SAMARITANS

Suicide prevention principles: from policy to practice

Suicide Prevention Consortium

March 2025

National Suicide Prevention Alliance

Support After Suicide Partnership

withyou

VCSE health & wellbeing alliance

Executive summary

The Suicide Prevention Consortium has identified two fundamental principles for ensuring effective, compassionate care for people experiencing suicidal thoughts or feelings, self-harm, suicide attempt(s) and / or bereavement by suicide:

- there must be **no wrong door** to accessing support, and
- care must be **person-centred**.

In this report, we call for policy makers and practitioners to take sustained and targeted action to improve care by:

- **Fostering collaboration**
- **Prioritising inclusion**
- **Raising staff awareness and building confidence**
- **Supporting the workforce**

We believe that delivering on these commitments will improve outcomes and ultimately save lives.

What is the Suicide Prevention Consortium?

The Suicide Prevention Consortium is made up of four organisations: Samaritans, National Suicide Prevention Alliance (NSPA), Support After Suicide Partnership (SASP) and WithYou, alongside three NSPA Lived Experience Influencers (people with lived experience recruited from the NSPA's Lived Experience Network). 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.

Contents

Overview

Since 2021, the Suicide Prevention Consortium has identified systemic barriers, amplified the voices of people with lived experience, and advocated for meaningful reforms in service delivery, including in relation to alcohol and suicide[1], economic disadvantage[2], and people with no fixed address[3].

Over the course of our work, two key principles emerged:

- there must be **no wrong door** to accessing support, and
- care must be **person-centred**.

No wrong door to support

When people reach out for support with suicidal thoughts or feelings, self-harm, suicide attempt(s) and/or bereavement by suicide, they should be supported to access the care they need, the first time they seek support, wherever that may be. Services should directly support people who are seeking help and provide support to access additional or alternative support where needed, for example through referral or signposting.

Person-centred care

People should be treated as individuals. They should be taken seriously and treated with compassion whenever and wherever they seek support for suicidal thoughts or feelings, self-harm, suicide attempt(s) and/or bereavement by suicide. This means that people should be listened to, with their personal wishes and perspectives prioritised, able to take a lead in decisions about the care they receive.

Care must make accommodations and remove barriers. It should be informed by, and sensitive and inclusive of, people's identities and experiences. Everyone deserves support for experiences related to suicide and self-harm that makes them feel supported, and that recognises them as individuals.

Overview

Throughout our engagement with professionals and people with lived experience, we have consistently heard about a critical gap between policy and practice. For example, while the Suicide Prevention Strategy for England (2023-2028) calls for a 'no wrong door' approach[4], many people still encounter rigid eligibility criteria, services working in silos and stigma, which prevent them from accessing the help they need. We've heard that this disproportionately affects those with co-occurring needs, such as alcohol use and / or stigmatised diagnoses such as Personality Disorder. Our findings indicate that mental health services often exclude individuals with alcohol-related issues, while alcohol services are unwilling or feel unable to discuss mental health or suicidality[5]. This siloed approach exacerbates risk factors and denies people holistic, person-centred care.

In 2024/25, we have brought together learning from previous projects and from focused engagement activity (see appendices A and B for more detail on methodology and previous work), to offer insights and practical actions to address these principles. We firmly believe that the principles of 'no wrong door' and 'person-centred care' are essential for people to receive the best support for suicidal thoughts or feelings, self-harm, suicide attempt(s) and / or bereavement by suicide.

We have identified four actions (all equally important) where sustained and significant effort is required from policy makers, commissioners and practitioners to make these principles a reality for people experiencing suicidality:

Action 1: Fostering collaboration

Collaboration – between services, staff and people receiving support – must be at the heart of service design and delivery. Services need to work in a joined-up way, collaborating with each other and the people they support. This includes improving technology and ensuring data can be shared securely, as well as involving people with lived experience in design, implementation and evaluation of services.

