

Higher Risk Settings and Circumstances Engagement Summary

Purpose of the engagement

The Higher Risk Settings & Circumstances engagement sessions were designed to support the continued development of national work focusing on those at higher risk of suicide, in line with our Creating Hope Together priorities and associated delivery actions.

The sessions aimed to:

- ♥ Update on national work underway on Higher Risk Settings & Circumstances
- ♥ Test and refine a shared understanding of what is meant by “higher risk settings” and “higher risk circumstances”
- ♥ Create space for different sectors and settings to share current practice, challenges and learning
- ♥ Support engagement, dialogue and relationship building across sectors to help shape future priorities and development of this work

What we did

A total of four engagement sessions were held during March 2026, comprising a mix of in-person and online events, to enable broad participation across sectors and geographies. These sessions were hosted by Public Health Scotland as part of the Suicide Prevention Scotland programme.

Format and locations

The sessions included:

- ♥ In-person events, in Edinburgh, Glasgow & Aberdeen
- ♥ An online session hosted via Microsoft Teams

This blended approach was intended to maximise accessibility while retaining opportunities for in-depth discussion and networking.



Session structure and content

Across all four sessions, a consistent core structure was used:

1. Welcome and context setting

- ♥ Overview of the purpose of the engagement
- ♥ Ground rules emphasising care, respect, lived experience and psychological safety

2. Update on national work

- ♥ An overview of current national work on Higher Risk Settings & Circumstances
- ♥ Links to Creating Hope Together delivery priorities, including Action 1.2 on giving particular consideration to people at higher risk of suicide depending on settings, circumstances or population groups

3. Practice examples

A range of practice examples were shared to illustrate how suicide prevention activity is being taken forward in different higher-risk contexts. These included:

- ♥ Practice from HMP Barlinnie Prison Health Care, the University of Strathclyde, the Offshore Energy Sector & RSABI was showcased (one example at each event)
- ♥ These examples highlighted elements such as the development and use of tailored resources, and commonalities between settings/sectors.

The intention of the sessions was to offer practical, real-world examples that could prompt reflection and discussion across sectors.

4. Facilitated discussion and engagement

- ♥ Small-group table or breakout discussions
- ♥ Participants were invited to reflect on a range of prompts, including:
 - ♥ What “higher risk settings” or “higher risk circumstances” mean in their own context
 - ♥ Which settings or circumstances might you prioritise and why (e.g. impact, feasibility, equity)
 - ♥ What the focus of work should be over the next three years

Light-touch facilitation and note-taking supported the capture of key themes and reflections without placing an undue burden on participants.

Engagement and participation

The sessions brought together participants from a wide range of sectors and roles, including statutory services, third sector organisations, policy colleagues and practitioners working directly within higher-risk settings or with populations experiencing higher risk.

Feedback from participants highlighted the value of:

- ♥ Hearing directly from people working in different settings
- ♥ Opportunities for discussion, reflection and shared learning
- ♥ Making new connections and understanding parallel work happening across Scotland

This approach was intentionally designed to support dialogue rather than consultation alone, recognising that learning and change often emerge through discussion and shared reflection.



Summary of learning from engagement

1. What “Higher Risk Settings / Circumstances” Mean in Practice

Across all tables, higher risk was understood to be something that is dynamic, contextual and cumulative, rather than fixed to particular places/settings or population labels. Risk was viewed to increase when people experience loss of control, identity or connection, particularly where systems feel unsafe, inflexible or difficult to navigate, which reflects available evidence and literature.

Higher risk commonly arises through the interaction of:

Transitions and disruption, including:

- ♥ Education (school → college/uni, CAMHS → adult services)
- ♥ Justice (in and out of prison)
- ♥ Addiction services (rehab → community)
- ♥ Work (job loss, shift work, retirement)
- ♥ Migration and resettlement

Isolation and disconnection:

- ♥ Social, geographic, cultural or digital isolation
- ♥ Rural and remote living
- ♥ Language barriers and stigma
- ♥ Fear of seeking help or disclosing distress

Trauma, loss and cumulative adversity:

- ♥ Suicide bereavement and postvention impacts
- ♥ Sexual trauma and complex trauma histories
- ♥ Care experience
- ♥ Poverty, housing insecurity, substance use

System pressures and fear:

- ♥ Inflexible or siloed services
- ♥ Over-medicalised responses that miss underlying needs
- ♥ Gaps between crisis identification and meaningful support
- ♥ Fear of consequences (e.g. punishment, loss of autonomy) if people say they are suicidal

Overall, higher risk was consistently framed as what is happening to someone, not simply where they are and the understanding amongst participants reflective of the available evidence and data.



