disengaging from usual activities** – Not wanting to do things they usually enjoy.
- **Self-destructive behaviour** – Increased alcohol or drug use, reckless driving, unsafe sex. Taking unnecessary risks.

Physical signs:

- **Physical indicators** - Weight loss, lack of interest in appearance

Situations the person might be in[25]:

- Bereavement through suicide or for another reason
- Relationship and family problems
- Housing problems
- Financial worries
- Difficult circumstances
- Job or college related stress
- Bullying, abuse, or neglect
- Loneliness and isolation
- Physical illness
- Depression
- Heavy use of substances

Many people, including those who are currently homeless, will experience many of the above without feeling suicidal. However, it is important to be alert to the signs and not to dismiss someone's feelings as the inevitable result of their homeless situation. Any concern should be taken seriously and acted upon.

25. Samaritans, How to support someone you are worried about https://www.samaritans.org/how-we-can-help/if-youre-worried-about-someone-else/how-support-someone-youre-worried-about/

Assessing risk

When carrying out any form of risk assessment, staff and volunteers should ensure they are applying the key principles outlined above.

Risk assessments that are purely carried out as a tick box exercise can feel impersonal and potentially re-traumatising for people. This can remind people of some of the institutional experiences that may have been traumatic in the past. This approach to risk assessment can re-enforce power imbalances and make people feel less comfortable sharing information.

To make risk awareness as positive an experience as possible, staff should first build a trusting relationship with the person. If formal risk assessments must be carried out early in the relationship, staff should prioritise making the person feel comfortable.

The main factors to consider when carrying out a risk assessment are:

- Holding the conversation within a relaxed environment/private and positive space
- Holding the conversation at a time and place that suits the individual
- Asking open questions
- Listening
- Being non-judgemental
- Showing genuine interest and concern
- Gathering specific details about the individual's strengths and supports. To this end, asking "What is important to you?" "What do you find comforting?" "What should I know about you?" can be helpful
- Allow the individual enough time to respond to questions and avoid any assumptions or interruptions.
- Acknowledge that some topics may be particularly sensitive and difficult and allow more time for answers to questions. It may be beneficial to inform people of the benefits of gathering this information to aid formulation of a plan so that they can move forward.

To learn more about assessing risk of suicidality, see accompanying resources created by EASL. You can also read more in this A guide to Suicide Risk Assessment and Management for Homeless Hostel Staff written by EASL for Glassdoor.

Staff competencies, training, and support

As outlined above, the most important factors in preventing suicide is compassion and listening. To deliver trauma-informed services, staff need appropriate training and support as well as trauma-informed governance and organisational structures around them.

Staff competencies

In 2018, the National Collaborating Centre for Mental Health and UCL produced a Self-harm and Suicide Prevention Competency Framework that can be applied to those working in community settings, and specifically includes services for people experiencing homelessness. It is recommended that you read the document in full and explore the competencies. The competency framework is reproduced with permission below.

The document lays out the core competencies that staff and organisations should have to enable them to successfully support people at risk of self-harm and suicide and provides a useful guide for induction and training. In addition to specific knowledge about mental health, self-harm and suicide, the framework emphasises the importance of good communication skills.

In addition to the main framework, their expert panel identified the following key issues for consideration:

1. **Working collaboratively with the person** to enable the individual to make choices and share decision making about how they wish to be supported.
2. **Person-centred rather than protocol-centred** by translating standardised processes into an individualised and supportive approach.
3. **Sharing information with families, carers, and significant others** by routinely discussing whether the person would like to involve others, staff having a good understanding of the Mental Capacity Act and when an individual may lack the capacity to make decisions themselves.
4. **Managing transitions between services** as these present a key time of risk for people who self-harm or are suicidal.
5. **The relationship between self-harm and suicide** is complicated. People who self-harm are more likely to die by suicide than those who do not self-harm. However, people who self-harm do not always have suicidal intent. Professionals should try to understand the motivations behind self-harm, which may differ over time.
6. **Risk assessment** needs to be undertaken with an understanding that standard risk assessments are of limited predictive value and can even be a barrier to an individual talking about their needs. The emphasis should be on collaborative assessment of needs, risks, and strengths.
7. **Postvention** should take the form of individualised support for those who have been affected by a persons' death. We will discuss this in more detail later in this document.
8. **Conducting investigations into deaths by suicide and / or serious incidents** should be undertaken in a way that involves those closest to the individual.
9. **Reflective practice** can be helpful for professionals.

