

Partners in prevention



Introduction

The Westminster Government published a new five-year national suicide prevention strategy for England in September 2023. The opportunity to contribute to the Government’s new strategy was a once in decade moment for people with lived experience to directly input into its development. The final document makes clear that the actions that the Government has committed to in the strategy were shaped and strengthened by people with lived experience of suicide.

“To back up these actions requires high-quality evidence – data and research but also the personal narratives of bereaved families and those who feel at risk. It is their experiences that have raised the public profile of suicide, that have shown us the urgent necessity of doing better on prevention. They deserve our thanks and support – their contribution has been literally vital.”

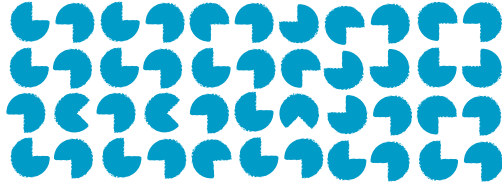
Foreword to the suicide prevention strategy from national adviser Professor Sir Louis Appleby

The Suicide Prevention Consortium brings together Samaritans, National Suicide Prevention Alliance, Support After Suicide Partnership and WithYou. Led by Samaritans, the group works together to use the knowledge of its members and the voices of people with lived experience to influence policymakers to improve suicide prevention in England.

Our work over the last two and a half years has been focussed on informing and influencing the publication of the new national suicide prevention strategy. We responded to the consultation on the creation of the new strategy, and then

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have carried those insights through into the subsequent projects of the Consortium.

In May 2022, we gathered insights for the new strategy through four focus groups with a total of 55 people with lived experience of suicide, self-harm, and / or alcohol or drug misuse. We designed these focus groups together with our policy lead and our Consortium lived experience advisors. The insights were shared directly with officials leading the Government's consultation, who also attended some of the workshops that we ran. Samaritans also shared recommendations drawn from ongoing work exploring, understanding and amplifying the voices of people with lived experience, including the work of the Consortium and inspired 200 people with lived experience to respond directly to the consultation.

This work was highly impactful, with clear priorities articulated by people with lived experience included in the final strategy. In particular, the strategy's ambition:

“ there is no wrong door – when people experiencing suicidal thoughts or feelings reach out, they receive timely support, no matter what service the individual initially accesses. Systems and services are connected around individual's needs ”

resonates very strongly with what the Consortium heard from people with lived experience, both in our specific projects to engage with the strategy's development and more broadly across all the work we have done over the last three years.

We wanted to therefore dig deeper to gather reflections from people with lived experience in the development of the strategy and the success of the Consortium's Health and

Wellbeing Alliance projects. **Our aims with this project were to:**

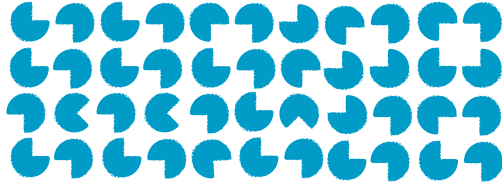
- Highlight how the Health and Wellbeing Alliance programme commitment to inclusion of lived experience voices can directly impact policy and practice.
- Understand the success of engagement of people with lived experience in the suicide prevention strategy, as well as where improvement is needed so the ground is laid for future work in the Consortium, Alliance and beyond.
- Reconnect people with lived experience to the national Suicide Prevention Strategy so they can see the impact of their involvement as well as an opportunity to feed into next steps.
- Add to the evidence base of how involvement of people with lived experience in evaluation of key government policy can inform future practice.

What we did to create this report

We undertook a desk analysis to identify areas where the Consortium's work with people with lived experience informed the new suicide prevention strategy. We then worked alongside the Consortium's lived experience advisors and our policy lead to co-design a survey to both the National Suicide Prevention Alliance and Samaritans' Lived Experience panels.

In our survey, we asked people about their awareness of the suicide prevention strategy and the extent to which they feel that they have been able to contribute. We then sense-checked what we heard in the Consortium's engagement work against what it says in





the Government’s strategy to gain insights on whether the final document adequately reflects what people said needed to change. Finally, we offered the opportunity to tell us more about lived experience engagement to inform our future work.

In total we received 114 responses, all from people who have lived experience of suicide and self harm or of using Samaritans’ service. There was a spread of people from different genders, sexualities, age groups and geographical locations across England.

