Sussex Suicide Prevention Strategy and Action Plan

2024 -2027

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Contents

1.0 Introduction

1.1 Background

Suicide is used in this strategy to mean a deliberate act that intentionally ends one's life. The World Health Organisation highlights suicide as a major public health risk, accounting for one in 100 of all deaths globally[1]. They estimate that for every suicide there are 20 non-fatal suicide attempts[2].

Every death by suicide is an individual tragedy and a cause of huge distress to friends, families, and communities. It is estimated that the cost to the economy of each suicide is £1.67 million[3]. For every one suicide there can be up to 135 people significantly impacted[4]. For any one year, approximately 24,000 people in Sussex were affected by suicide. We know that across Sussex, the number of people who have enduring and in many cases a life-long negative impact from suicide is substantial.

There is rarely a single reason why someone takes their own life. Suicide is often the end point of a complicated history of risk factors and distressing events. It is best understood through life circumstances, in a complex interplay of risk factors and adverse experiences. Suicide risk also reflects wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances, with those in poorer communities and those who are socially excluded more likely to be affected.

Suicides are not inevitable. There are many ways in which individuals, communities, services, and society can help to prevent suicides. An inclusive society that builds individual and community resilience, avoids the marginalisation of individuals, and supports people at times of personal crisis will help to prevent suicides.

As a significant percentage of people who die by suicide are not in contact with secondary mental health or social care services, action is also required beyond the health and social care system. Many have not told anyone that they're feeling suicidal or made a suicide attempt in the past, although it is known that many men will have visited their GP for other reasons in the 3 months prior to their death.[5] Real partnership is required with community groups, local business and the third sector to help identify and support people at risk of suicide and those bereaved by suicide.

Preventing suicide is therefore achievable. The delivery of a comprehensive local partnership suicide prevention strategy is essential to reduce deaths by suicide by suggesting interventions that build community resilience and target groups of people at heightened risk. This Strategy and Action Plan have been developed using the combined knowledge, expertise and resources of organisations and individuals across the public, private and voluntary sectors in Sussex.

On 11th September 2023 the government published its new national strategy "Suicide Prevention in England: 5-year cross-sector strategy.[6] This strategy is the update to the

previous strategy published in 2012 and there have been five government progress reports published since then, with the most recent report issued in March 2021. The new national strategy reflects the latest evidence and national priorities for preventing suicides, outlines 8 action areas and covers the following priority groups and risk factors at population level.

Priority groups	**Risk factors at a population level**
• Children and young people • Middle-aged men • People who have self-harmed • People in contact with mental health services • People in contact with the justice system • Autistic people • Pregnant women and new mothers	• Physical illness • Financial difficulty and economic adversity • Gambling • Alcohol and drug misuse • Social isolation and loneliness • Domestic abuse

Throughout the life of this strategy, we will we continue to measure and monitor progress against implementation and set out ambitious actions that will tackle these challenges as they arise, focussing on the interventions and actions that will make the biggest difference.

1.2 Vision and Aims

In line with the national strategy*, Suicide prevention in England: 5-year cross-sector strategy*[7], and associated *Suicide prevention strategy: action plan*[8] the aims of the Sussex Suicide prevention Strategy and Action Plan are to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- improve support for people who have self-harmed.
- improve support for people bereaved by suicide.

It is our vision that Sussex is a place where:

- we are committed to reducing the risk factors and increasing the protective factors for suicide across the life course.
- we build individual and community resilience to improve lives and prevent people falling into crisis by tackling the risk factors for suicide.
- we recognise that suicides can be prevented, and that people do not inevitably end up considering suicide as a solution to the difficulties they face.

- we create an environment where anyone who needs help knows where to get it and is empowered to access that help.

In line with the national strategy this is a multi-agency partnership strategy whereby suicide is everybody's business and there is joint responsibility and joined up accountability for delivery of action at local levels.

At a place-based level all three areas in Sussex have suicide prevention action plans delivered via multi-agency partnerships. Each organisation may also have their own strategies and plans in place, this includes Sussex Partnership NHS Foundation Trust, the local mental health trust.

The pan-Sussex Suicide Prevention Strategy builds on local plans and capitalises on the added value and economies of scale inherent in a pan-Sussex approach. It serves as a framework for action at both Sussex level and for local approaches at place level- highlighting actions best delivered at system wide level, whilst recognising that implementation will be assisted by the existing local stakeholder strategies and groups.

