Suicide Prevention Consortium: Insights Report (March 2026)

How could the 10 Year Health Plan support suicide prevention?

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1. Overview

In early 2026 the Suicide Prevention Consortium (SPC) engaged with people with lived experience of suicide to better understand how the 10 Year Health Plan can support people at risk or with experience of suicidality, and have maximum impact on suicide prevention. Conversations focused on the establishment of Neighbourhood Health Centres and the expansion of digital NHS services; however, feedback is relevant to implementation of the Plan more widely, which we hope these insights will inform.

2. Key insights

There were some strong themes across conversations, with participants calling for:

- ‘Safe spaces’: recognising the importance of face-to-face and online ‘safe spaces’ for people with experience of suicidal thoughts or feelings, and for people bereaved by suicide.
- Accessibility and inclusion: ensuring that developments will reduce (not worsen) health inequalities, and support that meets the needs of marginalised and excluded groups.
- Involvement and coproduction: working with communities and service users in design, development, and ongoing review, listening to and acting on feedback for continual improvement.

- ‘Parity of esteem’: prioritising suicide prevention, thinking carefully about how to support people to manage their mental and emotional health on a day-to-day basis and how to improve access to support when people are in crisis.
- Collaboration: integration of services; holistic, coordinated, person-centred care.
- Human connection and compassion: valuing care and kindness.
- Empowerment: supporting choice and control including through transparency and personalisation. Building trust through honest communications.

3. Activity

During January and February 2026, the Suicide Prevention Consortium hosted six online engagement sessions recording 46 participants (some people attended more than one session). Participants had lived experience of suicidal thoughts or feelings and/or suicide attempt(s), and included people bereaved by suicide.

For more information about our methodology see the appendix.

4. Summary of findings – Neighbourhood Health Centres

Neighbourhood Health Centres will bring together a range of NHS and community services, supporting care closer to home and improved access.

Overview

> *“…warm, welcoming safe space, non-clinical looking where you can get the right support at the right time, with everything under one roof, no waiting list...”*

Overall, participants felt cautiously optimistic about Neighbourhood Health Centres, recognising the potential for improved accessibility and experience. However, they highlighted the need to ensure that suicide prevention and mental health were prioritised alongside physical health. They hoped that the opportunity would be taken to tackle stigma and improve crisis support. The three overarching themes were to ensure that the Centres offer a **safe and welcoming environment**, **improved access to NHS services** and support, and are embedded as part of **communities**.

Theme 1: a safe and welcoming environment

Safety

> *“…one of the most important things…is that safe space…No matter what else is going on in their lives, they can go there and they can feel safe, they can feel heard.”*

Safety has a broad definition in the context of healthcare, including physical, practical and psychological dimensions. Participants were clear that people accessing Neighbourhood Health Centres must feel safe and be kept safe, and that Centres need a reputation as ‘safe spaces’ locally. This includes thinking carefully about how to design Centres and how they operate to ensure they can safely and effectively support people experiencing crisis and / or psychosis, as well as those seeking low-level support with their mental or emotional health. Participants also flagged that the co-location of support for people with issues with alcohol or drugs needs to be managed to ensure the safety of all service users.

The Centres must be accessible and welcoming for all, and keep everyone safe, including vulnerable people, marginalised and stigmatised groups. Spaces, services and ways of working should be trauma-informed and designed with sensitivity and awareness of diverse needs. This includes quiet spaces and consideration for those whom privacy may be particularly valued, such as NHS professionals seeking mental health support themselves. Safety also has clear links to addressing stigma (as below).

> "*How do we ensure that [it's] a safer space than the spaces that currently exist that people don't want to visit?"*

Location and layout

> *"…that idea of a safe space and it not being so clinical and harsh."*

A common theme was for careful consideration to be given to the location of Neighbourhood Health Centres, ensuring that they are accessible by car (with free or affordable parking nearby) and by public transport, and ideally having pleasant surroundings (such as access to green space). Centres should be safe, welcoming, comfortable, clean and calm environments. They should be light and airy, as 'non-clinical' in appearance as possible, and designed in a way which is trauma-informed and avoids stigmatising people accessing support for their mental health or suicidality (thinking about signage, terminology and location of specialist services).

