Health Innovation Network South London

ZSA Resources

ZSA Resources Stakeholder Report

Zero Suicide Alliance

Because ONE life lost is ONE too many

Introduction to the ZSA Resources and the evidence reviews developed by the Health Innovation Network

The Zero Suicide Alliance (ZSA) secured funding from the Department of Health and Social Care to develop a world leading 'ZSA Resources' digital suicide prevention resource for its members that work across all sectors engaged with or influenced by suicide prevention.

The ZSA Resources are based on our core belief that everyone, everywhere, in every population can take action to promote good mental health, and prevent mental ill health and suicide.

The content of the ZSA Resources has therefore a very practical focus: to constantly seek out the needs of our membership, and to provide members with the resources and implementation tools they tell us they need, to turn their ambition into action. These resources include easy access evidence briefings, new accessible data, visualised into maps of their local area, live examples of implementation solutions in practice, peer learning and support networks, 'help' clinics, virtual conferences and webinars, and links to international communities of practice, research, innovation, and more.

To develop our resource, the ZSA initially commissioned our ZSA Alliance partner, the Health Innovation Network, to undertake a stakeholder consultation of people from each of our membership sectors to identify their needs. This report is available here: www.zerosuicidealliance.com/ZSA-Resources/introduction/zsa-evidence-briefings

The Health Innovation Network (HIN) is the Academic Health Science Network (AHSN) for south London, one of 15 AHSNs across England. As the only bodies that connect NHS and academic organisations, local authorities, the third sector and industry, they are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients. The HIN is therefore uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations.

At the request of our members, ZSA commissioned the HIN to undertake research, bring together experts, and produce a series of evidence briefings on the state of knowledge in a number of key suicide prevention areas. Rigorous desk top research took place over a period of 10.5 weeks mid May 2019 – 2 August 2019. All sections were subsequently reviewed by relevant Virtual Steering Group members. The information sources in this report are correct at time of research.

The Evidence Reviews will be continuously updated as new knowledge becomes available, and to include the impacts of COVID. We will reach out to our members and Alliance partners to secure feedback on how the resources are used, how they can be updated and how they can be improved to support action.

We very much hope you find these briefings useful. Please continue to tell us how we can help you save lives, to get in touch please visit: www.zerosuicidealliance.com/get-involved/contact-us

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About

The Health Innovation Network is the Academic Health Science Network (AHSN) for south London, one of 15 AHSNs across England. As the only bodies that connect NHS and academic organisations, local authorities, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients. This means we are uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations.

The wider Zero Suicide Alliance (ZSA) programme secured funding from the Department of Health and Social Care to develop a world leading 'ZSA Resources' digital suicide prevention resource for NHS professionals and leaders working across all sectors engaged with or influenced by suicide prevention.

Aim of the resource:

- To provide key leaders from a range of influential sectors with a range of accessible mental health information on their local area to support them in suicide prevention
- To provide them with role specific learning events and materials on suicide prevention
- To provide 'sound bites' on local, national and international progress.

The HIN was commissioned by Mersey Care NHS Foundation Trust to undertake national engagement with key leaders and stakeholders involved in suicide prevention, to gather opinion on desired content, key population groups, how best to manage validity of the content, and resource design and navigation.

The report consists of 9 chapters. Chapter 3 provides a collation of the findings across all engagement methods. Chapter 4, 5 and 6 provide detailed analysis of telephone, digital questionnaire and workshops respectively. Chapter 7 provides recommendations for the ZSA to consider to inform the development of the' ZSA Resources' resource.

Executive summary

The HIN used a mixed methods approach to engage, resulting in 942 stakeholders from across the NHS (clinical and non-clinical), Public Health England (PHE), education, emergency services, third sector, local government and industry contributing to this report.

- **Support for ZSA Resources:** The responses to the stakeholder engagement indicate there is overwhelming support across all sectors for development of a national digital ZSA Resources. Respondents gave detailed responses on what was needed .They want ZSA not to duplicate existing websites and to consider working with leading suicide prevention online leaders. Less than a third of stakeholders engaged via the digital questionnaire, stated that they currently access suicide prevention resources online.
- **Prioritisation of topics:** A wide range of topics were requested to be included within the resource. The two that were most commonly cited across all the methods of engagement:
    1. Evidence based suicide prevention interventions
    2. Suicide Prevention training
- **Population:** The majority of stakeholders stated that suicide prevention requires a whole population approach. The most selected (approx. 50% of respondents or more) across all three were:
    1. People with serious mental illness
    2. People with personality disorders
    3. Suicide attempt survivors
    4. Self harm
    5. Children and young people
    6. Bereaved through suicide
    7. Men
    8. LGBT+
    9. University / college students
    10. Substance misuse
- **Validity:** Overwhelmingly respondents requested that the validity of content should be managed by a multi-disciplinary approach.
- **Design:** Stakeholders requested that the resource be clear, simple and easy to navigate. Stakeholders requested the resource to not have a clinical / NHS feel as they felt it should reflect the multi-sector/multi professional suicide prevention audience.
- **Summary of recommendations:** There is overwhelming stakeholder support for the development of the 'G0 To' digital suicide prevention resource. To meet the needs of stakeholders it recommended that ZSA:
    - Ensure the digital resource has a multi sector feel and accessibility
    - Link to other digital sites and avoid duplication – consider forming alliances
    - Have a whole population approach – with information on specific groups
    - Have a multidisciplinary approach to content validation involving people with lived experience
    - Focus on evidenced based suicide prevention interventions and suicide prevention training as priority areas
    - Have a robust communication and marketing plan to ensure suicide prevention stakeholders are aware of the planned ZSA Resources
    - Resource the set up, ongoing development and maintenance of the resource.

The full list of recommendations is on pages 29 and 30 of this report.

Collation of findings – all three engagement methods

3.1 Methodology

Using a mixed methods approach (see table 1) the HIN engaged with 942 stakeholders from across the NHS (clinical and non-clinical), Public Health England (PHE), Education, Emergency Services, Third Sector, Local Government and Industry. There was strong representation at CEO and Director level throughout the organisations represented. Amongst the NHS, there was a wide divergence of professions including nursing, GPs, pharmacists, psychologists, psychiatrists and commissioners.

Table 1: Engagement Method

Engagement method	About
Digital Survey (Survey Monkey)	A digital questionnaire (appendix 1) was sent to 1289 pre-identified stakeholders. Many of these stakeholders distributed the questionnaire on our behalf the overall number of recipients is unknown. The HIN also attended NHS Confed and opportunistically asked delegates to complete the survey. 724 people completed the survey. See appendix 1 Q1and2 for breakdown by profession and organisation group.
Engagement Workshops	Workshops were held in Leeds, London and Bristol. A total of 189 delegates attended. See appendix 2 (2.1.1 and 2.1.2) for breakdown by profession and organisation type.
Telephone interviews	Phone interviews were carried out with 29 significant influential leaders/ experts in their field. See acknowledgements p.31 for a list of stakeholders interviewed.

3.3 Engagement design

The format of questions/engagement was replicated for each method. The digital questionnaire was developed and tested with ZSA and relevant experts to inform the final version. The workshops and telephone interviews used the same questions, the time allocated to these methods enabled more detailed discussion. See appendix 1 for digital questionnaire.

3.3. Findings

3.3.1. The need of a suicide prevention 'ZSA Resources' digital resource

Respondents stated clearly that the need is to bring together existing resources and not duplicate previous and current work happening in this area. Many respondents referred to existing 'centralised' resource hubs, for example the National Suicide Prevention Alliance, and suggested the need to amalgamate and not develop another stand alone resource. It was questioned 'what would be different' about the ZSA Resources, to encourage specific professional groups to choose to use it over their own sources, eg. the Royal College of Psychiatrists resource site on suicide prevention. Overall it was felt the ZSA Resources should link to existing resources, in addition to hosting material not easy to access elsewhere.

3.3.2. Current use of online suicide prevention resources

Only one third (33% n:239) of the digital survey respondents and 22 of the 189 workshop delegates stated they frequently access online suicide prevention resources. It is not known whether the low search rate is due to lack of knowledge about where to look for information or identifies a gap in the market for a tool such as the ZSA Resources. The most commonly mentioned websites and apps were those aimed at people at risk of suicide and the people who may be worried about them, with respondents citing the Samaritans, Papyrus, Zero Suicide Alliance and Stay Alive App.

When looking for local resources, local authority websites were commonly mentioned, with the focus being on signposting to local resources and for those at risk of suicide.

3.3.3. Content - topics that are important to you

Stakeholders cited a wide range of important topic areas for inclusion. A full breakdown is available in appendix 1 (Q6 and Q7). Two topic areas were common across all methods of engagement:

1. Evidence based suicide prevention intervention
2. Suicide prevention training

Stakeholders agreed that suicide prevention interventions and training content needs to be based on robust evidence or based on good practice; and if good practice this should be clearly stated to avoid misinterpretation. It was felt this to be the most critical aspect of the tool. Displaying contact information was requested frequently, to enable those interested to find out how interventions worked in practice and can be applied within their own locality. Intervention sources should be local, national and international if success had been demonstrated. A number of stakeholders suggested it is important to share what doesn't work along with what does work, to ensure time is not invested in activities which return little value.

A further four topic areas were mentioned frequently by stakeholders engaged via the workshops and digital survey: It is noted that the first two listed below (3 and 4) align with the top 2 priorities.

3. Brief Intervention training (91% - Slido, 49%- Survey Monkey)

Brief intervention training was mentioned as important to help professionals respond in a crisis. Specifically, three stakeholders engaged via telephone interviews cited training resources for non-clinical professionals who receive crisis calls. Training in how to respond to and support family, friends and carers bereaved by suicide, for those worried about someone at risk of suicide or caring for a suicide attempt survivor was frequently mentioned by respondents.