The Sussex Suicide Prevention Strategy has been developed by the pan-Sussex Suicide Prevention Steering group with support from place-based suicide prevention groups. Members include Brighton and Hove, East and West Sussex Public health, Sussex Integrated Care Board, Sussex Partnership Foundation Trust, Sussex Police and representatives for the Community and Voluntary sector.

The progress of the strategy will be monitored through this group based on the *Sussex Suicide Prevention Strategy One Year Action Plan*, updated annually. See section 8.3.

In 2022, prior to the publication of the latest national strategy, an engagement exercise took place with key stakeholders from the Sussex Suicide Prevention partnership, giving partners the opportunity to shape the 'Statements of Intent' for national Action Areas. The approach of this strategy is based on the action areas of the 2023 national strategy. These are set out below.

Eight key action areas in Sussex Suicide Prevention Strategy and Action Plan (2024-27):

Action Area 1: Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.

Support learning, research, data collection and monitoring.

It is critically important to improve system learning from available data and to adapt/escalate approaches where possible, taking account of intersectionality of factors that contribute to suicide.

Action area 2: Provide tailored, targeted support to priority groups, including those at higher risk.

Several population groups face an increased risk of suicide. Our first priority is to reduce risk in these groups. We will ensure there is bespoke action and interventions that are effective and accessible for everyone.

Action area 3: Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.

Tailor approaches to improve mental health in specific groups.

Work done 'upstream' to promote good mental health, emotional resilience and wellbeing can play a role (by reducing the flow of people into 'at risk' groups) in our plans for suicide prevention. This includes giving people the tools and confidence to talk openly about their mental health.

Action area 4: Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.

There has been emerging evidence of the link between the online environment and suicide across different age groups. Internet use for suicide-related purposes has been linked to children and young people who have presented to hospital for self-harm or a suicide attempt and middle-aged men who have died by suicide.

Action area 5: Providing effective crisis support across sectors for those who reach crisis point.

It is essential that timely and effective crisis support is available to those who need it.

Research by NCISH suggests that, of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 15% were under the care of crisis resolution and home treatment teams[9] (CRHTTs). This is equivalent to 180 suicides per year on average. NHS 24/7 mental health crisis lines currently receive around 200,000 calls each month. And many more people are in contact with crisis services provided by other organisations, including those from the voluntary sector.

Action area 6: Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

Suicides often take place during a period of crisis. Reducing access or delaying access to the means of suicide for that crisis moment can prevent a suicide from taking place.

Action area 7: Providing effective bereavement support to those affected by suicide.

People who are bereaved through suicide are at greater risk of suicide and poor mental health.

Action area 8: Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

System leadership, quality improvement and communications requires clear leadership and governance across the wider suicide prevention system are essential to coordinate and drive suicide prevention efforts. Effective, sensitive cross partner and wider communication also sits at the heart of impactful suicide prevention approaches.

Several other national frameworks, evidence, and resources were also used to shape the Sussex Suicide Prevention Strategy and Action Plan (2024-2027). See **Appendix 1.**

2.0 Moving to Action in Sussex

The Sussex Suicide Prevention Strategy and Action Plan (2024-2027) supports taking early action across a range of settings to prevent individuals from reaching the point of personal crisis where they feel suicidal, whilst also ensuring that those in crisis will get the support they need.

The Sussex Suicide Prevention Steering Group, a multi-agency partnership group, will oversee the delivery of this strategy and action plan. Members of the partnership include: Brighton and Hove, East and West Sussex Public health, Sussex Integrated Care Board, Police, Sussex Partnership Foundation Trust and representatives for the Community and Voluntary sector.

The multi-agency Sussex Suicide Prevention Steering Group share the following values:

2.1 Values

- Across Sussex we don't tolerate health and social inequalities or stigma. We want to dismantle prejudicial attitudes and discriminating behaviour directed towards suicide and at people with lived experience of mental illness, suicide, and self-harm.
- We use a people-first and trauma-informed approach which acknowledges the challenges that individuals face. We involve people with lived experience to inform our approach to suicide prevention and suicide bereavement.
- Collaborative working with partners - we use a whole-system approach, working in collaboration with partners and stakeholders to address the complex nature of suicide and self-harm. Suicide is everyone's business.
- Data driven, evidence based-we are guided by local data and real-time surveillance which enables us to quickly and effectively help those who are most at risk. We are committed to improving data collection with a focus on recently identified risk factors and high-risk groups.
- System leadership (we act as system leaders to drive change throughout Sussex).
- We look after our front-line staff, and support an inclusive, 'no-blame' culture.