Access for disabled people including wheelchair users, and neurodivergent people, should be built-in, including thinking about the sensory environment. Participants suggested that food and refreshments – especially hot drinks – should be available at all times, as well as Wi-Fi, and that distractions such as jigsaws, (live) plants and colouring books can all help people to settle and feel safe. The availability of more private, quieter spaces, where people can 'take time out' and feel less 'on show', was felt to be important. The possibility of Centres offering people somewhere to sleep if they were in crisis was suggested.

Accessibility and inclusion

Participants felt strongly that Neighbourhood Health Centres must be accessible for all and have inclusivity 'designed in'. This includes taking action to identify and address potential barriers to accessing services and support, thinking particularly about access for groups and communities who are more likely to experience exclusion and discrimination, such as Gypsy, Roma and Traveller people. Centres must be welcoming to everyone including young people and marginalised groups.

Accessibility needs to include physical access into the building and to internal spaces, how services are provided (such as having drop-in opportunities as well as bookable appointments), and addressing psychological barriers, such as stigma and the perception of the Centre locally. The latter means thinking about the terminology used to refer to the Centre and to describe the services available. For example, being clear that preventative and early-intervention support is available as well as support for people in crisis.

Inclusivity includes staff attitudes and the ability to be welcoming and supportive for anyone who may be in crisis and/or who is bereaved by suicide, even if they are not clinically trained (linked to 'supported and supportive staff'). This includes being able to provide culturally sensitive support. The best way to ensure accessibility and inclusivity is to codesign Centres and services with local communities and marginalised groups, as well as learning from regular feedback (see 'designed with local communities and informed by service user feedback' below).

> *"…certain populations…migrants and refugees…the homeless, Gypsy, Roma [people]…It can't be that they're forgotten or excluded as they set up the Centres…"*

Participants queried the definition of 'neighbourhood' and how 'local' and 'accessible' Centres will be, particularly for disabled people and people living in rural areas, especially areas with poor transport links.

Supported and supportive staff

> *"The first person you see/speak to must be welcoming and friendly."*

> *"Supporting the wellbeing of service providers, preventing burn out..."*

As a key part of creating and maintaining a welcoming environment, participants highlighted the culture and support available for staff. This includes ensuring that all staff – clinical, managerial and administrative – receive training in suicide prevention and how to support someone in crisis, struggling with their mental health, experiencing suicidal thoughts or feelings, or bereaved by suicide. It also includes putting systems and ways of working in place – building a culture – which enables and empowers all staff to support someone in suicidal crisis or distress. Even if this is 'just' making a hot drink and helping them to feel comfortable whilst they wait to be seen. Participants spoke about the need to support staff, and to avoid 'empathy fatigue'.

The importance of 'the first person someone sees', especially reception staff, in 'setting the tone' for a visit, making a 'human connection' and helping people feel safe, was highlighted. Above all, everyone who is working at a Centre should treat others with compassion, and wherever possible give people time and space to talk.

Theme 2: improved access to NHS services and support

Access to specialists

> *"…the ideal Neighbourhood Centre surely would have some community mental health team in there, or possibly an urgent care and assessment team."*

To be effective, participants called for Neighbourhood Health Centres to enable improved access to a wide range of NHS professional support. This would include mental health specialists such as crisis support, talking therapies, and liaison psychiatry (in addition to 'access to wider (non-NHS) services and support', as below).

Participants suggested the Centres as venues for mental health outpatient appointments (currently usually at a hospital) and drop-in mental health support, as well as assertive outreach and specialist support groups. They also suggested that they could be places where people could access online Cognitive Behavioural Therapy (CBT), and other online learning programmes and resources which support self-management and self-care. The Centres could act as bases for Social Prescribing Link Workers and for advocates including Independent Mental Health Advocates (IMHAS). Centres could act as hubs to enable quicker and more effective access to psychological therapies, as well as speeding up access to crisis support. At the same time, they should explicitly also focus on prevention, early intervention and supporting people to avoid crisis.