4. Risk assessment / risk management tools (74% - Slido, 54%- Survey Monkey) and screening tools for specific groups and services (69% - Slido, 36%- Survey Monkey)

Having access to evidence based tools and understanding the context in which they are used was thought to be important. Caution was expressed from several workshop and phone interview respondents as although used widely, evidence is weak for their use as a prediction tool. Senior leaders commented that the tools should be branded as a 'discussion aid', to help tailor support and safety plans for patients.

Stakeholders from phone interviews and workshops highlighted the need to be open to recognising that there are a number of people who sit 'outside' of the known risk factors, yet are still susceptible to suicidal thoughts.

5. Digital apps for suicide prevention (82% - Slido, 47% - Survey Monkey)

Feedback from workshops and one telephone interview suggests that digital apps are increasingly being used, specifically by younger people and can support people quickly in a crisis. No qualitative data is available from the 47% of digital survey respondents who selected digital apps within their top five topics for inclusion.

6. Examples of existing suicide prevention websites (95% - Slido, 31% - Survey Monkey)

Additional suggested topic areas for inclusion varied by professional groups and organisational type, as would be expected when engaging with people across a wide range of sectors. If the ZSA Resources is to be successful in delivering its aims to be a comprehensive resource for all sectors working in suicide prevention, it is important to note the specific needs of each sector. Topics that ranked lower in priority were still important to specific groups. For example, national and local statistical data was mentioned frequently by academics, the police, PHE and local authority staff. Policy and guidance were important to professionals directly working in this area, particularly what makes a good suicide prevention plan and care pathways for suicide attempt survivors or people with active plans.

Although not captured widely in the digital survey responses, accessing local contact information eg. suicide prevention leads, and crisis support services, was cited as crucial by most telephone interview stakeholders and mentioned frequently during workshop table discussions. Displaying national helpline information on the home page, for both members of the public that may access the resource and for professionals in a working or personal capacity was frequently cited.

Artificial Intelligence (AI) ($n47_2$) and evaluated care planning ($n.94_2$) were mentioned by a lower number of digital survey respondents. This may be due to limited evidence and / or availability of information relating to these topics. Workshop attendees and one telephone stakeholder discussed AI with interest, but there was scepticism as to its reliability.

3.3.4. Population groups

Most stakeholders stated that suicide prevention requires a whole population approach, and that the ZSA Resources should not create restrictions at the risk of excluding people if they don't fit within a specific group. It was felt that suicide is complex, and the focus should be on supporting people exposed to or experiencing difficulties across a range psycho-social economic areas. All three methods of engagement permitted multiple population groups to be selected and the most dominant (approx. 50% of respondents or more) across all three were:

1. People with serious mental illness
2. People with personality disorders
3. Suicide attempt survivors
4. Self harm
5. Children and young people
6. Bereaved through suicide
7. Men
8. LGBT+
9. University / college students
10. Substance misuse

Several respondents highlighted the need to not assume a population group is homogenous. For example, men were routinely mentioned, yet migrants, specifically eastern European men were cited by some to be at increased risk within this group. Similarly, children and young people were frequently cited as a group where more information is needed. A number of respondents mentioned the need to look at supporting young people 'transitioning' e.g. within services, life stages and educational settings or within their sexuality. Self harm was frequently mentioned in relation to young people, particularly rising rates within females, citing a need for better information and resources to support this group.

Workshop and telephone interview stakeholders frequently mentioned students, yet one senior leader urged caution for not over emphasising the risks to this population based on recent high profile cases in the media.

Other groups routinely mentioned in workshops and telephone interviews were:

- Older people were mentioned as a neglected group, less likely to access services and at increased risk of depression and isolation
- Bereaved by suicide: it was felt there are limited resources or training available as to how best support this group
- High risk occupational groups: e.g. medical professionals, farmers, vets, construction workers, along with information for employers and organisations to support people at risk of, or affected by suicide of colleagues or patients

A full breakdown of identified population groups from the digital questionnaire is available in appendix 1 (Q7).

3.3.5. Validity

Stakeholders were asked if there was a specific professional group who should oversee the validity of the ZSA Resources. Overwhelmingly respondents requested this to be managed by a multi-disciplinary group. Particular emphasis was given to Public Health England as it was felt suicide prevention should be anchored in a public health approach; the third Sector, to ensure the focus is not solely clinical and that it is important to include experts by experience. Over half of the digital survey respondents suggested a psychiatrist, mental health nurse or psychologist be involved. Additionally if was stated by some that experts that experience should be included.

Telephone interview stakeholders requested a strong academic focus to ensure content is evidence based. Several stakeholders requested that content relevant to specific population groups or sectors is reviewed by experts in these areas and not a clinically or academically led team.

3.3.6. ZSA Resources design

Overall, stakeholders requested that the resource be clear, simple and easy to navigate. It was stated that the ZSA Resources should not have a clinical / NHS feel as it needs to reflect the multi-sector / multi-professional audience. Respondents felt the ZSA Resources would not be widely used by non-NHS stakeholders if so. The content needs to be written in plain English, so it is easy to understand for non-specialists. Specifically, it was requested that:

- The user journey is as short as possible with minimal clicks
- Clear signposting to content in terms of resource type, population group and sector
- Easy to find local services and support with contact information: searchable by postcode or map
- Be available in website and app format.

3.3.7. Conclusion

The responses to the stakeholder engagement indicate there is overwhelming support across all sectors for the development of a national digital ZSA Resources. At present less than half of respondents the HIN engaged with via the digital questionnaire currently access information online. Stakeholders welcomed the proposed centralisation of evidence based resources and information, but expressed concern that there are similar initiatives that exist or that are in development. Stakeholders felt it important not to duplicate effort as this may result in confusing the landscape in terms of where to look for evidence based resources and information.

Stakeholders requested a wide range of content be made available on the ZSA Resources, with evidence- based suicide prevention interventions and training cited as the most important topics. Stakeholders felt it is important to know what doesn't work in suicide prevention initiatives, as well as what does work, to ensure time is spent on initiatives that are likely to deliver improvements in services and care. The resource should include both international, national and local resources, specifically local crisis and support services searchable by postcode or area name.

A wide range of population groups were cited as important to include, stakeholders requested that the ZSA Resources take a whole population approach, so not to exclude people that do not 'fit' within current groups. Stakeholders frequently cited it important to recognise that specific groups of people within wider population groups are known to be at increased risk, eg. middle aged men, Eastern European men and young people who self-harm or who experience difficulties at transitional points.

Stakeholders felt strongly that validity of the content should be overseen by a multi-disciplinary team, have a strong public health focus and include representatives from the third sector and experts by experience.

Most stakeholders requested that the design and navigation of the resource reflects the proposed multi-sector and multi-professional audience. It needs to not have a clinical feel, be easy to navigate by population, sector and resource type and language in plain English. Although the resource is aimed at professionals, many respondents requested a crisis helpline eg. Samaritans, or text message support such as SHOUT, be visible on the homepage for members of the public who may access the resource, and forprofessional's own wellbeing or to signpost patients/clients if needed.

Telephone Interviews: Findings

4.1. Overview

Telephone interviews were held with 29 influential leaders or experts in their field, from across a wide range of organisation types eg. PHE, NHS, police, fire, ambulance, HM Prison Service the third sector, charity and academia. See acknowledgements (p31) for a list of stakeholder name and organisation.

There was consensus that a centralised digital resource would be highly valuable. The leaders stated that current online landscape can be confusing, and a central resource would enable the ability to do work at scale. All stakeholders reported that there is a considerable amount of existing information and resources available which are often difficult to locate, and at times can be conflicting in terms of what is an evidence based intervention versus good practice. Many stakeholders expressed concern that existing 'centralised' websites are already available eg. resources hosted by the Royal College of Psychiatrists, National Suicide Prevention Alliance and Hub of Hope. It was questioned as to how the ZSA Resources would be different, whether there was a need for another stand alone resource or whether it would be better to amalgamate into one national digital resource.

4.2. Content

There was consensus across stakeholders interviewed that the ZSA Resources should reflect best practice. It was frequently mentioned that there is limited evidence as to which interventions have demonstrated reductions in suicide. It was acknowledged by all stakeholders that suicide is multifactorial and specific to the individual; therefore, it is extremely difficult to evaluate interventions to generalise to the wider population. Consequently, some stakeholders urged caution to be applied to ensure there is no bias in signposting to content. It was felt by many that it is important to include what doesn't work as well as what has worked, to ensure effort isn't spent on ineffective interventions. Being able to contact organisations who have implemented interventions and demonstrated success was felt to be extremely important, as was having access to local information in terms of data and signposting to support. Many stakeholders felt strongly that self harm needs to be a priority area within the 'ZSA Resources. Table 2 details suggested content topics for inclusion.

Table 2: Stakeholder content recommendations from telephone interviews

Topic	Recommendations
Self Harm (13 people)	Need for more information and resources as there is an increase in rates particularly among young women.
Evidence based research articles (10 people)	Peer reviewed articles, both international and national. A mix of academic and clinical literature. To include active research pilots eg. Public Health England trailblazer sites / 8 STP funded projects.
Evidence based interventions (21 people)	For all population groups. Interventions designed specifically for children and young people were requested as often these are adult interventions applied to this population. Contact information where available should be listed. Three people requested international examples.
Training (15 people)	It was noted that awareness / skills development training is a crowded and competitive arena, yet evidence is fragile as to outcomes. Specific training was requested for non-clinical professionals and call handlers; how to start a conversation about suicidal thoughts, how to respond to a person in crisis, working with and supporting family and carers and better training for school / further education counsellors to ensure uniformity in knowledge and regulation of skill set.