Action 2: Prioritising inclusion

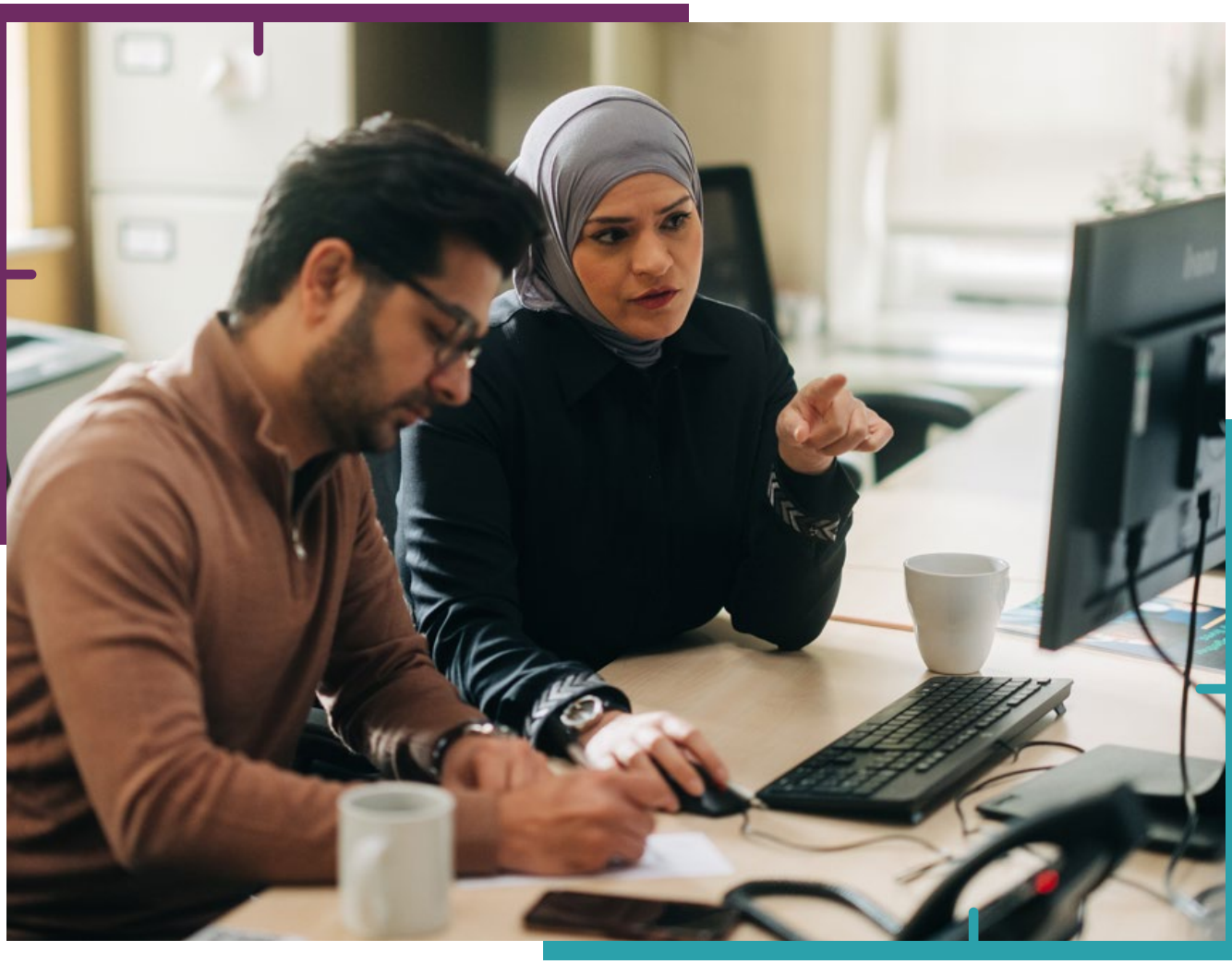
Services should take an inclusive, holistic approach, recognising individuality and the diverse ways people access support. A person's identity, background or specific needs must not be a barrier to accessing high quality care. Individuals should be empowered to make decisions and engage openly with healthcare professionals without fear of judgment. Accessible and culturally sensitive approaches are essential for building trust and ensuring meaningful support.