Parity of esteem

> *"…I think the danger is that it will become more centred around the physical health…there should be surely a lead GP in these Neighbourhood Centres that advocates for mental health and suicide prevention…If there's not…we'll miss the opportunities to actually support around suicide prevention."*

One of the strongest themes from participants was a call for Neighbourhood Health Centres to explicitly and demonstrably prioritise mental health and wellbeing, and specifically suicide prevention, alongside physical health. The need for 'parity of esteem' came through clearly, with participants often expressing concern that mental health and suicide prevention might 'lose out' or be less of a priority.

Communication and information must be clear that the Centres are for support with mental and emotional health and wellbeing – in terms of prevention, self-care, self-management and early intervention – as well as for mental health services and treatment, including (but not limited to) crisis support. Alongside this, the holistic nature of health and wellbeing, and the strong connections between physical and mental health were highlighted, including as part of calls for more personalised care.

Actions to address health inequalities should consider access and outcomes relating to mental health and suicidality, as well as physical health inequalities.

Linked to discussions around stigma, staff training and the need for safe and welcoming environments, participants highlighted the ongoing need to tackle lack of understanding and awareness around suicidality. They called for training and commitment to suicide prevention from all clinicians, and for all staff to understand how critical their actions can be for someone in crisis. It was suggested that professional leads for suicide prevention were identified within all Centres, making responsibility and priority clear, ideally including at least one GP.

Round the clock care

> *"…if it's going to be 24/7, actually 24/7, and if you'd go at half ten in the morning, or at half ten at night, you're actually getting the same service."*

Participants hoped that Neighbourhood Health Centres would provide genuine '24/7' access to services and support, for everyone, including people in crisis. In an ideal world, this would mean that all services are available any day of the week, and at any time of the day or night, and that the environment is always welcoming and supportive. Examples of this were whether you could always get a hot drink and whether someone in crisis could always 'just drop in' and find a safe space and receive the support they needed. In person 24/7 services should also be supported by a telephone helpline. 24/7 services cannot be for some people and not for others.

Joined-up and personalised care

> *"It's about responsivity; listening and responding to individuals' needs."*

> *"…we can have all these services, but if they're not communicating between themselves…people fall through the net…a mental health plan should be a treatment plan with follow-ups…a sense that somebody else is carrying this load for the person who cannot, at the moment, carry it for themselves."*

Neighbourhood Health Centres have the potential to support improved collaboration and communication between teams and services, breaking down professional silos and providing more personalised, patient-centred care.

Multi-disciplinary teams, working well together, with shared records across both mental and physical health, could transform the service user experience. Participants hoped for better connection between services, with professionals having access to shared records. There were calls for drop-in opportunities as well as easy access to bookable appointments, options for joint appointments, and better coordination. This would reduce the need for multiple visits and support a more holistic approach to wellbeing. Some participants called for access to consistent professionals, including a GP, where this is helpful.

Improved sharing of information was also felt to improve safety and safeguarding, ensuring that vulnerable people did not ‘fall through the gaps’.

The Centre as a hub

> *“…I'm an absolute advocate of, you know, you have a Centre, but you've also got to have that outreach area and have that hub-and-spoke type approach…”*

At their best, it was felt that Neighbourhood Health Centres could act as a ‘hub’ and coordination point in a network of connected care and support. Participants spoke about home visits and follow-up after appointments, including as part of a Mental Health Treatment Plan, and the need for outreach support. Services should identify people who may find it difficult to access support and take steps to connect with them instead, recognising how difficult it can be to reach out when experiencing suicidal thoughts or feelings. This should be aligned with personalisation, prevention and early-intervention.

Participants felt that Centres should be linked into, and coordinate, different NHS support and services, as well as being well-connected into communities. For example, through Social Prescribing and wider links with Voluntary, Community and Social Enterprise (VCSE) organisations, training and development opportunities, and actions to tackle stigma. They could also support people to access online support.