2.2 The Case for Working at a Pan-Sussex Level

Between 2019 and 2023, Sussex benefited from an NHS England funded suicide prevention and self-harm programme which was delivered across Sussex. This initiative capitalised on cross partner collaboration and integration of programmes of work involving many local organisations, both statutory and voluntary. The work highlighted the benefits of working at scale, bringing efficiencies and innovations across Sussex whilst also enhancing placed based approaches. (See **Appendix 2** for evidence of achievements of NHSE Sussex programme)

Now the NHS England funded programme has come to an end, the need for a more cohesive and formalised response to emerging trends across Sussex has become apparent.

Working at a Pan-Sussex level will bring many advantages. This does not negate the need for local place-based plans and activities but brings added value to the work already taking place. The Sussex Suicide Prevention Strategy and Action Plan can serve as a framework for both pan-Sussex and local approaches.

2.3 Areas Best Approached at Pan-Sussex Level

The following areas lend themselves to strong collaboration at Sussex level:

Suicide Response:

This includes collation of timely suicide data, including Real Time Surveillance, leading to ascertainment of ongoing suicide risk and the need for bereavement support (including support for front-line staff).

Response will also incorporate engagement with organisations outside Sussex when people who die as a result of suicide in Sussex are not Sussex residents.

Working with Sussex-wide partners:

Collaborative working with key partners that operate under a Sussex wide footprint: Sussex Police, Sussex Partnership NHS Foundation Trust, Sussex Integrated Care Board, Acute Medical Trusts, educational settings, voluntary and community sector etc.

Suicide Prevention and awareness training:

Where possible training will be developed and co-ordinated at Sussex level.

Online Harms, Communications and Responsible Media Reporting:

Communications relating to suicide and suicide prevention will be co-ordinated and harnessed across the wider Sussex partnership, bringing communications teams from partner organisations together for a collective approach. This will include wider mental health communications strategies e.g., to tackle mental illness stigma.

Specific action will be taken to reduce online harms and the media will be encouraged to consistently portray suicide and self-harm content responsibly, following high-quality guidelines and resources to do this.

Lived experience:

Approaches to tackling causes of suicide will be informed by input from those with lived experience across Sussex (includes people who are bereaved by suicide, people who have felt suicidal, people who have attempted suicide, and their families and carers)

Self-harm:

Addressing the causes and impact of self-harm lends itself to a Sussex wide approach by building on recent work by the self-harm learning network and addressing the recommendations of the Foundations for our future Strategy (children and young people's mental health).

Co-existing illness:

Tackling mental illness and substance abuse will be more effective at pan-Sussex level given that there is a single main secondary mental health service provider across Sussex (SPFT) and a single organisation (CGL) that provides substance misuse treatment services for each of the three places across Sussex.

Expanding focus on existing, new, and emerging priority groups

Newly emerging priority groups e.g., Children and young people, looked after children and care leavers, pregnant women and new mothers, LGBTQ+, neurodivergent individuals, ethnic minorities including those who are Gypsy, Roma or Travellers, refugees and asylum seekers, people with harmful gambling behaviours, victims and witnesses of domestic abuse, people who misuse substances, people in contact with criminal justice system, younger Armed Force Veterans may be best tackled at Sussex level.