2. Priority Populations and Settings

While participants noted that many groups experience higher risk, strong convergence emerged around populations more likely to experience multiple risk conditions at once:

Children and Young People

- ♥ Care-experienced young people
- ♥ Transitions between CAMHS and adult services
- ♥ Online harm, bullying and social media pressures
- ♥ Limited support at home
- ♥ Need for early, preventative, non-medicalised support

Students and Education Communities

- ♥ Students, international students and graduates
- ♥ Living away from home and transient populations
- ♥ Universities and schools as high-risk but high-opportunity settings
- ♥ Staff capacity and wellbeing as a linked concern

People in the Justice System

- ♥ Prisons and wider criminal justice settings
- ♥ High trauma prevalence
- ♥ Fear of disclosing suicidal thoughts
- ♥ Risk during transitions in and out of custody

Marginalised and Minoritised Communities

- ♥ Gypsy/Traveller communities
- ♥ Refugees, asylum seekers and New Scots
- ♥ LGBTQ+ people
- ♥ Communities experiencing intersectional stigma and discrimination

Rural, Remote and Farming Communities

- ♥ Social and geographic isolation
- ♥ Lone working and visibility concerns
- ♥ Overlapping roles (e.g. farming and emergency response)
- ♥ Reduced access to specialist services

Workforce in High-Pressure Roles

- ♥ Social work, healthcare, emergency services
- ♥ Education, hospitality, construction, offshore and fishing industries
- ♥ Shift and night workers
- ♥ Repeated exposure to trauma and high responsibility



People Experiencing Major Life Loss

- ♥ Suicide bereavement and previous attempts
- ♥ Job loss, poverty, housing insecurity
- ♥ Retirement and ageing
- ♥ Caring responsibilities, including dementia care

3. Compounding Risk Factors

Participants strongly emphasised that suicide risk is rarely driven by a single factor. Instead, risk escalates through combinations such as:

- ♥ Poverty + housing insecurity + mental ill-health
- ♥ Trauma + isolation + stigma
- ♥ Occupational exposure + rurality + lack of support
- ♥ Substance use combined with access to means
- ♥ Pain (emotional, psychological or physical) without relief
- ♥ Demographic risk layered with life stage or service transition

There was also recognition that trauma may surface years later, and that risk profiles change across the life course.

4. Structural and System Barriers

System-level factors were widely seen as amplifying risk, including:

- ♥ Fragmented services and poor coordination across systems
- ♥ Difficulty sharing information appropriately in times of concern
- ♥ Generic training that does not fit complex or specific settings
- ♥ Inconsistent supervision and peer support for staff
- ♥ Political, financial and resource constraints
- ♥ Short-term funding driving crisis response over prevention
- ♥ Absence of attempts data and reliance on incomplete evidence
- ♥ Lack of alignment between national strategy and local delivery

5. Protective Factors (Consistent Across All Groups)

Despite contextual differences, there was strong agreement on protective factors that help reduce risk:

- ♥ Human connection: being listened to, believed and valued
- ♥ Time, space and compassion in everyday interactions
- ♥ Meaningful activity, routine, work or learning
- ♥ Peer support and shared lived experience
- ♥ Safe spaces (community, training rooms, drop-ins)

- ♥ Continuity and follow-up as circumstances change
- ♥ Trust in services, professionals and systems

Relationship-based work was repeatedly recognised as protective in its own right.

6. What Helps: Effective and Promising Approaches

Participants identified several approaches already working or worth strengthening:

- ♥ Postvention as prevention
- ♥ Early intervention through schools, universities and communities
- ♥ Peer-led and community-based support
- ♥ Trauma-informed and anti-oppressive practice
- ♥ Multi-agency collaboration beyond health services
- ♥ Recognising and valuing preventative work already happening under different labels
- ♥ Designing safer physical environments (e.g. transport, buildings)

7. Workforce Support and Capacity

There was a consistent and strong emphasis on the workforce:

- ♥ Many staff are holding suicide risk as part of non-specialist roles
- ♥ Emotional impact and vicarious trauma are significant
- ♥ Supervision, debriefing and occupational health support are uneven
- ♥ Interpreters and peer workers also require support
- ♥ Workforce wellbeing was seen as integral to suicide prevention, not separate from it

8. What Would Participants Focus on for the Next 3 Years

Across all discussions, shared priorities emerged:

- ♥ Making transitions a central organising theme for prevention
- ♥ Shifting upstream towards prevention and early intervention
- ♥ Improving coordination between national and local work
- ♥ Supporting staff as well as people at risk
- ♥ Reducing stigma through education and open conversation
- ♥ Using data intelligently while recognising its limits
- ♥ Embedding suicide prevention into wider systems (housing, education, employment)
- ♥ Designing systems and environments with safety and compassion in mind

Key themes for consideration

1. Make Transitions the Primary Organising Focus

What to take forward



- ♥ Explicitly frame future work on *higher risk settings and circumstances* around transitions, rather than attempting to prioritise endless populations or locations.
- ♥ Use transitions as the “common language” across sectors (education, justice, housing, health, third sector).