Theme 3: embedded as part of communities

Access to wider (non-NHS) services and support

> *“I see them as a real opportunity…to embed mental health peer support...there should be a real focus on prevention and for early help…to rethink how mental health care is delivered and how suicide prevention is based in the community.”*

To better support health and wellbeing, participants suggested that a wide range of (non-NHS) services and support should be co-located as part of Neighbourhood Health Centres. This includes ‘practical support’ for problems known to impact on people’s mental health, such as housing and homelessness, debt, gambling and domestic abuse. It includes consideration of the social determinants of health and responding to the demography and challenges facing local communities. Where it is not possible to co-locate services, Centres should be able to signpost and support individuals to access alternative sources of support in the community. There should be links to education, and advice and support for parents of children/young people experiencing suicidality.

Where possible, Centres should also act as (or be part of) ‘community spaces’, including facilities and services which support people’s wider health and wellbeing. These could include cafés, libraries, hairdressers, art and craft groups, holistic therapies, sports facilities, and educational / learning opportunities. Having this kind of multi-functional space also improves accessibility and reduces stigma and barriers to accessing support. Such facilities could provide volunteering and work opportunities for young people and people who face barriers to employment, supporting their mental health in the long-term.

The importance of including, and funding, VCSE groups and organisations which support mental health and wellbeing, was reiterated. This included supporting access to peer support and lived experience-led groups, such as Andy’s Man Club and Bipolar UK support groups, as well as more informal peer support networks.

Designed with local communities and informed by service user feedback

> *“Making sure the new Neighbourhood Health Centres are truly ‘community focused’ i.e. taking in the views of the wider community (including lived experience) ...”*

> *“I think it's key that they're developed with people who have lived experience...But also, constant feedback… it's not going to be right or perfect to start off with, but hopefully, gradually, over time…things do improve…”*

Participants were clear that the best way to ensure that Neighbourhood Health Centres are accessible, inclusive, effective and impactful, is to codesign them with local communities and people with lived experience, ideally from the start and then on an ongoing basis. As well as shaping the services and support available, this will enable Centres to be truly embedded into the communities they serve.

Centres should be informed by local demographics, including health inequalities, as well as ongoing feedback from service users. They should be able to respond and adapt, listen and learn. Centres should be community-focused and reflect their local area, recognising that what is needed in different locations, including urban or rural areas, will be different. Decision-making, including about commissioned services, should include people with lived experience, for example as part of steering groups. Involvement and coproduction should include groups at higher risk of suicide.

A focus for tackling stigma

> *“…how about developing a better suicide informed community? We have a better-informed society with respect to what to do when someone has a heart attack…”*

There is an opportunity for Neighbourhood Health Centres to be at the forefront of tackling stigma around mental health and suicidality, both universally and for groups that face particular barriers to accessing support, such as Gypsy, Roma and

Traveller communities, and men. This links to parity of esteem, safety, connection with local communities, and the creation of welcoming, compassionate spaces.

Participants spoke about the ‘culture change’ needed to open up conversations about suicidality, and normalising discussion about mental health challenges. They hoped that everyone, not only all NHS and Centre staff, but across society, would one day be equipped to have a supportive conversation with someone about their suicidal thoughts or feelings, and be able to listen and signpost them to local support. It was suggested that the Centres could be a focus for opening up conversations locally and removing stigma around suicidality, stressing that ‘it’s ok not to be ok’. Through being embedded as part of their localities, involving and working with local people, Centres could help communities to be more ‘suicide-aware’.

Sustainable

Participants are well aware of the financial challenges facing the NHS – one of the reasons for concerns about ‘parity of esteem’ and for Centres to explicitly prioritise suicide prevention. They called for long-term commitment to investment in the Centres including funds for building maintenance, safe staffing, staff support, continual improvement of services and ways of working, and ongoing involvement of service users. Funding for services and support which contribute to suicide prevention must be protected, including for patient groups and VCSE organisations. Improved access to NHS care and support, including 24/7 services, must not be a short-term phenomenon.