2.4 Governance (Oversight)

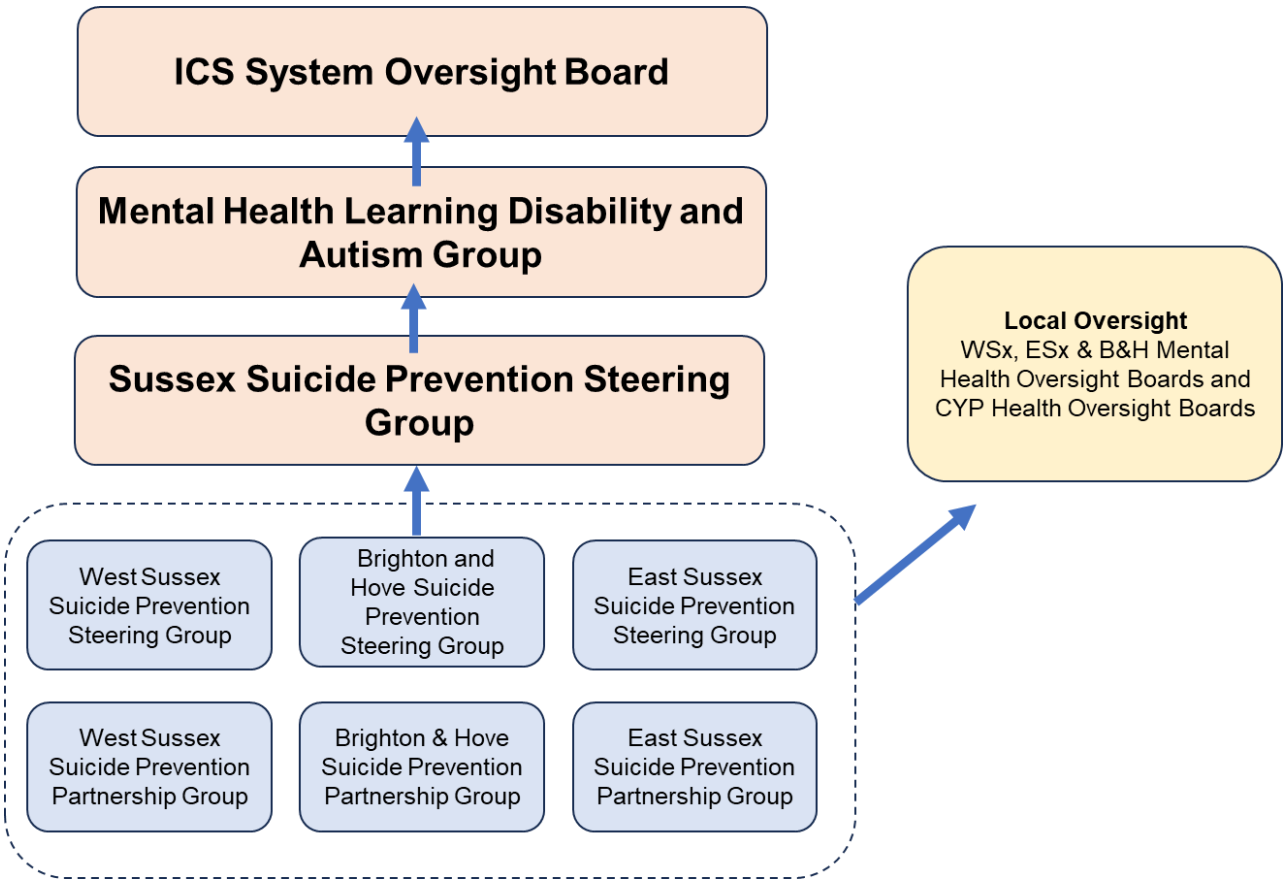
The need to develop local plans that engage a wide network of stakeholders was established in the government's national strategy for England, '*Preventing suicide in*

England[10]' released in 2012. Councils were given the responsibility for leading the development of local suicide action plans through their work with health and wellbeing boards.

The new national strategy highlights the importance of cross-sector working and joint action, including at a local level through integrated care partnerships, integrated care boards (ICBs), local authorities and local suicide prevention organisations.

The Sussex Suicide Prevention Strategy (2024-2027) will be governed by the Sussex Suicide Prevention Steering Group. This group will provide feedback directly to local Directors of Public Health, to local oversight boards and to the Mental Health Learning Disability and Autism Board of the ICS.

Governance of the Sussex Suicide Prevention Strategy



The Sussex Suicide Prevention Steering Group will work to ensure that prevention is co-ordinated well both at a Sussex level and with the three places of Brighton and Hove, West Sussex and East Sussex. It will further work to ensure it aligns with and complements other plans and strategies, including,

1. The Sussex Partnership NHS Foundation Trust (SPFT) 'Towards Zero Suicide' plan based on NCISH's 'Ten ways to improve safety'.

2. Sussex Foundations for Our Future (FFOF) Children and Young People's Mental Health Strategy.

2.5 Working Together

Whilst public health teams in local authorities provide leadership, multi-agency partnerships have responsibility for overseeing and delivering much of the suicide prevention activity, addressing as they do many of the known risk factors, such as alcohol and drug misuse[11].