We built on our survey findings through in-depth discussions with the four lived experience advisors who have been part of our Consortium to date, seeking their views on the survey findings and how lived experience can best be harnessed going forward in suicide prevention policy-making.

The remainder of this report details what we found, and offers reflections and recommendations for the future.

What we found

The majority of people who responded to our survey did not feel that they have been able to contribute to the suicide prevention strategy with 26 per cent of Samaritans panel respondents and 21 per cent of NSPA panel respondents stating yes. However, a further 23 per cent of Samaritans panel respondents and 16 per cent of NSPA respondents were unsure if they have been able to contribute.

This is most likely down to the length of time that has passed since we held our focus groups – it could be that the people who completed this survey were not members of the panel in May 2022 and so did not have the opportunity to contribute, or it could be that they did take part without connecting it to the strategy specifically – or it could

simply be that they do not feel they were able or asked to contribute.

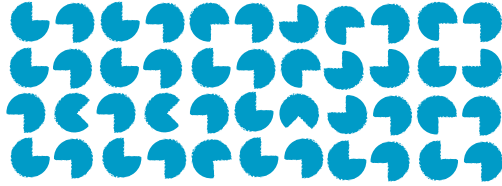
71 per cent of NSPA panel respondents and 45 per cent of Samaritans panel respondents said they were aware of the Government’s strategy. This was the part of the survey with the greatest difference in overall responses between the two panels which is why we have included the findings separately for each panel. It is likely that this difference is due to the fact that NSPA panel members receive more communication about suicide prevention policy and strategy than those connected with Samaritans.

Turning to the key themes we identified, overall respondents were supportive of the strategy and the extent to which it reflects the perspective of people with lived experience. For each of the questions that we asked about whether particular statements in the strategy corresponded to what we heard from people with lived experience, the majority of people responded ‘yes’ or ‘partially’.

Support was strongest for the below statement on **NHS crisis services**, where 92 per cent of all respondents answered ‘yes’ or ‘partially’.

In the workshops, another key thing we heard was – ‘the need for better and more consistent crisis services.’ In the strategy, it says – ‘NHS crisis services, including crisis lines, will continue to be expanded. There will be investment in mental health ambulances and in crisis cafes and other safe places away from emergency services. The quality of crisis services will also be better monitored.’ Do you think this reflects what is needed in the strategy?





However, the comments alongside this top line finding demonstrate that people are continuing to have negative experiences of accessing crisis support, both in terms of being able to make use of this provision and, for some people, unhappiness with the quality of the service that they then received.

“Crisis services are themselves in crisis, its a traumatic service to be part of, from my experience.”

“Crisis services need to be approachable and compassionate. In recent times the staff have become overburdened and burnt out.”

“Crisis cafes sound great in practice, but the three that have opened in our area are nowhere near where I live, so will be inaccessible to many.”

There was also scepticism about the extent to which this commitment in the strategy will translate into reality, given well-known and publicised pressures on public finances.

“I feel like this is something that is desperately needed. What worries me is that the NHS is currently stretched to the limit as it is and further strain without additional resources will lead to major issues.”

“It sounds a good plan but knowing about staff shortages, lack of funding etc and a major problem of poor quality staffing, I do not anticipate this will improve anything sadly.”

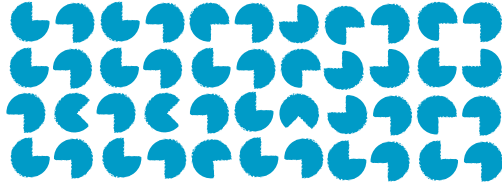
Our discussions with Consortium lived experience advisors reiterated these comments and concerns around the current state of play for crisis service provision, and the need to consider this within a broader difficult environment with lengthy waiting lists for both mental and physical health services. They expressed concern that there is too much reliance on charities to be providing crisis support at a time when there is so much demand across the whole system. Advisors also noted that staff are trying to do their best in under-funded services and that sometimes people with lived experience might have expectations that can't practically be met in the current environment.

There is therefore the risk of a 'translation gap' between the consensus between people with lived experience and policymakers on what is needed, and the challenges of implementation from policy into practice.

There was strong support for the **priority at-risk groups that are outlined in the strategy**, with 84 per cent of people responding 'yes' or 'partially' to this question:

In the workshops, a key thing we heard was – 'the need for targeted action to reduce deaths by suicide in groups at higher risk'. In the strategy, it says – 'there will be tailored and targeted support for children and young people, middle-aged men, people who have self-harmed, people in contact with mental health services, people in contact with the criminal justice system, autistic people, and pregnant women and new mothers.' Do you think this reflects what is needed in the strategy?