Topic	Recommendations
Statistics (17 people)	Stakeholders cited a need for local and national data linking to the Public Health England Fingertips tool. One stakeholder made a request for 'clean' data that has not being interpreted as this often increases bias. The Police requested data on attempted suicides and prevented suicides, as currently this information (if known) is not available to them. PHE highlighted issues with time lag in data. Having real time data will enable prevention in terms of identifying trends / high frequency areas etc.
Guidelines (8 people)	Eg. Suicide prevention strategies, competency frameworks; care pathways; Public Health England guidance; local suicide plans: what makes a good plan and to embed; guidance on how to make a case for change and translate local plans within organisations and care plans / pathways for people with active plans.
Local contact information (12 people)	Local suicide prevention leads, local crisis services, contact information attached to all hosted resources. National helplines eg. Samaritans / SHOUT text message service.
Case studies (4 people)	Important to be explicit whether evidence based, best practice or untested.
Risk Assessment (3 people)	There was recognition that risk assessment tools are used widely, but the evidence is weak for their use as a prediction tool. It was noted that individuals deemed 'not at risk' based on screening tools are still susceptible to suicidal thoughts. Therefore, guidance should be used to ensure professionals do not use as a predictor. Instead, screening tools should be used to identify individuals at increased risk to help them ask the right questions to tailor support and safety interventions.
Funding opportunities (1 person)	Funding opportunities be listed to drive traffic to the site and help organisations know where to look for funding sources.
High Frequency Locations (3 people)	To highlight 'suicide hotspots' areas on a map and to support high frequency areas in restricting access to means of suicide.
Film clips (3 people)	Inclusion of films were felt to be extremely powerful. Healthtalk.org for bereavement was cited. A request for one minute 'information' films for non-clinical professionals eg. teachers 'what to do if a pupil says they are suicidal' was suggested as being helpful.
Apps (1 person)	Recognised as an alternative way to support people. Self harm and student mental health was mentioned.
Myth busting (3 people)	To help non-clinical professionals eg. it is okay to use the word suicide and ask if a client/patient is having suicidal thoughts / made plans.

4.3. Population groups

All stakeholders reported that suicide prevention is a universal issue which requires a whole population approach. It was felt that the ZSA Resources should not be limited to specific groups. Stakeholders frequently stated that suicide is complex and multifactorial, so a strong focus should be on supporting people across a broad range of areas eg. social, economic, psychological and behavioural (addictions / substance misuse).

Middle aged men were routinely mentioned within conversations. Stakeholders urged caution in generalisation, stating that within groups such as men, there are subgroups eg. men of Polish nationality were specifically mentioned as being at increased risk and requiring tailored interventions. Likewise, in the younger population, students were mentioned as an at risk group along with young people transitioning between care or education settings. Specifically, people who self harm were noted as a key group to focus on by most stakeholders, in terms of understanding the associated risks and evidence based interventions to support them. It was felt this is an area of growing concern in terms

of the younger population. How best to support families, friends, siblings and colleagues bereaved by suicide was frequently cited as being a marginalised group where more information and resources would be useful. Table 3 details populations identified by stakeholders for inclusion and why these specific groups were important.

Table 3: Stakeholder population group recommendations from telephone interviews

Population group	Commentary
Students (6 people)	Better information relating to intervention programmes and access to support services, both within the student environment and external services. One respondent expressed caution about over emphasising the risks within the student population, based solely on high profile cases in the media and that a measured and fair assessment of risk is communicated through the ZSA Resources. One stakeholder identified an unmet need for BAME students who may not access support as counsellors are often white, middle aged and middle classed.
Children and young people (CYP) (7people)	Respondents urged the focus to be on CYP 'transitioning' eg. between services, life changes (school to university or within their sexuality). One respondent expressed recognition that not all suicides in this group reflect the evidence eg. CYP are self harming or have suicide ideation within the perceived 'support structures' of emotional support via family and friends, economic security and are academically able. Young women were mentioned frequently in context to social media, body dysmorphia, eating disorders and self harm.
High risk occupational groups and Employers (9 people)	Doctors, nurses, vets and farmers were flagged as groups that would benefit from a specific focus within the ZSA Resources. It was felt there is limited support for health professionals affected by suicide of a patient, due to the blame and stigma associated with the care delivered to the patient. Specific resources related to emotional, legal and employment concerns was requested. Resources to support employers and small businesses was mentioned.
LGBT+ (11 people)	Respondents stressed the need for better evidence relating to the LGBT population.
Criminal Justice System (6 people)	People within the criminal justice system were identified as at risk. It was felt there is limited evidence based information as to how best support this group.
Bereaved by suicide / managing those with active plans (7 people)	Information is needed on how to support to families, friends and colleagues bereaved by suicide, as well as interventions for families and friends supporting a person with suicide ideation or who has active plans. Specific resources on how to support children and young people bereaved by suicide of a parent was requested.
Older people (7 people)	Older people were cited as a neglected group, particularly within primary care when presenting with low mood and or depression. This population group was mentioned as a particular need within the criminal justice system. The self perception by older people that they are a 'burden' to family, friends and society needs to be acknowledged as a potential risk factor. Older people are not a homogenous group and interventions aimed at specific population groups should not exclude older people. It was felt there is limited UK evidence based research to draw upon with most research undertaken in the USA.
BAME / Migrants (8 people)	Respondents specifically highlighted the disproportionate number of completed suicides for eastern European men and women compared with other ethnicities. Younger men from BAME communities was mentioned by one stakeholder.
Autism and Learning Difficulties (1 person)	A need for better evidence relating to this group and how to tailor interventions to meet their needs.
Suicide survivors (1 person)	Better support for people who have survived a suicide attempt and/or those whose injuries have resulted in poor physical health and the families that support them.
Eating disorders (1 person)	Awareness of associated risk due to poor mental and physical wellbeing.

4.4. Validity

Most stakeholders suggested that validity of the ZSA Resources is overseen by a multi-disciplinary group to reflect that responsibility for suicide prevention cuts across all sectors. Representation from Public Health England and the third sector was deemed important as was including several experts by experience. A strong academic focus was requested in terms of ensuring content is evidence based, along with representation from sectors delivering services eg. secondary/ primary care, social care and emergency services eg. police. Ensuring content is validated by the sector it applies to was recommended. One stakeholder requested that a pharmacist should be involved given the importance of medication in managing mental health, another mentioned the importance of including representation from the police.

To ensure equal representation across sectors, it was suggested by a few stakeholders to establish a smaller, experienced group supported by a wider reference group familiar with the literature.

4.5. Design and navigation

Stakeholders were of the opinion that the design needs to be welcoming and inclusive to all sectors, with several stakeholders mentioning that if it had a clinical or NHS feel it would not be widely adopted by non-NHS stakeholders. It should be of simple design and easy to navigate. Recommendations were:

- Be explicit about what is evidence based (proof of concept) and what is good practice (consensus that is the best way to work in absence of evidence based interventions)
- Language: plain English in terms of being accessible to everyone and ensuring inappropriate terminology associated with suicide is not used.
- Clear signposting:
    - By resource type: training, interventions and statistics
    - Local / national split: local services searchable by postcode or map.
    - Sector specific
    - Population specific
- To include information on 'how to have the conversation about suicide' in different setting with different groups of people including children
- A tier based design to not alienate by expertise or profession; to reflect base level of knowledge
- Inclusion of key word search and glossary of terms and acronyms
- Have downloadable resources
- Include a safety standard to give assurance that the ZSA Resources is GDPR compliant

Although the ZSA Resources is for professionals, many respondents requested inclusion of crisis helplines for members of the public and professionals accessing the site.

Survey: Findings

5.1. Overview

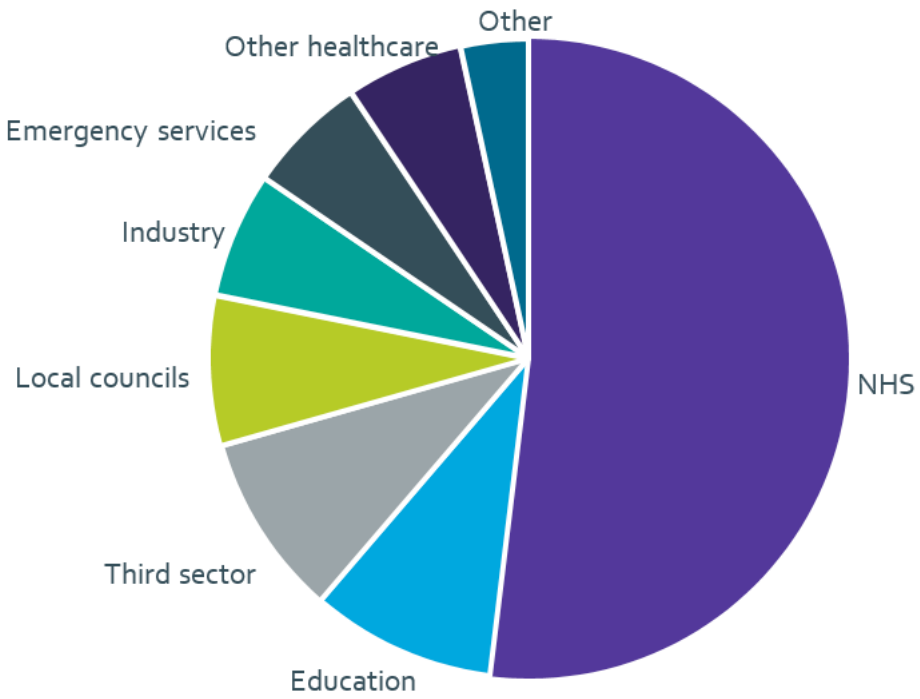
The digital survey was designed, developed and tested with ZSA and relevant experts prior to approval of the final version.