Practical actions

- ♥ Identify a small number of priority transition points to focus on (e.g. leaving school, leaving prison, leaving addiction services, retirement, migration/resettlement).
- ♥ Build guidance and examples around “*what good support through transitions looks like*”.
- ♥ Encourage local areas to map where transitions create gaps in support rather than mapping “high-risk groups”.

2. Strengthen National-Local Coordination Without Creating New Structures

What to take forward

- ♥ Play a clear national convening and enabling role rather than a delivery role.
- ♥ Focus on helping areas understand who is already doing what, and how it connects to suicide prevention.

Practical actions

- ♥ Support local areas to map suicide-relevant activity across housing, education, justice and third sector.
- ♥ Create simple prompts or templates to help areas link existing work to suicide prevention.
- ♥ Use national forums to connect local leads doing similar work (e.g. housing, rural, justice).

3. Treat Workforce Support as a Core Prevention Activity

What to take forward

- ♥ Make it explicit that supporting the supporter is suicide prevention.
- ♥ Shift the narrative so workforce wellbeing is not seen as secondary or optional.

Practical actions

- ♥ Promote consistent expectations for supervision, debrief and peer support in high-risk roles.
- ♥ Embed reflection and support prompts into existing training and guidance.
- ♥ Normalise staff who are affected by trauma and needing support as part of safe practice.

4. Focus on Relational, Person-Centred Practice Over New Training Programmes

What to take forward

- ♥ Shift emphasis from “more training” to how people work day-to-day.
- ♥ Reinforce that listening, compassion and trust are protective interventions.

Practical actions

- ♥ Highlight practical examples of compassionate conversations, especially in non-health settings.
- ♥ Support staff to feel confident asking direct questions and responding humanely.
- ♥ Reduce over-medicalisation by validating solution-focused and relational approaches.

5. Be Selective and Honest About Data and Evidence

What to take forward

- ♥ Use data to inform, not dictate, action.
- ♥ Be transparent about gaps (e.g. attempts data) and value frontline and lived experience insight.

Practical actions

- ♥ Encourage local areas to use national statistics alongside local intelligence.
- ♥ Avoid over-precise targeting when patterns are complex or changing.
- ♥ Frame prevention as iterative and adaptive, not fixed.

6. Prioritise Environment and Systems Where Influence Exists

What to take forward

- ♥ Focus on structural elements that can realistically be influenced, rather than broad societal change.

Practical actions

- ♥ Encourage suicide-aware thinking in housing allocations, temporary accommodation and resettlement.
- ♥ Influence planning, transport and infrastructure discussions to consider safety early.
- ♥ Align suicide prevention with wider work on poverty, housing and inequality rather than treating it separately.

7. Keep the Scope of Work Tight to Avoid Dilution

What to take forward

- ♥ Accept that not everything can be prioritised at once.
- ♥ Be clear about what this work *will* and *will not* try to do.

Practical actions

- ♥ Clearly articulate a limited set of priorities (e.g. transitions, workforce, coordination).
- ♥ Use these priorities consistently across messaging, tools and engagement.
- ♥ Reiterate that local flexibility is essential within a clear national direction.
- ♥ Select sectors willing to engage – i.e. Vets, Prisons, Construction.
- ♥ Share messages with wider sectors via mechanisms they are already engaged with i.e. Employers Network, Industry Bodies.



Summary

Taken together, this feedback paints a coherent picture: suicide risk is not confined to a set of identifiable places or groups, but emerges when people experience change, loss, trauma and uncertainty without sufficient connection, safety or support. Higher risk is shaped by life transitions, layered adversity and system responses, and it can affect anyone as circumstances shift. At the same time, the discussions highlight that prevention is already happening every day through relationships, communities and frontline practice, often unnoticed or unsupported.

The opportunity now is to build on what is already working, while bringing greater coherence, co-ordination and confidence to action across national and local levels. Creating Hope Together's ambitions for suicide prevention in Scotland highlight the action that needs to be taken on the wider cause of suicidal ideation, and highlights work around transitions and connection rather than crisis alone; investing in the workforce as a key preventative resource; embedding compassion and flexibility into systems; and ensuring that lived experience and marginalised voices shape future design. By doing this, the work can move decisively from reacting to crisis towards creating the conditions which reduce suicide risk and improve liveability, particularly among more disadvantaged communities.

Across our action and delivery plans, many of the actions raised by attendees are already taking place. You can view Creating Hope Together: Scotland's Suicide Prevention Action Plan 2026-2029 [here](#).

Please note, practice examples shared at each session reflected the work at that time.

Please get in touch with us if you have any queries.

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