However, within this broad support there was recognition that some groups at higher risk were not included, with younger people, people who have attempted suicide, and people bereaved by suicide mentioned most frequently as important omissions.

“ I don't think it covers men enough in the description. All of the suicides I know were young men. ”

“ It doesn't take account of those who attempt suicide – or bereaved people. Both groups are at higher risk of suicide. Focusing on those who complete suicide may omit those who attempt, or have lost someone to suicide and distort your demographic. ”

“ What about people bereaved by suicide? Postvention support can prevent suicide in this community. What about young men? 16-30? ”

Some respondents also felt that an emphasis on at-risk groups was misguided as anyone in the population can be at risk of suicide:

“ Doesn't fully support all groups that are high risk. Anyone can be high risk not just certain groups of people in society. ”

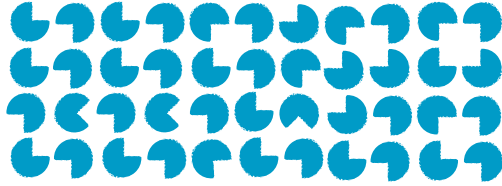
“ Although you have targeted the most high-risk groups, there is a risk of excluding those, like myself, who do not fit in any category, who are not immediately identifiable as at risk within these definitions. Therefore access to effective support could be denied if the criteria do not match. ”

“ With any strategy that makes certain groups a priority, there will be “winners” (those who receive the attention/funding etc) and losers (those who haven't ever received such support or maybe have in the past but under the new strategy no longer will). ”

Our discussions with the Consortium lived experience advisors identified the importance of an intersectional approach to targeting at risk groups. For example, it may be helpful to think about LGBTQ+ men or ethnic minority men when focusing on middle aged men, given the link between protected characteristics and multiple disadvantage.

There was strong support for action to **reduce stigma and increase societal understanding of suicide**, with 88 per cent of respondents answering 'yes' or 'partially' to this question:





In the workshops, another key thing we heard was – ‘the need for education and awareness raising to reduce stigma and make it easier for people to open up about suicidal feelings and to seek support.’ In the strategy, it says – ‘every individual across the country should have access to suicide prevention training, employers should have well-being support in place for their staff, and there should be a national conversation so that everyone feels responsible for ensuring that they are using language that supports people while reducing shame and stigma’ Do you think this reflects what is needed in the strategy?

However, the accompanying comments show that there is the risk of another ‘translation gap’ in this area as many respondents were unsure how this would work in practice or had prior poor experiences of attempts to reduce stigma.

“ Saying isn’t always doing. I don’t believe the stigma around mental health has gone in many parts of life in particular the workplace. ”

“ The conversation around suicide must change so we can freely admit our struggles. Professionals have to hide behind a mask when suicidal, which can contribute to ever increasing pressures to appear to be coping, leading to greater mental crises. ”

“ The strategy sounds good. I’m not sure how it can be delivered, particularly to those who are digitally excluded or unable to access services. ”

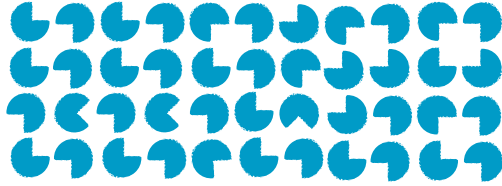
Our discussions with Consortium lived experience advisors emphasised the importance of working towards normalising conversations about suicide, everywhere – in services, in workplaces, in communities and in families. Advisors also noted that lived experience involvement in awareness raising and reducing stigma of suicide has come a long way in recent years, and that awareness days can be a particularly useful tool to build wider understanding.

Our final two questions asked people about the intersection between suicide and alcohol. 83 per cent of survey respondents answered ‘yes’ or ‘partially’ to this statement:



One of the findings from the survey was – ‘alcohol use can exclude people from being able to access support for their mental health.’ In the Suicide Prevention Strategy, it says – ‘the Government and NHS will have an action plan for mental health and substance misuse which will include improving access to mental health services for people using drugs and alcohol as people are currently too often excluded from, and/or fall between the thresholds of services. It will also promote better links between mental health services and substance misuse treatment services to ensure people receive joined-up care.’ Do you think this reflects what is needed in the strategy?