Another aspect of sustainability – and ongoing impact – is to ensure that Centres operate on the basis of continual learning and improvement. This includes learning from previous initiatives, both ‘successes’ and those that have not been sustained or have not achieved their goals. It also includes listening to feedback from service users and acting on concerns and areas for improvement.

Transparent and trusted

Participants felt that honest communication about Neighbourhood Health Centres was important, especially to build trust. It should be clear what Centres will deliver, and what they will not, as well as what is new and what is building on what has gone before. There were questions about which services will transfer into the community, how long this will take, and how this will affect current service users and future pathways, for example for inpatient mental health care. It must always be completely clear where someone should go for urgent mental health and crisis support.

Participants queried how consistent services will be across the country – wanting to get away from a ‘postcode lottery’ but also wanting Centres to best support their local communities. There was uncertainty about how different the Centres will be from existing Health Centres with multiple GPs and other services, and about what has been learned from previous attempts to co-locate services.

5. Summary of findings – digital NHS services

In the future, the NHS will use more digital tools and online services, and the NHS App will be developed and expanded.

Overview

> *"…earlier detection of risk / personalised interventions / faster access to crisis support / safer online environments / better coordination across services..."*

Overall, participants were more cautious about the expansion of digital tools and services in the NHS. They recognised that they could have benefits – including 24/7 access and personalisation – but raised concerns about accessibility/inclusion and use of data, as well as about them not being a replacement for human connection. They were keen to see technology used to support people in crisis, to keep people safe and to support self-care and management. Many participants stressed the importance of online safety, calling for digital NHS developments to prioritise the safety of individual users, especially those who may be at risk of suicide. Key words in these discussions were **safety**, **choice** and **control**.

Accessibility, inclusion and health inequalities

Participants recognised that digital expansion may improve access to services for some people, such as younger people and those who are isolated or without transport. And at some times, for example, when other services are closed. However, there were concerns about the potential for the expansion of digital tools and services to worsen existing health inequalities, and negatively impact on disabled people, older people and those experiencing poverty. They wanted reassurance that not being able to go online, or choosing not to, would not be a barrier to accessing care and support. Participants said that action was needed to support people with digital literacy, for example through courses and help in the community. The impact of digital poverty was specifically highlighted, as well as challenges faced by people with poor network coverage, for example those living in rural areas.

> *"…leaving people behind that may not be digitally able..."*

The importance of building accessibility into apps and digital tools was highlighted, including ensuring they are compatible with assistive technology such as screen readers, and that interfaces are easy to navigate and can be personalised. Apps, tools and services should be compatible with all types of devices including Apple and Android phones, tablets, smartwatches, smart televisions and smart speakers. They must keep pace as technology changes but also continue to be compatible with older devices/operating systems, recognising that not everyone chooses or can afford to upgrade. Funding is needed to ensure sustainability.

Participants highlighted the importance of culturally sensitive design and language, and building in features to support neurodivergent people and others who may communicate differently. The challenge of using digital services when mental health is deteriorating or when in crisis needs to be thought through as part of design.

The potential of Artificial Intelligence (AI) was acknowledged but there were concerns it could worsen existing biases, especially as the industry continues to be dominated by wealthy white men.

Usability and personalisation

> *“…it has to be easy to navigate. Too much information and choice may be unhelpful at certain times in a person’s situation.”*

Linked to accessibility, participants were clear that digital tools and services needed to be designed for ease of access and navigation, and to enable personalisation. Many felt the usability of the NHS App could be improved, citing repetitive questions, multiple access codes, being locked out and needing to re-enter information. They also shared frustrations about inconsistencies in the use of digital services across the NHS, including different healthcare providers using different apps and tools.

Many participants commented on the need to ensure that the NHS App/digital tools enable individuals to tailor the information they see; control over content, filtering and being able to hide information where this supports safety or wellbeing. They called for adjustable settings as preferences change over time. This links to the need for consideration as to how people interact with digital technologies when they are experiencing mental ill health, including when nearing or experiencing crisis.