Attitudes, values and style of interaction

Basic knowledge of issues related to self harm and suicide

Basic knowledge of mental health presentations

Knowledge of self-harm and suicide

Knowledge of the impact of social inequalities on self-harm and suicide

Understanding self-harm and suicidal ideation

Knowledge of pharmacological interventions

Knowledge of working with children and young people

Knowledge of development in children and young people and family development and transitions, and relevance to self harm and suicide

Professional competences

Knowledge of organisational policies and procedures relevant to self-harm/suicide

Ability to recognise and respond to concerns about child protection

Ability to recognise and respond to concerns about safeguarding

Ability to operate within and across organisations

Knowledge of, and ability to operate within, professional and ethical guidelines

Knowledge of legal frameworks relating to working with people who self-harm and/or are suicidal

Knowledge of, and ability to work with, issues of confidentiality and consent

Knowledge of, and ability to assess, capacity

Ability to work with difference

Ability to make use of supervision

Professional competences for organisations

Responding to, and learning from, incidents at an organisational level

Providing support for staff after a death by suicide

Training

Self-harm and suicide awareness and prevention training

Postvention

Support for people bereaved by suicide

Supporting people within and organisation after a suicide

Liaison with others

Managing transitions in care within and across services

Generic communication skills

Communication skill

Ability to communicate with children and young people of differing ages and developmental

Ability to communicate with people with neurodevelopmental conditions

Signposting / enabling

Collaborative assessment and planning

Ability to undertake a collaborate assessment of risk, needs and strengths

Ability to assess a person;s wider circumstances

Ability to develop a formulation

Ability to collaboratively engage a person with the intervention plan

Ability to signpost / refer to and coordinate with services

Structured support

Crisis Intervention

Safety planning

Meta-competences

Meta-competences

Self-harm and Suicide Prevention Competence Framework for working with the public (community and public health) NCCMH, UCL and NHS Health Education England, 2018

Staff training

A range of organisations deliver online and in-person training on suicide and related topics. A list is included in our Further Resources document.

Based on the framework above, to respond appropriately to people at risk of self-harm or suicide all staff should receive training on:

- Understanding and responding to mental health and common presentations
- Self-harm and suicide awareness and prevention including legal frameworks
- Safeguarding
- Mental Capacity Act
- Communication skills
- Undertaking collaborative risk assessments and safety planning

In addition to undertaking training in these areas, staff should be made aware of the following during their induction, with their knowledge refreshed at regular intervals:

- Organisational policies and procedures relating to self-harm and suicide
- Organisational policies and procedures relating to safeguarding
- Referral routes and information on other agencies who can offer support

Staff support

To feel confident in supporting people expressing suicidal thoughts, staff need to be well supported within their organisations. This includes regular supervision with their team leaders as well as debriefing and reflective practice with their team. To read more about the ways that staff can be supported by their organisation, see our resources on supporting staff to have conversations about health and the recorded presentation on Debriefs for Staff by EASL.

Our guide to Postvention After a Death by Suicide includes more information on how to support staff if a death takes place.

Co-production and involvement of people accessing services

For protocols to operate effectively, it is recommended that they are developed in collaboration with people accessing your service and others with direct experience of suicidality and homelessness settings. This will ensure that your protocols are appropriate for your setting and will give them greater legitimacy when you apply them in practice. See Homeless Link's resources on co-production for more information.

Working with other agencies

A Suicide Prevention Protocol will outline when referrals need to be made to appropriate health and wellbeing services (statutory and community). If your organisation does not already have strong relationships with relevant partner agencies including adequate referral routes, then this should be addressed as a priority. The exact nature of this part of the protocol will be specific to your local area and relationships that have developed between services. Having clear connections to relevant support agencies is an integral part of ensuring an adequate response to suicide prevention.

All staff should have an awareness of appropriate mental health and other support services that are available. For information on how to approach mental health services, see the accompanying resources by EASL and Pathway. See also Homeless Link's suite of resources on accessing mental health services, developed by EASL and other partners.

Responding after a suicide

A Suicide Prevention and Postvention Protocol should include procedures for responding should a suicide takes place. Please see our specific guidance Postvention After a Death by Suicide. See also the recorded presentation on DeBriefs for Staff by EASL.

What we do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

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