

## Lived experience insights to inform the refreshed National Suicide Prevention Strategy

### Summary report from virtual focus groups hosted by the Suicide Prevention Consortium

#### Overview

In late May 2022, the Suicide Prevention Consortium (see box) held four virtual focus groups with people with lived experience to discuss key questions relating to a refreshed National Suicide Prevention Strategy. This document summarises the key themes raised by participants and has been submitted as evidence to government through its ‘mental health and wellbeing plan: discussion paper and call for evidence’ process (July 2022).

The [Suicide Prevention Consortium](#) is led by [Samaritans](#) and also includes [National Suicide Prevention Alliance](#), [Support After Suicide Partnership](#) and [With You](#). As part of the [VCSE Health and Wellbeing Alliance](#), it aims to bring the expertise of its member organisations and the voice of those with lived experience directly to policymakers, to improve suicide prevention in England.

#### Focus groups

The Suicide Prevention Consortium hosted four virtual focus groups with people with lived experience of suicide, self-harm and / or alcohol or drug misuse, on 25<sup>th</sup>, 26<sup>th</sup>, 30<sup>th</sup> and 31<sup>st</sup> May 2022. The Lead for Suicide and Self-Harm Prevention at the Department of Health and Social Care attended the session on 26<sup>th</sup> May, as an observer.

In total 55 people attended. Participants were members of the Samaritans Lived Experience Panel and / or National Suicide Prevention Alliance (NSPA) Lived Experience Network, people in touch with the Support After Suicide Partnership (SASP), or the addiction support charity With You. All participants self-identified as having experience of suicidal thoughts, suicide attempt(s), bereavement by suicide, self-harm and/or alcohol or drug misuse. All participants were over 18 years of age and resident in England.

The questions discussed at the sessions were:

1. What are the top priorities relating to prevention of suicide?
2. Are there any specific considerations for particular groups, including those who may be at higher risk of suicide, and / or marginalised? For example people struggling financially.
3. What could be done to improve the immediate help available to people in crisis?
4. What difference would you like to see as a result of the National Suicide Prevention Strategy in 10 years’ time?

The discussions were facilitated by members of the Consortium, and discussions were recorded by note-takers. It is from these notes that the key themes below have been drawn.

### **Key themes – headlines**

The top priorities or actions participants felt were needed in order to prevent suicide can be summarised as:

- a) Education and awareness raising to reduce stigma and make it easier for people to open up about suicidal feelings and to seek support
- b) Improving access and quality of care, and consistency of services
- c) Better crisis support services
- d) Personalisation of care and support for individuals experiencing suicidal feelings
- e) Cross-government action to prevent suicide
- f) Targeted support for, and awareness-raising amongst, higher-risk groups

Participants also shared their priorities for the impact of the National Suicide Prevention Strategy in 10 years' time. A more detailed summary is included below.

#### ***a) Education and awareness raising to reduce stigma and make it easier for people to open up about suicidal feelings and to seek support***

Participants felt that information and communication to 'normalise' conversations about suicide, and to help people to feel more confident both about speaking up and supporting others, could be life-saving. They called for nationwide and extensive awareness-raising amongst the general public, including how to have supportive conversations, how to listen to someone who's feeling suicidal, how to recognise that someone might be suicidal, and how best to support them (including how to access services). As well as communication aimed at the general public, they also felt that awareness-raising should be targeted at people from groups who may be at higher risk of suicide. They hoped that this programme of 'consciousness-raising' would lead to 'supportive communities', safe places for people to discuss suicidality and thus prevent suicide.

There were also specific suggestions for awareness-raising about mental health conditions beyond anxiety and depression, specifically aiming to target stigma around, for example, personality disorders.

Many participants also supported the need for education for children and young people in schools and other youth settings about suicide prevention, acknowledging that this needed to be age-appropriate and evidence-based. There was widespread support for specific training for 'frontline' professionals including the police, paramedics, GP receptionists, teachers and call handlers speaking to people in financial difficulty. As GPs were felt to often lack understanding

or confidence to initiate conversations about suicide – to ‘ask the question’ of their patients – and to be equipped to take positive action when suicidality was raised, compulsory training was recommended.

There was widespread support for suicide-prevention training / awareness-raising in workplaces, and for mandatory rollout of Mental Health First Aiders or similar initiatives.