The survey was sent to 1289 pre-identified stakeholders throughout England, some of whom were encouraged to share the survey within their networks. The HIN also attended NHS Confed in June 2019 and opportunistically asked delegates to complete the survey. The survey was open for six weeks, and a total of 724 responses were received from across 316 organisations.

Respondents were from a range of organisation types as shown in figure 1, including, but not limited to: various NHS organisations (acute and mental health trusts, STPs, CCGs, NHSE/I, AHSNs, ambulance services), education (universities, schools, colleges), third sector, emergency services (police, fire), local councils (public health, social care) and industry (legal, business, digital). There was strong representation at CEO and director level throughout the organisations represented. Amongst the NHS there was a wide divergence of professions, including nursing, GPs, pharmacists, psychologists, psychiatrists and commissioners. The complete lists of profession groups and organisation types can be found in appendix 1 (questions 2 and 3).

In general, the consensus was for a resource that focuses on training and practical advice for professionals working with those at risk of suicide. The resource would be useful if accessible by both computer and mobile and would need to be easy and simple to navigate, possibly filtering by profession rather than target population group. It was suggested that the validity of the content should be overseen by a multidisciplinary team and would need to be regularly updated in order to stay relevant.

Figure 1



5.2. Use of online resources

33% of respondents reported that they currently access online suicide prevention resources, while 23% reported that they were unaware of any local suicide prevention resources. Respondents reported using a range of local and national online resources. The most commonly mentioned online suicide prevention resources are listed in table 4, and the full list can be found in appendix 1 (question 5).

In terms of national resources, the most commonly mentioned websites and apps were those aimed at people at risk of suicide and the people who may be worried about them, such as Samaritans, Papyrus, the Stay Alive app and CALM. Less common but also mentioned were resources for professionals working in suicide prevention, such as Health Education England and the National Suicide Prevention Alliance.

Local resources mentioned were categorised in order to determine the most commonly mentioned resources types. Local authority websites were the most commonly mentioned, indicating that many people are aware of local authority suicide prevention work. The focus across the majority of resources mentioned was on websites providing signposting to local resources and help for those at risk of suicide (local authorities, Mind, campaigns etc), indicating that signposting is a key area of focus for professionals.

Table 4: Top national and local resources

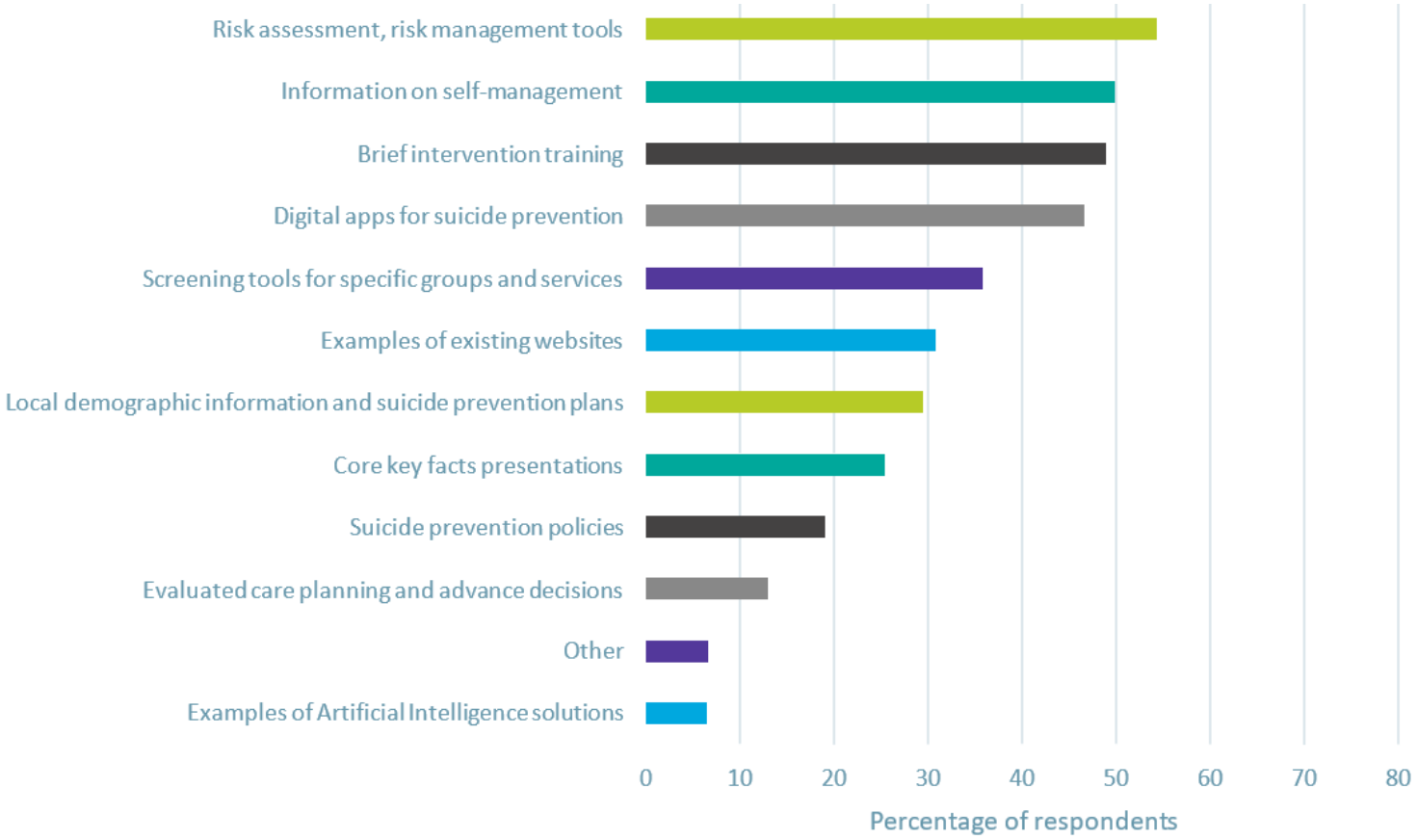
Top national resources
Samaritans (55)
Papyrus (18)
Zero Suicide Alliance (18)
Stay Alive app (15)
Staying Safe (8)
CALM (6)
Hub of Hope (5)
NHS (5)
Health Education England (4)
National Suicide Prevention Alliance (4)
Sane (4)
Top local resources
Local authority websites (43)
Local signposting websites (29)
Local Mind websites (27)
Local suicide prevention campaigns (20)
NHS Trust websites (20)
Local third sector / support organisations (12)
Internal sites (eg. trust intranet) (9)
CCG websites (7)
Health Education England (4)
Local health / wellbeing partnerships (5)
Healthwatch (4)

5.3. Content

Respondents were asked to select their top 5 topics for inclusion in the resource from a predetermined list that was developed in collaboration with the Zero Suicide Alliance. As shown in figure 2, the most popular topics were 'evidence based suicide prevention interventions', 'suicide prevention training' and 'risk assessment, risk management tools'. Generally, topics involving training and practical information on how to help those at risk of suicide were more popular than topics looking at demographics, policies and key facts.

Among the 48 'other' responses, there was a focus on access to information and resources to help those at risk of suicide (12), for example information on how to sport warning signs, as well as signposting to local and national resources for people in crisis (7). Five people specifically mentioned safety planning as a topic they would like to see information on, and four people said that testimonies from people with lived experience would be useful to instil hope and to understand how to help people.

Figure 2



In the "any other comments" answer box, 13 commenters made the point that there are already a lot of signposting, training and other resources out there, and it would be important not to duplicate work that has already been done. It was suggested by nine respondents that this resource could signpost people to other resources that are already available, and act as a central source of information. Five respondents also suggested that the content would need to be regularly reviewed and updated in order to stay relevant and useful.

"Overseeing and updating content regularly seems a vital aspect to ensure value and longevity. Validity of websites highlighted also seems crucial, with consideration of national vs local. Mapping initiatives, schemes resources across the country seems a challenging but helpful process."

5.4. Population groups

The 10 most selected population groups that respondents would like more information on are listed in Table 5. The full list of population groups can be found in appendix 1 (question 7).

Table 5: The 10 most selected population groups that respondents would like more information on

Top 10	Population groups	% (no.) of respondents
1	People with serious mental illness	66% (484)
2	People with personality disorders	62% (454)
3	Suicide attempt survivors	59% (428)
4	Self harm	58% (426)
5	Teens and younger people (13 - 25)	58% (424)
6	Bereaved through suicide	51% (376)
7	Men	51% (375)
8	LGBT+	49% (356)
9	College / University students	48% (351)
10	Substance misuse	46% (339)

Respondents were given the opportunity to name other population groups. Thirty eight respondents mentioned medical professionals, including doctors (23), nurses (11), paramedics / emergency clinicians (11) and dentists (3), particularly regarding access to means of committing suicide. A number of other occupational groups were also mentioned, specifically farmers (15), construction workers (6), teachers (4), veterinarians (4) and police (4) among others. People with health problems were another key area, particularly those with long term conditions (7) and disabilities (4).

Seventeen respondents specifically stated that all groups were important to include. Some respondents questioned how useful it was to specify categories, as there is a risk of excluding some people if they don't fit into a specific group. It was mentioned that it might me more useful to filter by profession or risk factor rather than population group.