And 75 per cent of survey respondents answered 'yes' or 'partially' to this question:

In the survey on alcohol and suicide, we also heard that – ‘there is a need to improve local commissioning of alcohol, mental health, and suicide prevention services through better national standards. Commissioning should involve people with lived experience.’ In the strategy, it says – ‘new guidance for local authorities has been published to support them in commissioning effective alcohol and drug treatment and recovery services in their area. This guidance encourages a partnership approach to commissioning that includes the local NHS and other health providers in the planning and delivery of these services.’ Do you think this reflects what is needed in the strategy?

There was strong support in the comments from survey respondents for considering alcohol and suicide as co-occurring needs. This was one of the themes that we fed in to the development of the Suicide Prevention Strategy during 2022 and 2023 but has also remained a key focus for the Consortium’s work beyond the publication of the strategy.

“Extremely important. In this area, Wigan, people struggling with substance abuse are regularly turned away from receiving crisis support, unless from a non-profit.”

“My son was often denied access to psychiatric services due to substance misuse. Mental health issues since aged seven so drugs came secondary to mental health not the other way around.”

“There needs to be a fully inclusive service for dual diagnosis in substance misuse and mental health. These problems need to be treated together. Alcohol and drugs worsen mental health; mental health problems often lead to substance misuse. To treat them separately is pointless.”

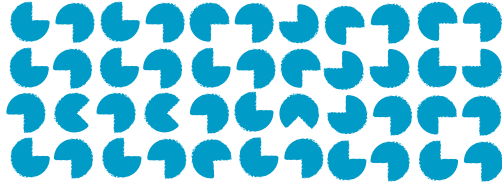
“Definitely think there is a strong link between alcohol and drugs and suicide. I have experience of this link.”

However, there was also a clear call for people with lived experience to be properly included in local commissioning and this came through strongly as an important omission.

“People with lived experience must be included. Who better to progress this forward?”

“It needs to involve people with lived experience of suicidal ideation/suicide as well as lived experience of substance use.”





“ I would like to see this requirement mandated rather than “encouraged”. ”

A **cross cutting theme** in the feedback that we received on all the areas that we asked about was the need to adequately resource the suicide prevention strategy.

“ It is meaningless rhetoric though – no funding has been attached to the strategy so it is just nice words in a report. ”

“ There didn’t feel like a true opportunity to change anything. Money is needed not words. ”

“ To set the aim of targeting specific groups without a huge amount of funding when the current mental health services, CAMHS, etc are failing is pie in the sky. ”

“ It needs proper realistic funding otherwise it remains a dream. ”

The current constraints on public finances therefore risk undermining confidence in how much the new strategy will deliver. In our discussions with lived experience advisors, they noted that there will always be funding constraints and that there could be an opportunity to engage people with lived experience in deciding which areas to prioritise.

There was a strong emphasis in the survey responses on **the importance of continuing lived experience engagement** in the strategy, and a genuine appetite to continue

to contribute and be involved. It is clear that future engagement needs to take a variety of forms to meet the diversity of people’s needs and preferences.

“ Promote a variety of ways in which to contribute to the strategy (focus groups, face-to-face, online, surveys, stakeholder events, etc). Engage people to share real life current lived experience, to learn from what works and what doesn’t. Engage wider stakeholders in the strategy, think outside the box. ”

“ Ask those with lived experience at every stage of designing, canvassing views, recommendations and implementation. ”

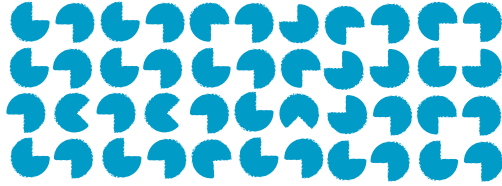
“ I think that like everyone bereaved by suicide we would like to think that our experiences can be shared to prevent others from walking in our shoes. ”

Respondents also emphasised the importance of ensuring people sharing their lived experience are well supported, especially given the nature of drawing on personal experience of suicide and self-harm.

“ Using recognised groups like this network, because people involved need support. ”

“ Recognising it is a task that takes it out of people. ”





These themes already inform the way that the Consortium undertakes its work – we have used a range of different methods to seek insights, including recording audiograms, holding discussions via trusted intermediaries and running our own focus groups and surveys. Our model also includes lived experience advisors in the design of our projects so they are involved throughout, from inception of the workplan through delivery and into evaluation. We have put ethical considerations at the heart of all our projects to ensure that we are keeping welfare at the forefront of our ways of working.