Action 3: Raising staff awareness and building confidence

Staff awareness should be raised, and ongoing training provided, to boost confidence in delivering compassionate, patient-centred care. It is also vital that good practice is recognised and celebrated – many practitioners are already delivering compassionate, inclusive care. The principles of 'no wrong door' and person-centred care should not, therefore, be presented as another new initiative.

Action 4: Supporting the workforce

It is essential to prioritise the mental health and wellbeing of staff, so they can effectively support people affected by suicide. Staff need time and space to reflect on their experiences of supporting people experiencing suicidality, as well as support to manage the impact of providing care. These are crucial for creating supportive environments for staff, minimising the potential impact of compassion fatigue or vicarious trauma, which impact both on the wellbeing of staff and on their ability to provide optimal care.



Chris O'Donovan Photography/Samaritans

Action 1: Fostering collaboration

Services should be designed and delivered in ways which facilitate collaboration across mental health, primary care, substance use and social care, and including the Voluntary, Community and Social Enterprise (VCSE) sector as trusted partners. Joint training sessions, shared care pathways and consistent communication across teams can reinforce staff confidence that they are not working in isolation.

The need for collaboration has been raised throughout our work, both in relation to how services meet the needs of different groups and how they work with each other. This is particularly important for people who may be accessing multiple services, and for those who are often stigmatised, excluded or underserved, such as those with co-occurring needs like alcohol use, or who have no fixed address[6].

Confidence grows and access improves when staff feel part of a well-coordinated, multidisciplinary system. Having dedicated suicide prevention specialists or crisis team liaisons can provide an additional layer of expertise and support for staff managing complex cases.

Effective collaboration means that people seeking support for suicidal thoughts or feelings, self-harm, suicide attempt(s) or bereavement by suicide should experience seamless care and support, provided by appropriate specialists. No-one should 'fall between the gaps' of eligibility criteria or be left 'in limbo' between services / support.

> "The home treatment team was excellent in supporting me. They were non-judgemental, kind and took the time to get to know me. They didn't invalidate my thoughts and they encouraged me to reach out for the appropriate support. They referred me to the CMHT [Community Mental Health Team] with whom I am receiving ongoing support, and even dropped me off at A&E when I felt unsafe."
>
> **Person with lived experience**

Effective collaboration with people with lived experience through involvement and coproduction in design and commissioning of services, as well as in service delivery, monitoring and review, will lead to more person-centred care, and improved outcomes for all.

Action 2: Prioritising inclusion

Services must be designed to be inclusive and delivered in inclusive ways. This includes practical adjustments to ensure accessibility, communication and information that reflects diversity, and the ability to be flexible in providing the right care for each individual.

Truly accessible service delivery is personalised and tailored to each individual, recognising that people access services in different ways, including in a physical setting and online or over the phone. Partnering with trusted organisations from the VCSE sector can help services to better understand and to proactively engage with underserved communities such as Gypsy, Roma and Traveller communities, faith groups and LGBTQ+ communities. For example, our work in 2023 looking at the experiences of LGBTQ+ people around alcohol, suicide and self-harm highlighted the need for inclusivity and personalisation in relation to identity[7]. When providing care, it is important to consider the cultural context and what improvement or recovery means for that individual, and what their support system might look like.

> “Faith is really important to me. [I] met someone who brought and reminded me of the value of faith last year, going to church every Wednesday, but couldn’t sustain it... I know that going is good for me and for the community.”
>
> **Person with lived experience**

It’s also vital to work with the person who is receiving care, ensuring they are empowered to make decisions, and to engage in open dialogue with healthcare professionals. We have heard throughout our work that participants felt concerned about opening up about suicidality for fear of being judged or referred immediately to the police or other emergency services. People accessing support, especially for the first time, may be anxious, have a lot of questions about their options and the practicalities of getting help. It is therefore very important that information is made easily available, accessible, and thoroughly understood.