Councils (including district, borough, and parish councils) span efforts to address wider determinants of health such as employment and housing. NHS Integrated Care Boards hold the responsibility for all health and care services and specific to suicide prevention, bereavement support. In addition, there are important opportunities to reach local people who are not in contact with health services through online initiatives and through working with the voluntary and community sector.

NHS trusts provide over half of all NHS hospital, mental health and ambulance services. Consequently, they have a crucial role to play in suicide prevention including front line mental health services. Wider services can be at the heart of delivering our ambition of 'every interaction matter's including :

- first appointments with midwives and ongoing antenatal care
- referrals to GPs and/or specialist mental health services
- engagement with health visitors
- engagement of a specialist teenage pregnancy or drug and alcohol specialist midwife

3.0 Context of Suicide Prevention

3.1 Policy Context

On 11th September 2023, the Department of Health and Social Care published a new national strategy*, Suicide prevention in England: 5-year cross-sector strategy*[12], and associated *Suicide prevention strategy: action plan*[13].

This new strategy sets out the national ambitions for suicide prevention over the next 5 years and the steps we need to take collectively to achieve them. This includes individuals, organisations across national and local government, the NHS, the private sector, the VCSE sectors, and academia.

To be successful, we should all consider and incorporate the following principles in the design and delivery of interventions, services, resources and activities to prevent suicides. These are:

- suicide is everybody's business. Everyone should feel they have the confidence and skills to play their part in preventing suicides – not just those who work in mental health and/or suicide prevention directly – and take action to prevent suicides within and outside of health settings.
- mental health is as important as physical health. We must reduce stigma surrounding suicide and mental health, so people feel able to seek help – including through the routes that work best for them. This includes raising awareness that no suicide is inevitable.
- nobody should be left out of suicide prevention efforts. This includes being responsive to the needs of marginalised communities, addressing inequalities in access to effective interventions to prevent suicides. It also requires listening to individuals and being responsive to their needs.
- early intervention is vital. In addition to providing support to those experiencing crisis and/or suicidal thoughts or feelings, action needs to be taken to stop people reaching this point.
- voices, perspectives and insights of people with personal experience should inform the planning, design and decisions at all levels of suicide prevention activity. This includes people with experience of feeling suicidal, those who have made previous suicide attempts, and people who are bereaved by suicide.
- strong collaboration, with clarity of roles, is essential. Suicide prevention is the responsibility of multiple government departments, as well as wider public, private and VCSE sector organisations.
- timely, high-quality evidence is fundamental. Practice and policy should be informed by high-quality data and research, and be responsive to trends and emerging evidence. This includes harnessing digital technology and data advancements to provide earlier interventions and wider access to support.

This will require a national government effort, as well as continued action across the NHS, local government, the voluntary, community and social enterprise (VCSE) sectors, employers and individuals. The aim of this cross-government strategy is to bring everybody together around common priorities and set out actions that can be taken to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- improve support for people who have self-harmed.
- improve support for people bereaved by suicide.

Over the next 5 years, national priorities for action include:

- Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.

- Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
- Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
- Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Providing effective crisis support across sectors for those who reach crisis point.
- Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- Providing effective bereavement support to those affected by suicide.
- Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Suicide prevention in England: 5-year cross-sector strategy sets out over 100 actions led by government departments, the NHS, the voluntary sector and other national partners to make progress against these areas, particularly over the next 2 years.

3.2 The Wider Context

Considerable progress has been made since the last Suicide prevention strategy for England was published in 2012.

All areas of the country now have local suicide prevention plans and suicide bereavement services, supported by a £57 million investment through the NHS Long Term Plan[14]. New programmes of work have been established to tackle methods and improve the coverage of crisis and bereavement support, and collective efforts to improve patient safety have led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020.

Within the last 10 years, we observed one of the lowest ever rates of registered suicides (a rate of 9.2 registered suicides per 100,000 people, in 2017).

In 2018, there was an increase in the suicide rate following several years of steady decline. Although this was partly due to a change in the 'standard of proof' required for coroners to record a death as suicide, we know that other factors have played a part too. In 2022, 2 years on from the COVID-19 pandemic, provisional data suggested there were 5,275 deaths by suicide registered, a rate of 10.6 per 100,000 people.