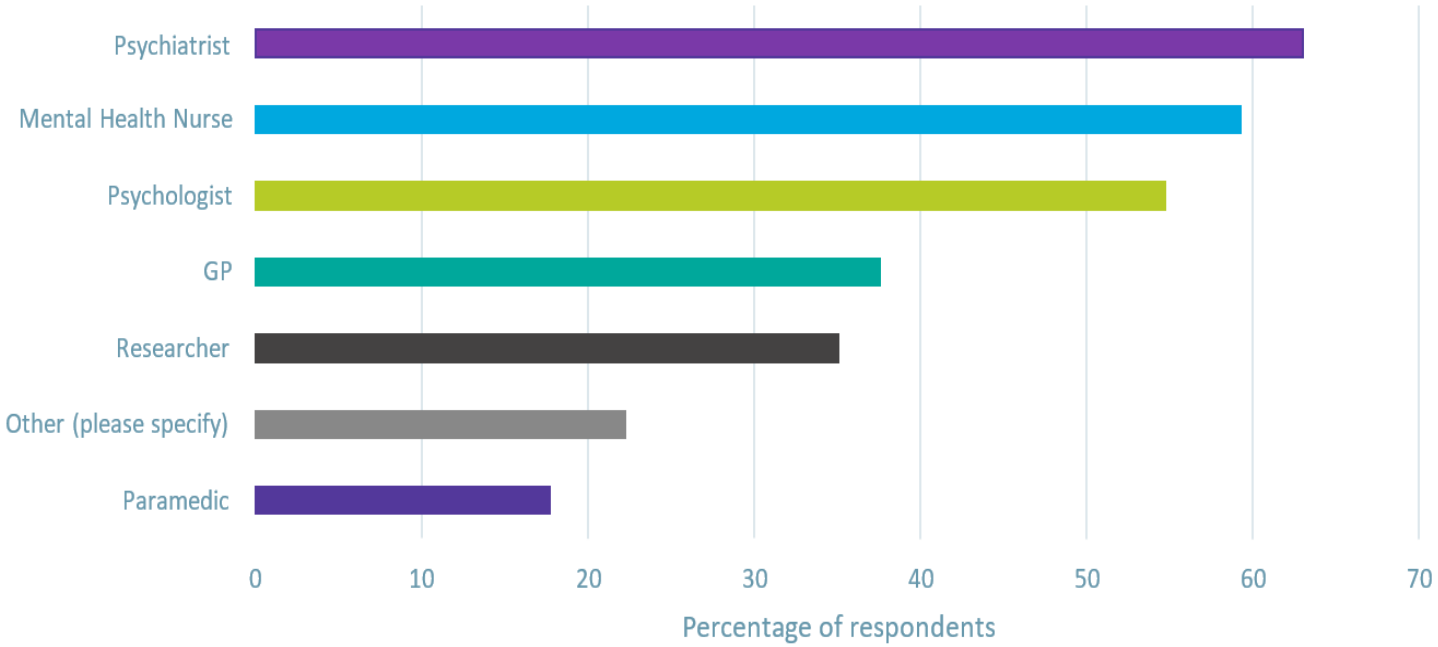
"Anyone who is hopeless, lacks belonging and is in despair could be at risk and they could fit into anyone of those categories or none at all."

"There is a danger in focussing just on some groups as we are all potentially suicidal and so we may get a false sense of security if someone is not in a high risk group."

5.5. Validity

As shown in figure 3, most respondents felt that a psychiatrist, mental health nurse or psychologist would be the appropriate professional to oversee the validity of the resource.

Figure 3



Among the other responses there was a strong emphasis on the need for a multi-disciplinary team (26 respondents), and many people suggested that different parts of the resource would need people with different expertise to review. Suggestions included public health teams (16), any professional with a background in suicide prevention (12), pharmacists (6), police (3), social workers (4), third sector (9).

Another key theme was the inclusion of people with lived experience (36), such as carers, family, service users and those who have attempted suicide.

"It will depend hugely on the nature of the content. Some of it will need clinical oversight, others research and others might benefit from Public Health oversight."

5.6. Design

In terms of how people would like to view the resource, 80% reported that they would use a desktop or laptop computer, 74% would use a smartphone and 51% would use a tablet. This was quite consistent between different organisation and profession types, suggesting that both computer and mobile access to the resource would be important.

A number of commenters made the point that the resource must be easy to access and use. This would involve ensuring that content is written in plain English so is easy to understand for non-specialists and keeping the interface and navigation as simple as possible.

"It must be easily navigated, accessible to all (irrespective of role/specialisation etc) and written in plain English with minimum use of professional jargon/acronyms. A virtual 'tool kit' for all those involved in suicide prevention."

"Thought needs to be given for how to ensure that this doesn't just become a directory of directories. There arealready lots of these. Start small. Iterate frequently."

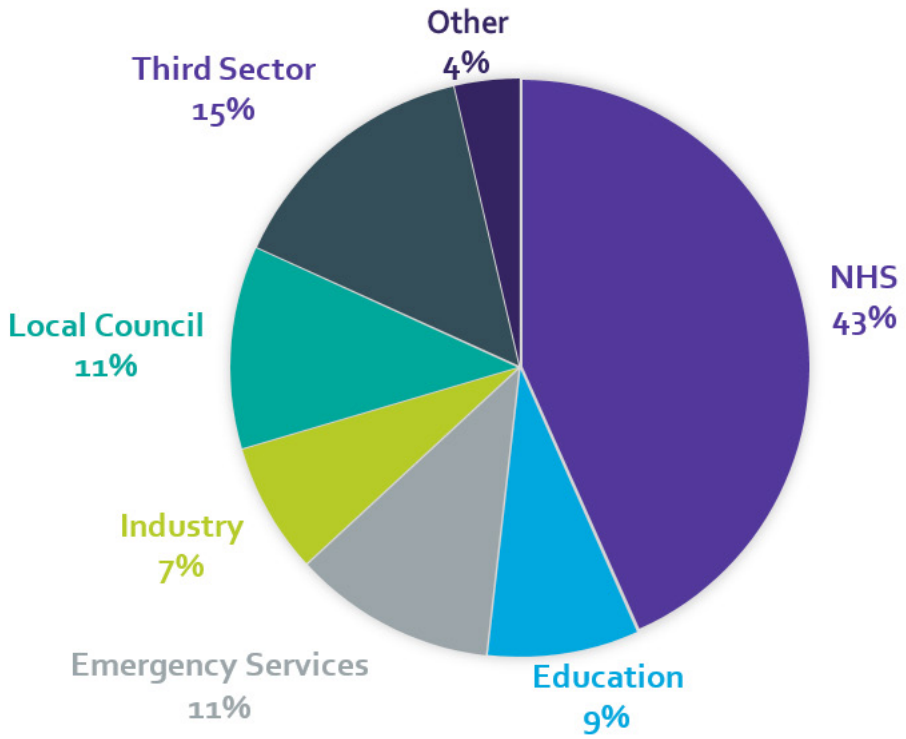
Workshop: Findings

6.1. Overview

Workshops were held in London, Bristol and Leeds to gather information to inform the content and design of the digital resource.

A total of 189 delegates attended the workshops, made up of various stakeholders from across NHS organisations (AHSN, acute, mental health, STPs, CCGs, NHSE/I), third sector, emergency services (police and ambulance), industry (business, digital), local councils (Public Health and Social Care). See figure 4 for split by sector. The complete list of professional role and organisation type can be found in Appendix 2 (2.1.1 and 2.1.2).

Figure 4: Split by sector



The workshops followed a similar format of questioning as per the digital survey. Delegates were asked to participate in several different methods of engagement which included:

Slido: an interactive question and answer and polling platform used to crowdsource questions and drive meaningful conversations. The HIN engaged participants with live polls and capture valuable event data, which was used to set the scene and get the audience thinking about the 'Go-To' digital resource. We asked the attendees:

- How often they look for suicide prevention information online
- To name the more commonly visited suicide prevention website
- To identify what topics would be useful in the digital suicide prevention resource

Workshop activities: two rounds of table activities were undertaken to help scope the design and content of the online resource:

1. To identify population groups 'you need to know more about and what you would like to know?'
2. To 'rate the highest priority key topics for inclusion on the digital resource'

Unlike the digital survey, each table were given just four different topic areas to discuss and prioritise, enabling the HIN to lead more in-depth conversation with the delegates to inform the ZSA Resources content.

6.2. Content findings

Delegates were given a list of quickfire questions via Slido, which was used to set the scene and get the audience thinking about the 'Go-To' digital resource, before the HIN moved to scope the content and design of the digital resource through group working. We asked delegates 'How often do you look for suicide prevention information online?' Figure 5 below provides the collated responses from the Slido sessions held in Bristol, Leeds and London. 36% of the respondents reported that they 'sometimes' access to suicide information resources online. 19% of the respondents stated they 'never' look for information online compared to 8% who stated they 'often' look for resources.

When questioned what was their 'most commonly visited suicide prevention website', the majority of respondents reported Samaritans as the most commonly visited website, followed by NHS, MIND and Papyrus (see Table 6). There were a limited number of responses to this question, which potentially backs the notion that most of the delegates choose not to look for suicide prevention information online.

Figure 5: How often do you look for suicide prevention information online?