Specific suggestions were made for: tools to be able to digitise handwritten input into the digital 'system'; being able to book appointments (including same day) through the NHS App; being able to have a text conversation with a mental health practitioner.

> *“…digital content filters are very important. They need to hide graphic or triggering material.”*

Safety planning and crisis support

One of the key ways in which participants felt that an expanded NHS App and NHS-approved digital tools could contribute to suicide prevention was through improving access to, and functionality of, safety planning apps and tools. These must be personalised and adaptable, focused on empowering people as well as keeping people safe. They should be robustly tested and subject to clinical oversight. The potential for technology to interrupt suicidal thoughts was recognised, as well as connecting to support from others. It was suggested that apps/tools could be set up so that they could alert contacts as part of someone’s safety plan if someone was reaching crisis point. Another suggestion was for location-based alerts notifying a named contact if someone enters a high-risk location.

“…safety planning apps […] listing personal warning signs, identifying coping strategies, supportive contacts, possibly choosing safe environments...”

Expanded NHS digital tools should also support people to access help when they are in/near crisis, enabling quick and easy access to 24/7 urgent support.

“…crisis hotline apps - and they offer one-tap calling, or live chat, with trained listeners, text-based crisis lines, like a crisis text line, maybe a lifeline chat...”

“The point at which the digital approach could be most useful for me, would be probably when I'm at the early stages of becoming unwell, where things are still salvageable, if you like.”

Self-care / self-management

“…you want people to feel empowered and confident in their health, their choices”

Participants were keen to see technology that empowered individuals, supporting choice, agency and control, including as part of self-care and self-management. Many participants had experience of using apps and digital tools for prevention and self-care, most commonly ‘mood trackers’. It was felt that these could be usefully included in the suite of NHS tools and/or in the NHS App. Examples of apps and digital support which some participants had positive experiences with included the Stay Alive app, Hub of Hope, Bipolar UK, Headspace and Samaritans. Some participants (but not all) found apps with breathing exercises helpful.

Some participants saw a positive opportunity for the NHS App to support people to stay well and to self-care, for example providing medication and appointment reminders, affirmations (audio, visual, different formats to suit individuals) and notifications. There was also support for use of the NHS App to make, change and cancel appointments and for communicating with staff (for example if running late).

A suggestion was made for digital pets which can support people to feel calm (although it was noted that it was important that they did not ‘die’).

Some participants suggested that the NHS App/digital expansion could be used to support online learning and education around suicide prevention, for example suicide prevention in the workplace, and how to support someone bereaved by suicide.

“…the mood tracker app has been helpful because it helps me identify when things are escalating.”

Integration

Participants hoped that digital services would be integrated with physical services, supporting coordination and collaboration as part of 24/7 care, as well as ‘maintaining a human connection’ (see below). They also hoped that improved and expanded digital tools would facilitate more joined-up working by professionals, simplification and standardisation of information including patient records, and more personalised care. In an ideal world, expanded digital tools would support more holistic, ‘wraparound’ care, including both physical and mental health, bringing together different NHS services as well as peer and community support. Also ideally, all NHS services would use the same digital platforms, tools and app(s).

Some participants suggested that technology could be used to connect people with sources of support in their local community and online. They suggested NHS services/support and also support for wider issues which may contribute to poor mental health such as gambling, debt, housing, substance misuse, and services which support wellbeing, such as sports facilities.

“…links to services that might help without necessarily having to go to the GP, whether in person or virtually, just as a first step.”

Maintaining a human connection

“There must be an 'offer' of human connection. Digital apps/services/AI cannot see body language, understand inference, non-verbal communication or change in thinking and this is vital to ensure appropriate safeguarding.”

Whilst many participants could see benefits of digital services and tools, there was widespread concern that digital must not be seen as a replacement for human connection or face-to-face support. Digital should support choice, enhance access to services and the quality of support, and complement in-person care, but it can never replace it. Digital tools should provide additional ways of accessing support but must never be the only way.