And so, whilst the current suicide rate is not significantly higher than in 2012, the rate is not falling and there is much more we can do to prevent more suicides and save many more lives.

4.0 Understanding Risk

We know the factors leading to someone taking their own life are complex. For many people, it is the combination and interplay of risk and protective factors that is important rather than one single issue. These can affect us at an individual, relationship, community and societal level. For example, stigma, prejudice, harassment, and bullying can all contribute to increasing an individual's vulnerability to suicide. See Appendix 3 for detailed examples.

The national strategy highlights the following high-risk groups.

- children and young people
- middle-aged men
- people who have self-harmed
- people in contact with mental health services
- people in contact with the justice system
- autistic people
- pregnant women and new mothers.

Common risk factors linked to suicide at a population level have been identified nationally, alongside other stressful life events which need early intervention and tailored support. These include:

- Physical illness
- Financial difficulty and economic adversity
- Gambling
- Alcohol and drug misuse
- Social isolation and loneliness
- Domestic abuse.

We know that that there are some other groups that are at elevated risk of suicide, but we have limited evidence or understanding of how specific issues relating to these groups should be addressed.

There is national ambition for more comprehensive research on, and better understanding of, trends and suicide rates in particular groups, including:

- occupational groups
- autistic people
- people affected by domestic abuse.
- people experiencing harmful gambling.
- ethnic minority groups including people who are Gypsy, Roma or Travellers
- refugees and asylum seekers
- people who are LGBT

5.0 Groups at Higher Risk

5.1 Children and young people

Concern has grown for children and young people as the numbers of suicides have risen. Suicide in the under 20s has seen increases for a decade[15]. In 2019 in England, there were 565 suicides registered under the age of 25. Whilst the number of suicides in children and young people remains relatively small in Sussex, the numbers in younger age groups are increasing, matching national trends.

A recent UK-wide study[16] of suicide deaths in young people aged 10-19 years, reported antecedents such as witnessing domestic abuse, bullying, self-harm, bereavement (including by suicide) and academic pressures. Overall, 60% of those young people who died by suicide, had been in contact with specialist children's services.

Self-harm rates have also been rising in children and young people[17].

The change in rates of suicide amongst young people is mirrored by increasing rates of hospital admissions for self-harm in the same age (10 to 24 years), particularly for young females.

What we know about suicide issues in children and young people[18]

- 52% of suicides in under 20's reported **previous self-harm**.
- **Events in childhood** impact negatively on health in adulthood (physical and mental health), reducing the impact will help reduce young people and adult suicides.
- **Trauma, including suspected or confirmed cases of abuse,** neglect, and domestic abuse, was seen in more than a quarter (27.1%) of children who died by suicide.
- **Family-related problems**, such as divorce, custody disputes, parental substance use, or a family history of suicide or mental health concerns, were seen in more than a third (39.8%) of children who died by suicide.
- **Bereavement** was a specific issue for young people with 25% of under 20's and 28% of 20–24-year-olds experiencing bereavement.
- **Looked After Children** were a population group accounting for 9% of suicides in under 20's, with specific issues highlighted around housing and mental health.
- Of suicides in under 20's, 8% had experience of the **care system**[19]
- 6% of suicides in under 20's occurred in **lesbian, gay, bisexual, and transgender (LGBT) people** of whom one quarter had been **bullied.**
- **Suicide-related internet use** was found in 26% of deaths in under 20s.
- **Students under 20** more often took their lives during April and May linked to academic pressures.

- **Mental health concerns** were identified in a third (31.4%) of the suicide deaths examined, with the most common diagnoses being attention-deficit/hyperactivity disorder (ADHD) or depression. One study of deaths by suicide in those under the age of 20 found that 15% had a **mental illness**[20].
- **Physical health condition** was identified in 30% of deaths by suicide in those under the age of 20[21]
- **ADHD** is a neurodevelopmental condition along with Autism Spectrum Conditions. Both have a significantly increased risk of suicide ideation, self-harm, attempted suicide, and death by suicide. Co-morbidities such as extreme levels of anxiety, depression and being the victim of severe bullying are common.

Looked after children and care leavers have an especially increased suicide risk[22].