In our discussions with Consortium lived experience advisors, they emphasised that lived experience engagement has to be meaningful and resourced properly, including funding the voluntary sector to take a lead on this engagement. There is also a need to expose the difference that people are making with sharing their perspectives – otherwise there is a risk that people, for example, complete a survey but don't feel like they are really contributing. They expressed concern that mergers and reorganisation of local services can make them feel even more remote and difficult to influence.

The advisors also outlined some initiatives that they have been involved with that have felt meaningful and powerful, such as being mentored ahead of holding discussions with politicians at a party political conference. They also suggested using a menu of topics so that people can choose the topic they are most connected to and provide really detailed insights. The attendance of the mental health minister at the 2024 National Suicide Prevention Alliance annual conference was also highlighted as an example of good practice because this felt like genuine engagement and a reflection of the value of where the minister spends her time.

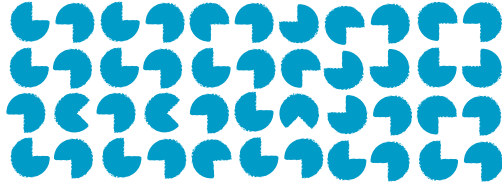
We also asked the advisors about how they are feeling about being involved **in year four of the Consortium's work**. They told us that they feel very optimistic because it is an opportunity for sustained engagement and dialogue rather than a single meeting. But they also rightly emphasised that there is work to do to ensure that this does result in policymakers listening and acting on what they hear from people with lived experience. Our advisors also noted that they have sometimes been disappointed by other projects that they have been involved in (outside of the Consortium's work), which means that their optimism for the Consortium's work in the year ahead is conditional on it continuing to be a high quality experience where they can see the impact that they have had. Advisors also commented that on the importance of maximising the ongoing impact of outputs beyond the end of projects, and showing how the Consortium's work may have fed in to or inspired other initiatives.

Our reflections and recommendations

It is clear that lived experience is a valuable and valued part of policy making on suicide prevention. The 2023 national strategy for England reflects and includes the perspectives of people with lived experience, including use of some of the specific messages from the Suicide Prevention Consortium's work as part of the Health and Wellbeing Alliance.

However, we found that the majority of people who responded to our survey were not aware of the suicide prevention strategy and felt that they hadn't had an opportunity to contribute. It is therefore vital that the Consortium, system partners and others continue to invest in offering as many





meaningful opportunities for involvement as possible – and that opportunities take a diverse range of forms to increase the likelihood of meeting people ‘where they are’. There is also a clear need to communicate the impact that lived experience involvement has had back to people involved, so they can see the value that they have added. While this is intrinsically valuable, it will also help to keep faith with people with lived experience to continue to be involved in shaping suicide prevention policy and practice.

Linked to this, there could be merit in policymakers adding more detail and articulation about why there is a focus on particular population groups in the suicide prevention strategy to build understanding amongst people with lived experience. While a focused approach will always be at the expense of universality, there could be a helpful role for people with lived experience to play in supporting a periodic review of the priority groups over the five-year lifetime of the strategy.

There was real strength of feeling in our survey responses about the importance of considering alcohol and suicide as co-occurring needs. A requirement to involve people with lived experience of these co-occurring needs in local commissioning of drug and alcohol treatment services would help to make the ‘no wrong door’ principle a reality.

This project also found a clear ‘translation gap’ where there is consensus on national policy solutions and priorities that doesn’t correspond with the reality of practice and lived experience in local areas. This has already informed our year four workplan for the Consortium which is focused on unlocking what the barriers are to implementation of agreed good practice.

However, it is also clear that resources are one of the significant barriers impeding delivery in this space. While the Consortium has limited power to influence the future allocation of public spending, it is vital for policymakers to consider the risks of losing faith from people with lived experience if there isn’t the funding to operationalise the commitment to taking cross-government action to reduce suicide rates.

Contact a Samaritan

If you need someone to talk to, we listen.

We won’t judge or tell you what to do.

Call us any time, day or night, for free on 116 123 or visit [samaritans.org](https://www.samaritans.org) for other ways to get in touch.

Whatever you’re facing, a Samaritan will face it with you.