### ***b) Improving access and quality of care, and consistency of services***

Participants felt that there was still a long way to go to reach ‘parity of esteem’ between physical and mental health services, with the latter in desperate need of more funding and of being treated as of equal value. They wanted consistent services across the country, including types of support available and opening hours, as well as clarity about what services were available and how to access them. There were strong calls for NHS mental health services to be available 24/7, and for timely access to support whenever and wherever it was needed.

Concerns were expressed about exclusion criteria which could prevent people from receiving support, for example because they were deemed ‘too complex’ or high risk for primary care but did not meet the threshold for secondary care. Participants also felt that there needed to be better coordination of care across different services and at points of transition (for example from Child and Adolescent Mental Health Services (CAMHS) to adult services, or from inpatient to community support). They felt that services could be much more joined-up, and better coordinated, for example with regards to signposting and referral, and with regards to access to medical notes including safety plans.

No-one should ‘fall through the gaps’ or be left without support, and everyone should be believed and taken seriously when they speak about suicidality, including if they are under the influence of alcohol / drugs, are well-known to services or if they ‘present’ as ‘in control’. There were calls for a greater focus on ‘early intervention’ and support, including safety planning, and for clear pathways and easy access to support (beyond medication) via GPs. Participants wanted improved access to talking therapies, with these services being available quickly and not time- or session-limited.

There was widespread support for improved access to peer support for people with experience of suicidal feelings, suicide attempt(s) and / or bereavement by suicide, as well as other challenges such as drug misuse. Many participants wanted NHS services to refer to appropriate charity- and peer-led support groups.

There were frequent requests for compassionate care, especially inpatient care, for treatment by professionals who acted with empathy, and services with enough capacity to care. The importance of services being trauma informed was also raised. The need for joined-up,

compassionate support for people with mental ill health / who are suicidal and have issues with alcohol and / or drugs ('dual diagnosis') was another key theme.

Participants strongly supported the more widespread and meaningful involvement of people with lived experience in decision-making, including coproduction and codesign of services.

### ***c) Better crisis support services***

The key calls were for NHS crisis support to be consistently available 24/7, for people to be believed and 'taken seriously' when they say they are suicidal, and treated as an emergency. It was felt that crisis services should be easy to contact and quick to respond at any time of the day or night. Participants wanted clear information about what support is available and how to access it, with consistent services across the country.

They also called for integrated crisis support and crisis teams available everywhere, including a crisis line providing access to both immediate telephone support and triage, professionals able to provide face-to-face support, and support to access a physical safe place such as a 'crisis house'. Participants shared examples of innovative local practice, and felt that this should be learned from and more widely rolled out, for example integrated teams and collaboration between different emergency services. They wanted alternatives to A&E for people in crisis in all areas, for example 'crisis houses', 'crisis units' or 'crisis hubs', or (at least) more supportive environments for people in crisis within A&E. No-one in crisis should be discharged from A&E or other statutory service without alternative support in place to keep them safe. There was also felt to be a need for improved connection between short-term crisis support and longer-term support, including non-NHS support such as peer support groups.

Staff providing crisis support should be able to access individuals' medical history and safety plans. They should provide personalised support, and involve carers / people's friends and family (as appropriate)– and listen to their concerns.

Participants recommended improved and more universal training for GPs and the police about recognising and supporting someone in crisis, as well as mandatory Mental Health First Aiders or people with similar training in all workplaces, able to recognise signs of crisis and provide support / signposting. They also felt that there should be awareness-raising for the public in how to support someone in crisis.

### ***d) Personalisation of care and support for individuals experiencing suicidal feelings***

As well as more consistent and readily-available services (above), participants wanted personalisation of support for people experiencing suicidal feelings including those who 'live with' suicidality, and after suicide attempt(s). There were calls for a more holistic approach to

care including connecting and considering emotional / mental and physical health / wellbeing, and access to support groups, such as charity- and peer-led groups.

There was strong support for people being listened to as individuals – moving away from standardised or formulaic assessment processes. Specifically, participants wanted to see the use of safety plans not ‘risk assessments’, with plans being coproduced with the individual and regularly reviewed, as well as practically used by professionals when someone is in crisis. It was felt that there should be a regular review of an individual’s needs / their safety plan, in line with the schedule of Annual Health Checks for physical conditions. Participants wanted an individual approach to information-sharing and the involvement of family members or close friends, which should be agreed with the individual when they are well.