Location	Rates of Looked After Children in Sussex (2022)	Number of Looked After Children in Sussex (2022)
East Sussex	62 per 100,000	628
West Sussex	49 per 100,000.	860
Brighton and Hove	82 per 100,000	389
South East	56 per 100,000	
England	70 per 100,000	

Source Fingertips 2022

While ONS statistics suggest that higher education students in England have lower suicide rates[23] compared with the general population of similar ages, given the range of unique challenges and stresses associated with the transition into higher education, tailored support for university students is essential for preventing suicides.

5.2 Men (including middle-aged men)

In the UK, the suicide rate of men is three times higher than that of women (a trend that is similar across the western world). Over the past decade, middle aged men in their 40s and 50s have had the highest suicide rates of any age or gender[24].

Socioeconomic disadvantage is strongly associated with suicide among this demographic and middle-aged men did not have the highest rates of suicide of any group until after the 2008 recession, suggesting a link between recession and suicides.

Middle-aged men, living in the most deprived areas, face even higher risk with suicide rates about three times those in the least deprived areas.

A history of alcohol or drug misuse, contact with the justice system, family or relationship problems, and social isolation and loneliness are also factors that are common in men who died by suicide[25].

A study published in 2021 of men aged 40 to 54 who died by suicide in the UK[26] found that two thirds had been in contact with frontline agencies or services in the 3 months before their death. Most had been in contact with primary care services (43%), and contact had also been made with mental health services and the justice system, among others.

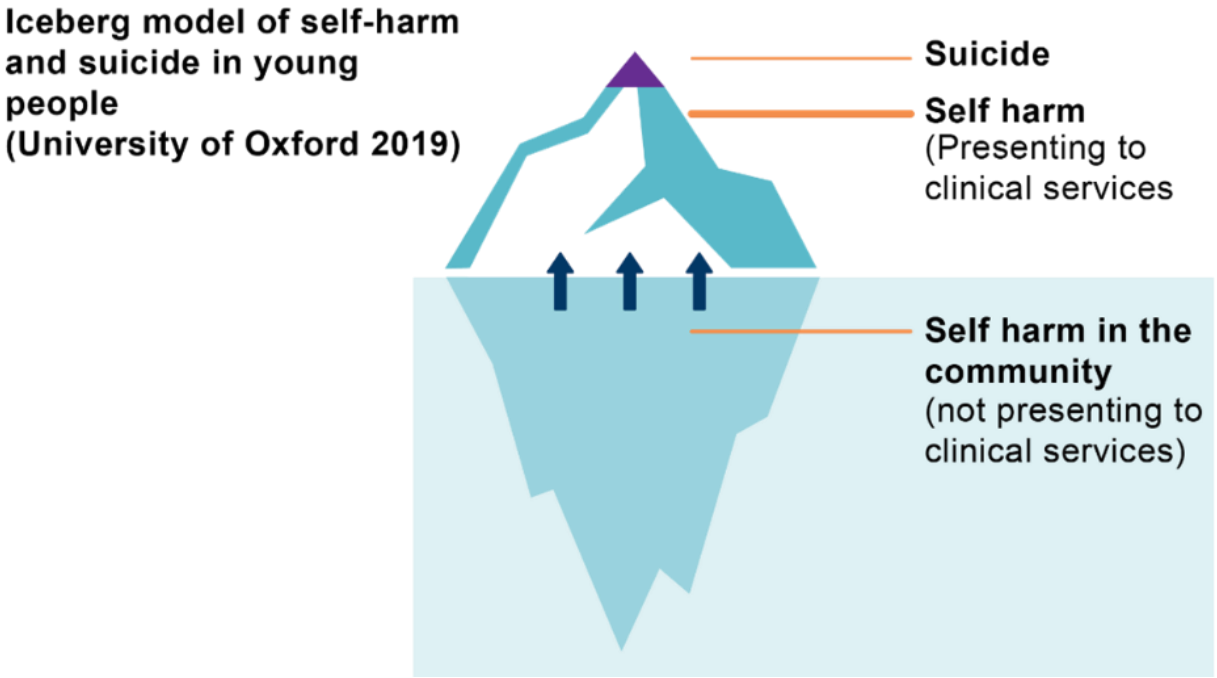
Men make up over 90% of the prison population[27].

5.3 People who have self-harmed

Self-harm, the deliberate action of causing physical harm to oneself is a clear sign of emotional distress. The relationship between self-harm and suicide is complex. In many cases self-harm is used as a non-fatal way of coping with feelings and stressors, particularly in young people. Nevertheless, self-harm is the single biggest single indicator of suicide risk.