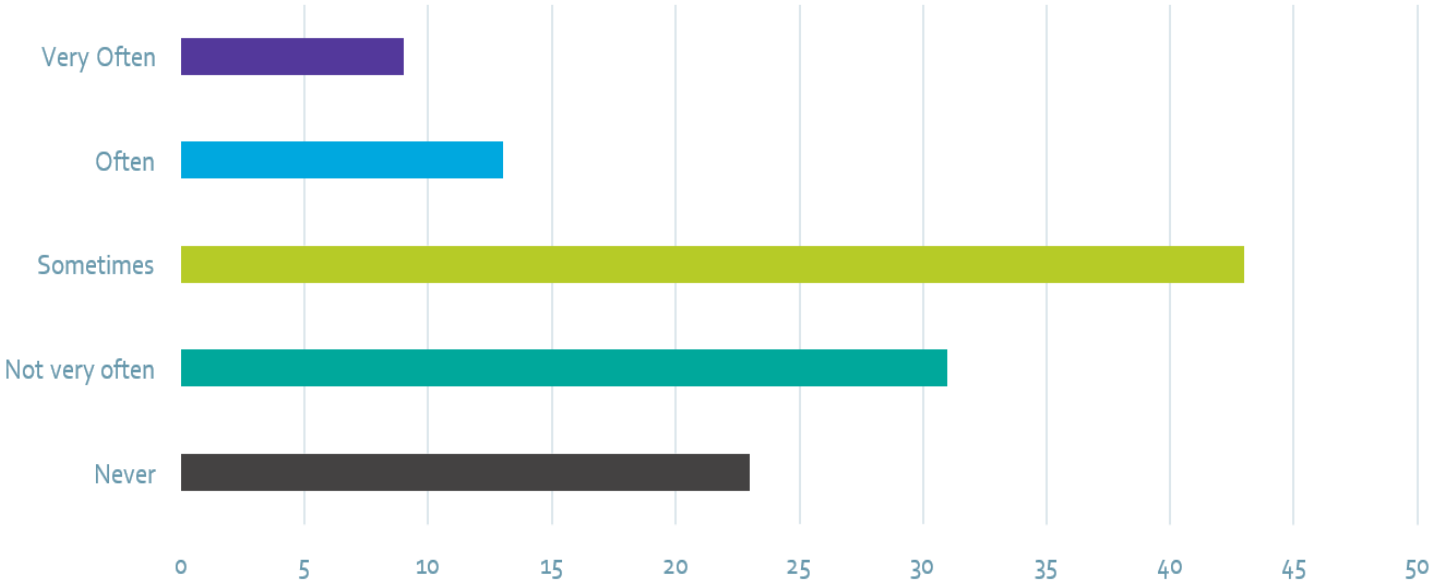
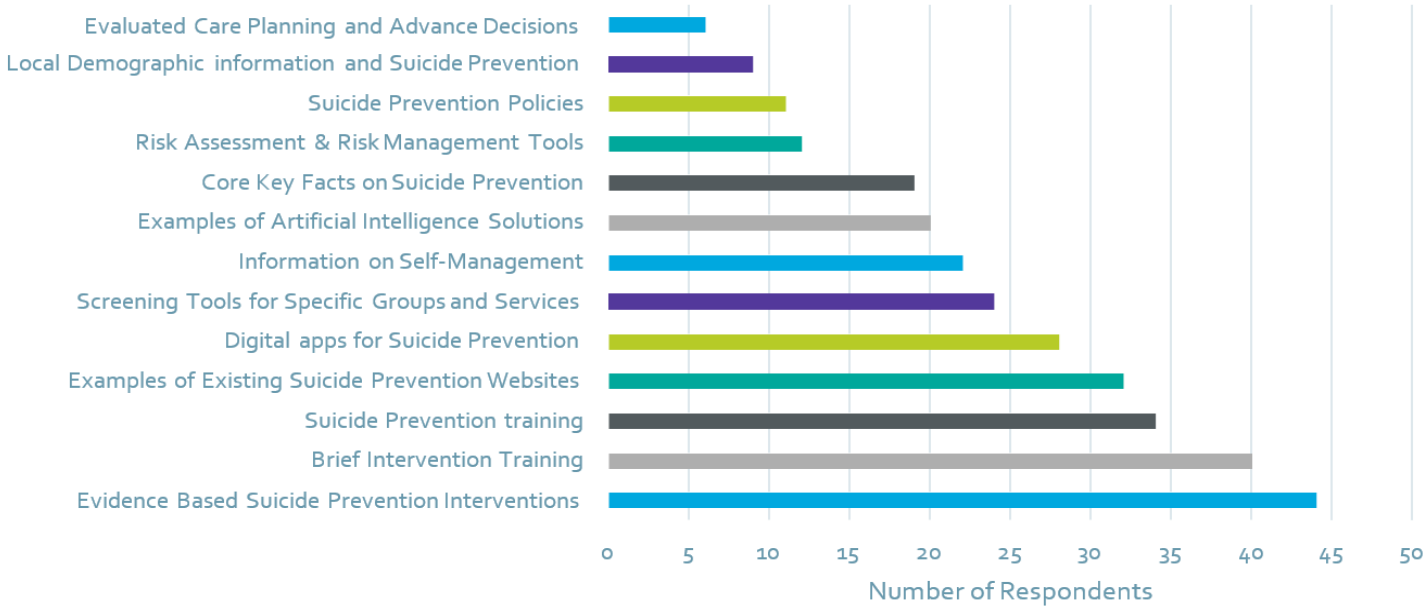


Table 6: Top 5 suicide prevention websites

Website	Number of responses
Samaritans	30
NHS	20
Mind	17
Papyrus	13
Zero Suicide Alliance	7

For the tabletop discussions, delegates were given topics from a predetermined list and were asked to choose if the topic was priority for themselves /organisation for inclusion in the digital resource. See figure 6 for collated results.

Figure 6: Topics of priority from table top discussions



As shown in figure 6 above, the topics that were voted for in greater numbers were 'evidence based suicide prevention interventions', 'brief intervention training' and 'suicide prevention training'. This mirrors the findings from the survey, where topics involving training, digital apps and screening tools were more popular than policies and evaluated care planning and advance decisions.

The table top workshop discussions are summarised below:

- Evidence based interventions were the dominant theme across the three workshops, as delegates mentioned the digital resource needs to provide a robust evidence base which can standardise interventions and develop effective training. They stated it is the most critical aspect of the tool as 'evidence informs policy and policy informs practice'
- Training - there was a clear need for a repository of useful guidance and training that professionals can use, and brief intervention training guides would be the 'most useful in a crisis'
- Digital Apps - delegates mentioned apps are increasingly being used, easily accessible, especially with younger audiences and can provide immediate use if someone is in distress
- Policies ranked lower in priority, delegates did mention their importance in terms of policies being essential for underpinning practice and helping professionals formalise their interventions
- Evaluated care planning and advanced decisions were mentioned as not often discussed, while some questioned its importance as an addition to the online resource.

Additionally, some delegates suggested the tool should also include communications campaign packages to help raise awareness across populations and professionals, and include core facts, images etc. Information on post intervention support was also highlighted as a need.

6.3. Population findings

All delegates were asked to complete a brief template to identify the population groups they felt were more at risk and would like to have more information on. While most delegates suggested that the online resource should cover a broader population approach and not become a targeted resource for specific groups, there were dominant population groups that were routinely mentioned from the findings:

- Young People were frequently mentioned as a key population group of interest. There was a clear need for more information on this group. Comments from delegates included that young people are a high-risk group and are often overlooked on the national agenda. There

is a need to know more about the psychological understanding in young people and what is their perceived notion on the value of life and reasons why suicide is their only option

- Men, specifically middle aged men (aged 30 – 50): delegates discussed that research shows that suicide is prevalent within this population. Delegates questioned how they could break the stigma on this group who do not engage well with mental health services and 'talk about their issues'
- LGBT+ communities were cited frequently as a group likely to encounter barriers in society and stated they would like to know more on guidance and best practice to best support this community
- BAME, migrants and people with learning disabilities were mentioned frequently. Delegates commented that there needs to be an emphasis on identifying statistics and research for these populations, knowing what training and interventions resources are available (covering risk factors, adjustments to interventions, accessibility of public resources) and effective signposting on existing resources.

Table 7 below provides an overview of the various population groups, the information needed and reasons why they found them important.

Table 7: Population recommendations from workshops

Population group	Comments
Young people	Cited frequently as a group at high risk/vulnerable. Delegates noted the links with self harm and suicide completion. Points were made on the group not being generalised, with support targeting ethnic minority cultures and social classes highlighted, as 'many young people may not share their thoughts and feelings with family or friends due to the stigma of mental health within their culture'.
Men	Men, specifically middle aged men, were featured quite highly as a group at risk, with more information needed on how best to support this group. It was felt this group is hard to engage with while having a high incidence rate. There was a clear need to understand which agencies own the problem and work together on creative ways to engage with men.
Learning disabilities	Many believed this population may present differently than others in regard to preventions strategies, as they are a vulnerable population, isolated and lack access across mainstream health and support services. Information on specific risk factors, adjustments to interventions, and accessibility of public resources were requested.
LGBT+	Delegates questioned why suicide is seen/viewed as a solution to LGBT+ issues and required more information on guidance, statistics and best approaches.
BAME	Examining the risk factors for this group was viewed as important as interventions will vary according to beliefs and values of cultural groups. It was commented that it can be more difficult to pick up on clinical indicators in those where English isn't their first language. It was questioned if there is enough statistics and research currently available and what are the bespoke services are available for them.
Migrants	Migrants were noted as hard to reach population, with difficulties in understanding the cultural difference and approaches to mental health and suicide. Several delegates stated younger people from immigrant families are more at risk as they likely to keep their issues a secret and do not access help unless it confidential. Greater engagement was needed and information on how to reach parent and communities that will pick their false assumptions and stigma around mental health.

Population group	Comments
Older People	Older people were highlighted as at risk due to: • Illness • Stigma • Bereavement • Isolation • Retirement and less likely to access services.
Autistic Spectrum Disorders	Better access to the support that is currently available, coping strategies and advice for families.
Serious Mental Illness	Delegates stated there is a gap between primary and secondary services and where patients are discharged from Community Mental Health Team to the GP. Self management can be challenging and may trigger a move from wellbeing to relapse or having suicide ideation. Delegates noted this group can receive poor experiences as service users and may 'fall through the cracks'. There was need beyond basic interventions - more medium / long term interventions that mental health professionals can unitise over a period of time.
Women	Rising evidence of self harm rates.
Professionals	Various factors (Stress to succeed, stress re finance)

6.4. Validity

Delegates were not asked specifically to feedback on validity of the resource, yet some delegates discussed this as part of their tabletop discussion. Commentary reflected that captured in the digital survey, requesting that the ZSA Resources is overseen by a multi-disciplinary team and includes experts by experience.