Participants were also concerned about digitisation of risk assessment and assessment for access to services, commenting on the limitations of using technology in this way, and the impact of barriers to accessing support. Digital assessment tools (including those used as part of referral) must not lose the ‘human touch’ and must comply with clinical guidelines and best practice. Specific safety concerns related to the use of AI and online algorithms, as well as the need for transparency in how information/advice is being generated.

“…worried that poorly implemented digital tools may actually create a false sense of security or fail to activate appropriate interventions…”

There were related concerns that, depending on their ‘score’ for mental health risk or need, people may be directed only to online support instead of support from a professional or peer group, when the latter may be more useful/appropriate. Similarly, there should be follow-up when someone comes to the end of an online course or intervention.

It was commented that there needs to be ‘humans behind the technology’, especially to help if things go wrong or someone cannot manage with the technology at a particular time. Participants also highlighted the need for contingency planning for when technology fails or needs maintenance, always ensuring there are alternatives. Technology/digitisation must not prevent anyone from accessing support.

The language used as part of apps or online tools should focus on being ‘human’ and compassionate.

> *“…use warm, stigma-free language…that mirrors how supportive humans speak. Allow people to describe feelings in their own words…”*

Sharing information online

> *“…fear that data may be shared without consent, lack of clarity about how the information is stored or used, worries about stigma or negative consequences…”*

Participants had mixed feelings about sharing information online. The benefit of shared records, and of all health professionals being able to access comprehensive information were recognised. This included supporting safety by setting out ‘the whole picture’/enabling cross-referencing, providing context to support clinical decisions/quality of care, and minimising the need to repeat information. The inputting of health and lifestyle information was also recognised as a way to monitor and manage health, wellbeing and mood. Some participants welcomed the opportunity to share health and lifestyle information with their GP/healthcare providers.

However, many participants were concerned about how their data would be used – especially given the sensitivity of data about mental health and suicidality – and who would have access to it. This included concerns about:

- Data security (such as data breaches and unauthorised access) and confirmation that data would never be sold on.
- Impact on care due to professionals making assumptions based on historical information about individuals’ mental health or suicidality.
- Information being used to restrict people’s freedom of choice or movement, including as part of being detained under a section of the Mental Health Act.
- Information, for example about exercise or activity, being shared with other agencies, such as the Department for Work and Pensions (DWP).

> *“…I wouldn't want there to be lots of access to my previous mental health record, because it can lead to assumptions about what I might or might not do next...”*

Some participants worried that without appropriate safeguards and assurances people would distrust online tools and either not use them and/or input ‘what professionals wanted to hear’, rather than being honest. This could put their safety at risk and/or impact on the quality of care and support they received. The key solution to these concerns was felt to be ensuring that individuals retained choice and control about what information to share, and who has access, including being able to limit who has access to different types of data. The NHS must be honest and transparent about access to individuals’ data.

> *“Re data…how is it going to be used? … if someone feels they are being ‘monitored’ they may ‘detach’ and / or provide the answer the system wants.”*

Some participants wondered if it would be possible to reach out for help anonymously, at least initially, as this could help people open up. Other participants were concerned about the accuracy of data held about them online, and the impact of this on their care, and their health and wellbeing.

"I'm wary of the NHS app in case I 'stumble across' incorrect notes about me, as I've heard bad experiences about that".

Some participants recognised the potential for data about suicidality to be used for research and to inform future policy/service-provision.

"…if we all feel like we can put the true data in…we're going to have this massive database…we could potentially gather massive amount of data, which in the right hands, could be suicide prevention…"

Some participants called for the tightening up of online safety legislation.

Peer support

"…peer support platforms with anonymous postings and communities, also group chats…forums…offering a safe space."