#### ***e) Cross-government action to prevent suicide***

In order to achieve real impact, participants agreed that targeted cross-government action – and more funding – was needed to reduce deaths by suicide. This should include processes to learn from suicide attempts and deaths by suicide, focusing on understanding ‘what went wrong’ and lessons for the future – with commitment to then making changes. The importance of listening to and involving people with lived experience was highlighted.

As well as improving mental health services (as above), it was felt that action and funding should seek to address known factors and circumstances which put people at higher risk of suicide, including poverty and inadequate / insecure housing. There were specific calls for a more ‘humane’ and compassionate welfare benefits system. In addition, action was recommended to reduce deaths at high-risk locations, such as the rail network, and to improve online safety including on social media.

#### ***f) Targeted support for, and awareness-raising amongst, higher-risk groups***

Participants felt strongly that targeted action was needed to reduce deaths by suicide in groups at higher risk. This included coproduction of services and other ‘solutions’ alongside and in partnership with higher risk communities, and tailored and targeted awareness-raising. They also felt that statutory services should reach out to marginalised and excluded communities, and that outreach services and culturally appropriate support should be readily available.

Groups that participants frequently raised as being at higher risk or that would benefit from targeted support included:

- Students and young people, especially those living away from home, for example at university.
- Prisoners and people leaving / who have recently left prison.
- People who are physically unwell / with a long-term health condition.

- People struggling financially including due to gambling, those with problem debt and those affected by the ‘cost of living crisis’, people affected by or at risk of unemployment.
- Autistic people.
- Lesbian, Gay, Bisexual and Trans (LGBTQ+) people, especially trans people and LGBTQ+ young people.
- People from minoritised, racialised and marginalised communities.
- People bereaved by suicide.
- Workers in high-risk industries and professions for example construction workers, agricultural workers, manual labourers, emergency services.
- Men, including young men.
- Rural communities.
- People living in areas of deprivation.
- People who are part of the same ‘cohort’ as someone who has recently died by suicide either locally or as reported in the press, for example school pupils, members of a particular community of identity.
- People with experience of trauma, including abuse.
- People with issues with alcohol and / or drugs including those with a ‘dual diagnosis’.
- Carers including carers of people living with suicidal thoughts.
- Military veterans.
- Homeless people.

***g) Priorities for the impact of the National Suicide Prevention Strategy in 10 years’ time***

Participants discussed their hopes for the refreshed Strategy, and what they would consider a ‘success’ in 10 years’ time. Overall, they wanted to see cross-government and society-wide focus on prevention and early-intervention – leading to an overall reduction in deaths by suicide, and suicide attempts (with dramatic reductions in deaths and attempts being the ultimate markers of ‘success’), whilst acknowledging that measuring attempts posed difficulties. Suggestions were made for better use of data – including near-Real Time Suicide Surveillance – to respond and learn, and for more nuanced approaches to measuring of ‘success’ and improvement, including consideration of the experiences of people with lived experience.

They also called for more funding for mental health services and suicide-prevention initiatives in the statutory and voluntary sectors. In articulating hopes for better support for people affected by suicidality, specific recommendations were made for trauma-informed services, better coordination and collaboration between services, personalised care, improved crisis support including access to mental health / crisis hubs, and no-one ‘falling through the cracks’ between services due to eligibility criteria or waiting times. Participants wanted coproduced / codesigned services, and support and education for families.

Other important ‘measures of success’ put forward were for everyone to be taken seriously when they say they’re suicidal – and to receive support, and for suicide to no longer be a taboo subject – the end of stigma, which was felt to be linked to the education of young people.

### Further information

For queries about this briefing, please contact [campaigning@samaritans.org](mailto:campaigning@samaritans.org)

Further information about the members of the Suicide Prevention Consortium is available at <https://www.samaritans.org/>  
<https://nspa.org.uk/>  
<https://supportaftersuicide.org.uk/>  
<https://www.wearewithyou.org.uk/>

For more information about the VCSE Health and Wellbeing Alliance please visit <https://www.england.nhs.uk/hwalliance/>

For up to date details of the Governments’ Suicide Prevention Strategy, we recommend visiting [www.gov.uk](http://www.gov.uk) and searching for ‘suicide prevention strategy’.