6.5. Design and navigation

As with validity, design and navigation were not explicitly posed as one of the questions for the workshop, a small number of delegates commented that:

- The resource needs to be easy to access and navigate
- Content should be built on a strong evidence base and not replicate what's already out there. While it would be good to have a huge repository of resources, there should be effective signposting and information on what has worked and what hasn't
- Some delegates stated that while the resource is for professionals, it should be open to the public in the future.

Recommendations

These recommendations are informed by the desk top research and stakeholder engagement reports and are duplicated within both reports.

Partnership opportunities

ZSA should:

- Investigate the opportunity for a variety of partnerships e.g. existing UK suicide prevention websites, app validators, technology developers and research partners
- Actively consider forming alliances with existing national leaders in suicide prevention to avoid duplication of material and a joined up approach
- Actively explore the opportunity to offer a space to facilitate partnerships eg. apps and AI solutions that need testing
- The National Suicide Prevention Alliance site hosts a number of suicide prevention resources. Their focus seems mainly on policy but has developed even during the time of research for this report. The HIN advises that consideration is given by ZSA to working with the NSPA to avoid duplication of resources and funding
- PHE Fingertips is a very comprehensive source of suicide prevention data. The HIN advises that ZSA considers how to work in partnership with PHE
- Thrive London are developing a heat map of London suspected suicides, they have indicated they are interested in discussions with ZSA. The HIN advises that ZSA contacts Thrive London to discuss opportunities
- ORCHA and Papyrus have recently formed a partnership - ORCHA is providing Papyrus with a microsite to allow young people to manage their own mental health, through the site they can gain access to approved apps alongside continued access to Papyrus's helplines. ZSA should explore options to work with ORCHA in relation to approved apps and Papyrus re youth suicide prevention
- Suicide Prevention Resource Center SPRC (USA). is the most similar resource to the ambition for the ZSA Resources, The HIN have had discussions with the SPRC and they are happy to engage with ZSA to advise them of their own experience (there maybe a cost attached to this advice).

Communication

ZSA should ensure that:

- A robust communication and marketing plan will be required to ensure suicide prevention stakeholders are aware of the ZSA Resources
- The digital solution needs to be 'accessible' to all professions working in suicide prevention, navigation and signposting needs to be simple and effective.
- The resource is welcoming to all professions/sectors and not just NHS focused
- Contact information is displayed for sources of information /resources to facilitate further discussion
- Data is handled in accordance with best practice and regulation
- User feedback informs the resource.

Validation and content

ZSA should:

- Adopt a multidisciplinary approach to content curation and validation should be adopted
- Be clear about validation process in place for content, display details on the multidisciplinary 'panel' who are responsible for content
- Include experts by experience within the advisory group
- Consider best practice solutions for inclusion where evidenced based solutions are not available
- Prioritise evidenced based suicide prevention interventions and suicide prevention training for development
- Include national, local and international resources
- Include crisis helplines for members of the public and professionals accessing the site
- Adopt a whole population approach with information on specific groups
- Include suicide prevention workforce /occupation resources.

Sustainability

ZSA will need to:

- Resource the set up and ongoing development and maintenance of the resource
- Continually review the purpose/intended outcome measures of the site, respond to need, user feedback and innovation.

Acknowledgements

Workshop presenters:

- Carol Lavelle, Lived Experience representative of the Humber Coast and Vale Suicide Prevention Steering Group
- Diane Lee, Head of Public Health, Barnsley Council
- Dr Sangeeta Mahajan, Thrive London Suicide Prevention Co-chair
- Geraldine Strathdee, Ambassador for Mental Health
- Mark Ames, Director of Student Services, Bristol University
- Steve Mallen, Zero Suicide Alliance
- Superintendent Mark Lawrence, Met Police Lead Mental Health
- Zoe O'Neill, Head of Engagement, Greater Manchester Health and Social Care Partnership

AHSN Network:

- Greg Harris, Project Support Officer, West of England AHSN
- Katherine Gale, Mental Health Programme Coordinator, Wessex AHSN
- Megan Kirbyshire, Senior Project Manager, West of England AHSN
- Sarah Appleby, Mental Health Lead, West Midlands AHSN
- Khalida Rahman, Programme Manager, Yorkshire and Humber AHSN
- Victoria Vaines, Programme Manager, Yorkshire and Humber AHSN

Stakeholders who participated in telephone interviews:

- Shelley Aldred, Programme Lead Health and Wellbeing, Public Health England
- Emma Austin, Young People Services, MIND
- Sara Bates, Executive Lead, Support after Suicide Partnership
- Melanie Brooks, Director of Adult Social Care, Nottinghamshire Council
- Vikki Cochran, Suicide Prevention Transformation Programme Manager, NHS England and Regional Mental Health Programme Team, NHS Improvement – South West Region
- Leah de Souza-Thomas, Health Improvement Manager, Public Health England London
- Aileen Edwards, Chief Executive, Second Step
- Lesley Elmes, Suicide Prevention Strategy Project Manager - North Region, NHS England and NHS Improvement
- Peter Fonagy, Head of Psychology and Language Sciences, University College London; Chief Executive, Anna Freud National Centre for Children and Families
- Tom Gentry, Policy Lead, AGE UK
- Dr Clare Gerada, MBE FRCP FRCGP MRCPsych, Medical Director, GP Health Service
- Rachel Gibbons, Therapy Director, Priory Group
- Rich Green, Adult Services, MIND
- Dr Daniel Harwood, Consultant Psychiatrist and Clinical Director for Dementia London Strategic Clinical Network. NHS England
- Julian Hosking, Her Majesty's Prison and Probation Service
- Sarah Hughes, Chief Executive, Centre for Mental Health
- Rachel Jenkins, Mental Health Lead (87-92) (CHECK), Department of Health
- Lisa Marzano, Associate Professor in Psychology, University of Middlesex
- Mark Matthews, Assistant Director Safer Communities BSc (Hons) MBA, NFCC Mental Health Lead, East Sussex Fire and Rescue Service.
- Dr Phil Moore, Deputy Chair (Clinical) NHS Kingston CCG; London Specialist Clinical Network for mental health.
- Jacqui Morrissey, Assistant Director, Research and Influencing, Samaritans

- Sacha Richardson, Director of Family Services, Winstons Wish
- Eileen Sutton, Head of Urgent and Emergency Care. Healthy London Partnership London Regional IUC Lead NHS England.
- Ian Toman, Technology Manager, Big White Wall
- Paul Trevers, Detective Super Intendant, Metropolitan Police
- Keith Waters, Self-Harm/Suicide prevention Clinical Director, Derbyshire Healthcare NHS Foundation Trust
- Professor Sir Simon Wessely, M.A., M.Sc., M.D., F.R.C.P., M.R.C.Psych, President of the Royal College of Psychiatrists
- Professor Steve West, University West of England, West of England AHSN
- Constance Wou, National Medical Director's Clinical Fellow, NHS England

Appendices

Appendix 1: Survey questions and full results

1. Please tell us your name
   [Free text response]

2. Job title
   [Free text response]

Profession group	Profession group 2	% (no.) of respondents
Healthcare related professions	Nursing	10% (70)
	Programme / project management	6% (47)
	CEO / Director level	6% (41)
	Pharmacists	5% (39)
	Public health	5% (33)
	Service delivery	4% (26)
	GPs	4% (26)
	Commissioning	3% (22)
	Therapists / Counsellors	2% (17)
	Psychologists	2% (16)
	Psychiatrists	2% (15)
	Clinical leads	2% (13)
	Mental health / Suicide prevention leads	2% (11)
	Recovery / Support workers	1% (8)
	Operations managers	1% (7)
	Occupational health	1% (6)
	Paramedics / emergency medicine	1% (5)
	Other	13% (97)
	Student wellbeing	3% (22)
Teaching / student facing professions	Lecturers	1% (7)
	Directors / Heads	0.4% (3)
	Other	2% (14)
Industry	Business	3% (19)
	CEO / Director level	1% (10)
	Lawyers	1% (8)
	Other	1% (8)
	CEO / Director level	3% (19)
Third sector	Managers / Leads	2% (12)
	Volunteers	0.3% (2)
	Other	2% (11)
Emergency services	Police officers	5% (39)
	Fire officers	0.4% (3)
Academia	Researcher	1% (8)
	Professor	1% (6)
Social care	Social workers	1% (6)
	Other	0.4% (3)
Other	Other	3% (25)

3. Organisation
[Free text response]

Organisation type	Organisation type 2	% (no.) of respondents
NHS	Mental health trusts	28% (202)
	STP / ICS / CCGs	6% (44)
	Acute trusts	4% (27)
	ASHN / Similar	3% (21)
	NHS England / Improvement	2% (15)
	Primary care	2% (13)
	Healthy London Partnership	1% (7)
	Health Education England	1% (5)
Education	Universities	7% (52)
	Schools / Colleges	2% (16)
	Mental health charities	6% (46)
	Addiction charities	1% (9)
	Think tanks	1% (4)
	Children and young people's charities	0.3% (2)
Third sector	Elderly people's charities	0.1% (1)
	Bereavement charities	0.1% (1)
	Travellers' charities	0.1% (1)
	Autism charities	0.1% (1)
	Healthcare charities	0.1% (1)
	Armed services / Veterans' charities	0.1% (1)
	Police	6% (40)
Emergency services	Ambulance services	2% (15)
	Fire services	1% (4)
Local councils	Public health	7% (52)
	Social care	0.4% (3)
	Digital	2% (14)
	Legal	2% (12)
Industry	Other industries	2% (12)
	Business	0.4% (3)
	Train service	0.1% (1)
	Rural	0.1% (1)
Other healthcare	Other healthcare	9% (68)
	Public Health England	1% (5)
	Unknown	2% (11)
	Prisons / Probation	1% (6)
Other	Housing	1% (5)
	Care homes	0.3% (2)
	Department for Work and Pensions	0.1% (1)