> “[My GP] actually listened to what I had to say and took the time to ask questions. After that, he asked me what I needed, he trusted me to know what I needed and he provided it where he could.”
>
> **Person with lived experience**

Action 3: Raising staff awareness and building confidence

> [We need] continuous improvement of services: don't just do things because we've always done them, we need to scrutinise and improve.

Practitioner

We heard from both policymakers and practitioners that they were keen to prioritise training, but had concerns around justifying the time away from delivering frontline services. This echoes what we heard from people with lived experience in previous projects, including our 2024 report 'Tomorrow is too late: suicide prevention support for people with no fixed address'[8].

> Are they fully trained on the challenges people are facing? Because sometimes if you don't know something, you're not even aware of it and you don't acknowledge it.

Person with lived experience[9]

Training on practical skills like personalised safety planning, recognising risk factors, and understanding the interconnected roles of mental health, physical health, substance use and social determinants in suicide risk can all help improve the confidence of staff and outcomes for patients. Practitioners mentioned being aware of changes to best practice and principles including 'no wrong door', but not always knowing how to implement them in their work.

Specialised training, particularly that led by VCSE organisations with relevant expertise and relationships, can address gaps in knowledge around specific populations such as LGBTQ+ people, people from racialised communities or people experiencing homelessness, enabling staff to provide inclusive and culturally sensitive care. These issues may not have been covered in initial training, and best practice evolves over time. Continuing professional development is crucial to improving outcomes for people experiencing suicidality, particularly for those with multiple needs such as co-occurring suicidality and alcohol issues[10]. Training that is led or informed by people with lived experience enhances impact for practitioners and helps to reinforce the need to centre people's experiences when providing care.

Practitioners explained that they need clarity about the pathways available to people in crisis. Managers can support their teams by ensuring up-to-date information is shared on local and national services, referral mechanisms, and crisis resources. Having clear protocols in place, including evidence-based approaches for managing risk, can reduce uncertainty and improve outcomes for patients. Managers and supervisors should also ensure that staff have time and space to engage meaningfully with people who are distressed, countering the pressure to move quickly through assessments that can feel impersonal or rushed.

Action 3: Raising staff awareness and building confidence

An essential part of building confidence among staff is recognising and championing current good practice, and compassionate, person-centred care. For instance, we heard from people with lived experience about practitioners routinely checking-in with them, especially during periods of waiting for a support worker or for longer-term support. This demonstrates empathy and person-centred care in practice.

> “The waiting time was not too long, and they checked in with me while I was waiting for a counsellor to be assigned.”

Person with lived experience

People with lived experience explained that person-centred care often begins with simply taking the time to allow them to speak openly about their suicidality.

> “My psychologist in particular is great at sitting with my suicidality and giving it space, and acknowledging and understanding its presence, and the role it has in my life. She doesn’t shut conversations down. [...] I am grateful she is able to hold her worries and prioritise what would be more helpful for me.”

Person with lived experience

Action 4:
Supporting the workforce

> “I’ve never heard from a colleague that they are struggling. We don’t talk about it in terms of ourselves so why would we with clients?”

Practitioner

> “We need to start with the basics: looking after and talking to staff about how they really are, making it normal for staff to talk about.”

Practitioner

Service managers as well as professional bodies and responsible directors all play a critical role in equipping frontline staff with the confidence and skills needed to effectively support people experiencing suicidality. Health and care professionals may feel uncertain about how to initiate conversations, respond with empathy, or manage the complexities of co-occurring issues like drug and alcohol use. Building a supportive, informed and empowered workforce requires a combination of training and development, resource allocation, and ongoing professional support including regular one-to-one meetings and opportunities for clinical / professional supervision. Working collaboratively across teams and services, including statutory and VCSE sectors, supports sharing of expertise and builds connections that enhance service delivery and staff wellbeing.