Many participants had accessed online peer support/communities and found them to be sources of hope, support and help with their suicidal thoughts or feelings, and/or their experience of bereavement by suicide. The definition of a space as 'somewhere that it was ok to talk about suicide' encouraged people to open up and many felt that they benefitted from peer support and hearing other people's stories. Being able to access case studies from people who have had similar experiences, as well as 'tips' and information about what has helped, was also felt to be useful. The role of moderation and community rules were acknowledged.

Service user involvement in design and development

"Involve those with lived experience in designing the system."

Participants were clear that a key part of the solution to concerns was for digital tools and services to be codesigned and developed with involvement and input from service users. This includes ensuring input into digital development by people with experience of mental ill health, suicidality and psychosis, and consideration of how people may interact and interpret technology / online information when they are unwell. As well as involving people at the outset, there is a need for involvement in ongoing review, assessment and improvement. Involvement and coproduction must include groups at higher risk of suicide, as well as groups more likely to be excluded from digital services.

6. The Suicide Prevention Consortium (SPC)

The SPC is made up of Samaritans, National Suicide Prevention Alliance (NSPA) and Support After Suicide Partnership. As part of the VCSE Health and Wellbeing Alliance, we aim to bring the expertise of member organisations and the voice of those with lived experience directly to policymakers, to improve suicide prevention in England. For queries about this document, contact campaigning@samaritans.org

7. 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. Call 116 123 or visit the website (https://www.samaritans.org/) for other ways to get in touch.

For help finding mental health support in your local area, go to Hub of Hope (https://hubofhope.co.uk/) and enter your postcode.

8. Acknowledgements

This work was led by the SPC, whose current members are:

- David, NSPA Lived Experience Influencer.
- Rosie Ellis, Executive Lead NSPA.
- Katie Hickmott, NSPA Lived Experience Influencer.
- Debbie Laycock, Head of Policy, Public Affairs and Campaigns, Samaritans.
- Jess Leigh, Participation Officer, Samaritans.
- Michelle Stebbings, Executive Lead, Support After Suicide Partnership.
- Andy Willis, NSPA Lived Experience Influencer.
- Jess Worner, Lived Experience Network Manager, NSPA.

It was also supported by two freelancers, Kate James and Sarah Marsay. We are grateful to everyone who participated in our online sessions or contributed via email. We are also grateful to former SPC member, With You, for their contribution to the earlier work of the Consortium.

Appendix – Methodology

The SPC hosted six online engagement sessions with people with lived experience of suicide, recording 46 participants (some people attended more than one session). Two of the sessions were for NSPA Lived Experience Influencers (people who draw on their lived experience to influence and inform suicide prevention activity) and four sessions were for any interested members of the NSPA's wider Lived Experience Network. All participants were over 18 years of age and resident in England.

- 26th January 4.30pm-6.30pm: online workshop for NSPA Lived Experience Influencers: Neighbourhood Health Service. Ten Influencers attended.
- 27th January 12pm-2pm: online workshop for NSPA Lived Experience Influencers: digital NHS services. Six Influencers attended.
- 23rd February 10am-12pm: online session for NSPA Lived Experience Network members, focusing on the Neighbourhood Health Service. Five participants.

- 23rd February 4pm-6pm: online session for NSPA Lived Experience Network members, focusing on the Neighbourhood Health Service. Ten participants.
- 25th February 12pm-2pm: online session for NSPA Lived Experience Network members, focusing on digital services. Six participants.
- 25th February 5pm-7pm: online session for NSPA Lived Experience Network members, focusing on digital services. Nine participants.

Those unable to attend any of the online sessions but with an interest in the topic(s) were invited to share feedback via email. Two emails were received, and comments have been included in the thematic summary.

This project built on earlier work by the SPC to explore how the 10 Year Health Plan can best support people at risk of or affected by suicide, including two online surveys – of people with lived experience, and of health, care or VCSE organisations. The findings from these surveys were used to inform this latest work.

Note: comments made by participants as part of online sessions are shown in italics and quotation marks. They are quoted verbatim from chat boxes or transcripts, except for standardisation of spelling, removal of 'filler' words, and deletions for length (indicated with …), and occasional insertion of words for clarity (marked with [square brackets]).