4. Do you currently access online suicide prevention resources?

Response	% (no.) of respondents
Yes	33% (239)
No	67% (485)

5.The digital resource for suicide prevention will include signposting to local suicide prevention information. Please provide the name of your local suicide prevention website:

[Free text response]

National resources	
Resource	**Number of respondents**
Samaritans	55
Papyrus	18
Zero Suicide Alliance	18
Stay Alive app	15
Staying Safe	8
CALM	6
NHS	5
Hub of Hope	5
Sane	4
Health Education England National Suicide Prevention	4
Alliance	4
Prevent Suicide	3
Time to Change	3
Fingertips	3
KOOTH	3
Young Minds	3
ASSIST	3
Students Against Depression	2
distrACT app	2
The Ollie Foundation	2
MECC Link	2
CalmHalm	2
Childline	2
Support After Suicide	2
Nightline	2
Good Thinking	2
Royal College of Nursing	2
Connecting with People	1
If U Care Share	1
Farming Community Network	1
Rethink	1
High Intensity Network	1

Local resource types	
Resource type	**Number of respondents**
Local authority websites	43
Local signposting websites	29
Local Mind websites	27
Local suicide prevention campaigns	20
Trust websites	20
Local third sector / support organisations	12
Internal sites (eg. trust intranet)	9
CCG websites	7
Local health / wellbeing partnership websites	5
Healthwatch	4
Local training	3
University websites	2
Local NHS suicide prevention websites	2
Local safeguarding partnership websites	2
STP websites	1
Local data sharing	1

Confidential Inquiry into Suicide and Homicide (University of	
Manchester)	
1	
Centre for Suicide Prevention	1
S12	1
Suicide Prevention Lifeline	1
Big White Wall	1
Heads Together	1
Help is at hand	1
Survivors of Bereavement by Suicide	1
harmInjury Support	1
Harmless	1
7 Cups	1
Mental Health	1
MoodPath app	1

6. What are the most important topics to include in this digital suicide prevention resource? Select your top five options only.

Topic	% (no.) of respondents
Evidence based suicide prevention interventions	74% (534)
Suicide prevention training	66% (481)
Risk assessment, risk management tools	54% (394)
Information on self management	50% (361)
Brief intervention training	49% (354)
Digital apps for suicide prevention	47% (338)
Screening tools for specific groups and services	36% (259)
Examples of existing websites	31% (223)
Local demographic information and suicide prevention Plans	29% (213)
Core key facts presentations	25% (184)
Suicide prevention policies	19% (138)
Evaluated care planning and advance decisions	13% (94)
Other	7% (48)
Examples of Artificial Intelligence solutions	6% (47)

7. Which population groups / topics would you like to access more information on in relation to suicide prevention? Please tick all that apply:

Population group / topic	% (no.) of respondents
People with serious mental illness	66% (484)
People with personality disorders	62% (454)
Suicide attempt survivors	59% (428)
Self-harm	58% (426)
Teens and younger people (13 - 25)	58% (424)
Bereaved through suicide	51% (376)
Men	51% (375)
LGBT+	49% (356)
College / University students	48% (351)
Substance misuse	46% (339)
People with autism	46% (339)
Bereavement	42% (311)
Older adults	39% (285)
Perinatal mental health	38% (281)
BAME	38% (277)
Women	38% (277)
Veterans	37% (274)
Lower socio-economic groups	37% (273)
Addictions / Gambling	36% (263)
Armed Forces	35% (260)
Children in care	35% (256)
Unemployed	32% (232)
Prisoners	31% (231)
Young offenders	30% (224)
Children (12 and under)	30% (221)
Occupational high-risk groups (please provide details in 'other' comment box below)	25% (181)
Other groups (please list below)	16% (122)
Sports high risk groups (please provide details in 'other' comment box below)	15% (112)

8. Validity of the content on the digital resource is a priority. Please indicate who should oversee this requirement.

Validator	% (no.) of respondents
Psychiatrist	63% (456)
Mental Health Nurse	59% (429)
Psychologist	55% (396)
GP	38% (272)
Researcher	35% (254)
Other (please specify)	22% (161)

9. How would you like to view the digital resource?

Method	% (no.) of respondents
Desktop / laptop	80% (581)
Mobile phone	74% (534)
Tablet	51% (369)

10. Any other comments?

[Free text response]

Appendix 2: Workshop and Slido

2.1. Workshop Information

2.1.1. Profession

Profession group	Profession group 2	% of respondents
Healthcare related professions	Nursing	6% (11)
	Programme / project management	21% (40)
	CEO / Director level	6% (12)
	Pharmacists	1% (1)
	Public health	2% (3)
	Service delivery	2% (4)
	GPs	1% (1)
	Commissioning	1% (1)
	Therapists / Counsellors	1% (1)
	Psychologists	0
	Psychiatrists	1% (1)
	Clinical leads	4% (8)
	Mental health / Suicide prevention leads	5% (9)
	Recovery / Support workers	4% (8)
	Operations managers	2% (4)
	Occupational health	0
	Paramedics / emergency medicine	4% (7)
	Other	1% (2)
	Student wellbeing	
Teaching / student facing professions	Lecturers	1% (1)
	Directors / Heads	4% (8)
	Other	3% (6)
	Business	2% (4)
Industry	CEO / Director level	3% (6)
	Lawyers	0
	Other	1% (2)
	CEO / Director level	3% (6)
	Managers / Leads	6% (12)
Third sector	Volunteers	1% (1)
	Other	1% (1)
Emergency services	Police officers	6% (11)
	Fire officers	0
Academia	Researcher	3% (5)
	Professor	0
Social care	Social workers	1% (2)
	Other	3% (5)
Other	Other	3% (6)

2.1.2. Organisation

Organisation type	Organisation type 2	% (No) of Attendees
NHS	Mental health trusts	17% (33)
	STP / ICS / CCGs	4% (7)
	Acute trusts	6% (11)
	ASHN / Similar	5% (9)
	NHS England / Improvement	5% (10)
	Primary care	5% (9)
	Healthy London Partnership	1% (2)
	Health Education England	1% (2)
Education	Universities	7% (14)
	Schools / Colleges	2% (4)
Third Sector	Mental health charities	8% (15)
	Addiction charities	1% (2)
	Think tanks	1% (2)
	Children and young people's charities	2% (3)
	Elderly people's charities	0
	Bereavement charities	0
	Travellers' charities	1% (1)
	Autism charities	0
	Healthcare charities	2% (3)
	Armed services / Veterans' charities	0
Emergency services	Police	7% (13)
	Ambulance services	4% (7)
	Fire services	0
Local councils	Public health	8% (16)
	Social care	2% (3)
Industry	Digital	3% (6)
	Legal	2% (4)
	Other industries	2% (4)
	Business	0
	Train service	1% (1)
	Rural	0
Other	Other healthcare	0
	Public Health England	2% (3)
	Unknown	0
	Prisons / Probation	0
	Housing	1% (1)
	Care homes	2% (3)
	Department for Work and Pensions	0

2.2. Slido results

2.2.1. How often do you look for suicide prevention information online?

Response	% (no.) of respondents
Never	19% (23)
Not very often	26% (31)
Sometimes	36% (43)
Often	11% (13)
Very Often	8% (9)

2.2.2. Name your most commonly visited suicide prevention website?

Resource	Number of respondents
Samaritans	30
NHS	20
Mind	17
Papyrus	13
Zero Suicide Alliance	7
National Suicide Prevention Alliance	6
Public Health England	5
Fingertips	5
Grassroots	4
Health Education England	4
MASH	4
Mind Mate	3
Men's Health Forums	3
RCPSYCH	3
Young Minds	3
Thrive London	3
Lighthouse	3
Trust Websites/Resources	2
Journal Papers	2
Local Foundations	2
Rethink	2

2.2.3. Interventions – do you believe the following would be useful to access in a 'go-to' digital suicide prevention resource?

1. Examples of Artificial Intelligence Solutions?

Response	
Yes	42%
No	17%
Unsure	41%

2. Examples of Existing Websites?

Response	
Yes	95%
No	0%
Unsure	5%

3. Suicide Prevention Policies?

Response	
Yes	81%
No	8%
Unsure	11%

4. Evidence based suicide prevention interventions?

Response	
Yes	97%
No	2%
Unsure	2%

5. Digital apps for suicide prevention?

Response	
Yes	82%
No	3%
Unsure	15%

6. Core key facts for presentations?

Response	
Yes	84%
No	3%
Unsure	13%

7. Suicide Prevention Training?

Response	
Yes	97%
No	0%
Unsure	3%

8. Screening tools for specific groups and services?

Response	
Yes	69%
No	5%
Unsure	26%

9. Risk assessment and risk management tools?

Response	
Yes	74%
No	12%
Unsure	14%

10. Brief Intervention Training?

Response	
Yes	91%
No	3%
Unsure	6%

11. Information on self management?

Response	
Yes	84%
No	6%
Unsure	9%

12. Evaluated care planning and advance decisions?

Response	
Yes	64%
No	5%
Unsure	30%

13. Local demographic information and suicide prevention plans?

Response	
Yes	81%
No	7%
Unsure	12%