> “Staff will need ongoing mental health support, [so] that they can reach out at any time in case they are affected by what they deal with.”

Practitioner

Practitioners need to feel that their organisation supports them emotionally and professionally when working with the challenging scenarios surrounding suicidality. Managers can foster a psychologically safe workplace by normalising discussions about the emotional impact of suicide prevention work, and offering reflective practice sessions and team debriefs. Embedding a culture of support also includes addressing the stigma that staff themselves may face when sharing their own uncertainties or emotional strain. Working with suicidality can have an emotional impact, and accessible peer support networks, mental health resources and regular supervision can mitigate burnout and build resilience among staff.

Fostering a supportive workplace culture and ensuring clear guidance and collaboration can empower practitioners to feel confident and prepared to provide compassionate care for individuals experiencing suicidality. A workforce that is well-supported will not only improve outcomes for people they are supporting but also sustain the wellbeing of those who deliver care.

Conclusion

The Suicide Prevention Consortium has worked to bridge the gap between policy and practice. Our findings have highlighted the systemic barriers that persist in delivering compassionate, inclusive, and accessible support for people experiencing suicidality. While national guidance promotes these principles, lived experience and practitioner insights highlight significant gaps in implementation, especially for individuals with co-occurring needs or those from marginalised communities.

To address these challenges, our recommended actions emphasise the need for integrated care pathways, tailored workforce training, and cross-sector collaboration. Recognising and celebrating existing good practice is critical, as is providing staff with the resources, mental health support, and time necessary to provide person-centred care. Fostering an inclusive culture that prioritises the diverse needs of individuals can ensure services meet people's needs and preferences, leading to better experiences and more appropriate care.

Our work reinforces the importance of embedding these principles across the sector. By prioritising collaboration, ongoing training, and the emotional wellbeing of staff, organisations can build confidence and capacity to support people effectively. Most importantly, services must actively engage with people with lived experience, whose perspectives offer invaluable guidance on how to make these principles a reality.

With a collective commitment from policymakers, practitioners, and the wider community, we can create a system where no-one seeking help feels excluded or unsupported, ultimately improving outcomes and saving lives.

Appendix A: Methodology

Overview

For our 2024/25 project, we built on insights gathered through previous work (see appendix B) and brought together the perspectives of people with lived experience, policymakers, and practitioners to understand how the principles of a 'no wrong door' approach and person-centred care should be implemented.

Engaging with policy leads and practitioners

We hosted two online workshops with practitioners, including drug and alcohol recovery workers, homelessness support workers, and social workers. We also hosted a workshop with suicide prevention leads from seven different local authorities and two Integrated Care Systems.

Following the workshops, a thematic analysis of all responses was conducted. We used this analysis to map the perceived barriers and enablers to both principles.

In order to better understand the different perspectives, we developed user personas based on workshop attendees, plotting their frustrations, needs, awareness of the principles, and their priority as a target audience.

Working with people with lived experience

We invited people with lived experience of suicide to share personal examples of receiving support that demonstrated 'no wrong door' or 'person centred and inclusive care' principles. People were invited to describe their experiences via writing on a free text survey, with the option of contacting us to share in a different way. We shared the invitation throughout our networks, including NSPA's Lived Experience Network, Samaritans Lived Experience Panel, and with National Survivor Network (NSUN). 17 people shared examples, and these were included in the thematic analysis and have informed this report.

Appendix B: The Suicide Prevention Consortium

The Suicide Prevention Consortium includes Samaritans, National Suicide Prevention Alliance (NSPA), Support After Suicide Partnership (SASP) and WithYou, alongside three NSPA Lived Experience Influencers (people with lived experience recruited from the NSPA's Lived Experience Network). As part of the VCSE Health and Wellbeing Alliance[11], it aims to bring the expertise of its member organisations and the voices of people with lived experience directly to policymakers, to improve suicide prevention in England.

Since 2021, the Consortium has sought to influence national policy and strategy, and local service design and delivery, to improve the experiences of people with suicidal thoughts or feelings, self-harm, suicide attempt(s) and/or bereavement by suicide. This has included a particular focus on services and support for people who may be more likely to experience exclusion, stigma or poorer outcomes - and ensuring their voices are heard.

The Consortium's work has focused on making actionable recommendations, including removing exclusionary eligibility criteria which can act as a barrier to accessing services, and enhancing workforce training to increase understanding of the different needs people may have. At the same time, we recognise the challenges posed by resource constraints, pressures on the workforce, and the persistence of stigma.

People with lived experience are part of the Consortium's main project team, collaborating in decisions at all levels of our projects. All the Consortium's projects have centred the voices, experiences and expertise of people with lived experience, recruited through our networks, including NSPA's Lived Experience Network, and Samaritans Lived Experience Panel. This has included:

- Workshops and focus groups to explore experiences of people with no fixed address, economic inequality and suicide, and to inform the National Suicide Prevention Strategy (2023-28).
- One-to-one conversations with people with lived experience through semi-structured interviews to hear about experiences of LGBTQ+ people and alcohol, and of support pathways for alcohol use and suicidality.
- Inviting a wide range of people to share their experiences and insights through surveys for our first project on alcohol and suicide.
- Working with people from Gypsy, Roma, Traveller and Showmen communities to share their experiences related to suicide, coproducing audiograms.
- Partnering with the Ideas Alliance, who used a community reporting approach to work with people with lived experience as part of our project on economic inequality and suicide prevention.

Appendix B: The Suicide Prevention Consortium

Our publications include:

- Insights from experience: alcohol and suicide (2022)
- Lived experience insights to inform the refreshed National Suicide Prevention Strategy (2022)
- Alcohol and suicide: insights from LGBTQ+ communities' experiences (2023)
- Insights from experience: economic disadvantage, suicide and self-harm (2023)
- Partners in Prevention (2024)
- Blog series:
  - Gypsy people and suicide;
  - New Travellers and suicide;
  - Roma people and suicide;
  - Showmen and suicide (2024)
- Exploring experiences of accessing support for alcohol issues and suicidal ideation (2024)
- 'Tomorrow is too late': suicide prevention support for people with no fixed address (2024)

Appendix C: Final reflections

We are proud of the work that the Suicide Prevention Consortium has accomplished and have deep gratitude to those who made it possible. We are particularly grateful to everyone who shared their personal stories, insights and expertise with us. We remain dedicated to driving meaningful, lasting improvement in suicide prevention efforts across England.

Our thanks to the members of the Suicide Prevention Consortium (past and present) who have co-authored this report:

- Eva Bell, Former Participation Officer, Samaritans
- Emily Butler, Campaigns and Involvement Manager, Samaritans
- David, Lived Experience Influencer
- Katie Hickmott, Lived Experience Influencer
- Debbie Laycock, Head of Policy, Public Affairs and Campaigns, Samaritans
- Sarah Marsay, Suicide Prevention Consortium Coordinator (Freelance)
- Robin Pollard, Head of Policy and Influencing, WithYou
- Amanda Saville, Statutory Lead, Samaritans
- Michelle Stebbings, Executive Lead, Support After Suicide Partnership (SASP)
- Andy Willis, Lived Experience Influencer
- Holly Wood, Former Senior Policy and Research Officer, WithYou
- Jess Worner, Lived Experience Network Manager, National Suicide Prevention Alliance (NSPA)

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Sources of support

Samaritans is available, day or night, 365 days a year, to listen and offer a safe space to talk whenever things are getting to you.

Helpline: 116 123

Website: samaritans.org

WithYou provide free, confidential support with alcohol, drugs or mental health from one of 80 local services in England and Scotland or online.

Website: wearewithyou.org.uk

Further information

For more information about this report, or the work of the Suicide Prevention Consortium, please contact the Policy, Public Affairs and Campaigns Team at Samaritans by emailing **campaigning@samaritans.org**

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