Rates of self-harm in the community have risen since 2000, especially in young people. Each year, there are an estimated 200,000 hospital attendances for self-harm in the UK[28].Most incidences of self-harm occur in the community and do not lead to hospital attendance:

'Iceberg model': People with a history of self-harm



The occurrence of self-harm in the community is likely to be much higher. Evidence also suggests that the suicide rate is highest in the year following hospital discharge[29] for self-harm, particularly in the first month.

Self-harm in Sussex

Rates of self-harm in each local authority area in Sussex (as measured using hospital admissions for serious self-harm) are higher than the England average:

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	93,895	163.9	162.8	164.9
Sussex	–	-	-	-	-
Brighton and Hove	–	885	284.1	265.3	303.8
East Sussex	–	1,240	250.3	236.4	264.8
West Sussex	–	1,575	189.2	179.9	198.9

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2023, Reused with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid year population estimates produced by ONS and supplied to Office for Health Improvement and Disparities Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

Evidence suggests that around 50% of people who die by suicide have previously self-harmed[30]. This risk is particularly heightened in the first year after self-harm, especially the first month. At least one person in every 100 who ends up in hospital after a suicide attempt will eventually die by suicide within a year, and up to five per cent do so over the following decade[31].

5.4 People with mental illness, including those in the care of mental health services.

80-90% of people who attempt/die by suicide have a mental health condition, but not all are diagnosed.[32] There is approximately an 8-fold increase in risk of suicide for people under mental health care for mental illness[33]. In the case of depression, on average, the risk of suicide is about 15 times higher than the average for the general population[34]. However, this is likely to be an underestimate, as many who die by suicide may not have been diagnosed.

People known to be in contact with mental health services represent around 27% of all deaths by suicide in England[35] – on average around 1,300 people each year. This includes anyone in contact with mental health community services, people in inpatient settings, and anyone that has been in contact with these services within 12 months.

Although this number has remained steady in recent years, the actual rate has been falling as the numbers of people coming under mental health services has been increasing. The rate of suicides in in-patient settings is also falling.

This fall is likely due to safer physical environments (including the removal of ligature points), staff vigilance, and wider improvements in mental health inpatient settings.

Of all people that had been in contact with mental health services who died by suicide in England, nearly half (48%) had been in contact with mental health services within 7 days

before their death[36]. A large proportion (82%) of patients that died by suicide in England were assessed to be at 'low' or 'no risk' of suicide in short-term risk assessments before their death.

We must also continue to explore opportunities to better support those with specific diagnoses of conditions associated with higher rates of suicide by working with policy, clinical and personal experience experts to provide bespoke suicide prevention activity where needed.

DHSC, with NHSE, intend to explore opportunities to improve the quality of care for patients with these diagnoses and ensure compliance with NICE guidelines. This includes patients diagnosed with:

- affective disorders, including depression and bipolar, who accounted for 42% of all patient suicides in England between 2010 and 2020[37]
- personality disorders, who accounted for 11% of all patient suicides in England between 2010 and 2020 (and this figure is increasing) [38]
- schizophrenia and other delusional disorders, who accounted for 16% of all patient suicides in England between 2010 and 2020[39]
- eating disorders, where one-quarter to one-third of people diagnosed with anorexia nervosa and bulimia nervosa have attempted suicide. NHSE continues to work with systems and healthcare professionals to support the adoption of guidance from the Royal College of Psychiatrists on medical emergencies in eating disorders[40]

5.5 People in contact with the criminal justice system

People in contact with the criminal justice system are five times more likely to die from suicide than those who have no criminal justice system exposure.[41] This is, in part, because the life trajectories of many people in contact with the criminal justice system are characterised by chronic instability, abuse, neglect, and intergenerational disadvantage, all of which increase the risk of suicidal thoughts and behaviours.

Men make up over 90% of the prison population[42].

5.6 Neurodivergent Individuals

Neurodiversity refers to the different ways the brain can work and interpret information. It highlights that people naturally think about things differently. We have different interests and motivations and are naturally better at some things and poorer at others.

Most people are neurotypical, meaning that the brain functions and processes information in the way society expects.

However, it is estimated that around one in seven people (more than 15 per cent of people in the UK) are neurodivergent, meaning that the brain functions, learns and processes

information differently. Neurodivergence includes a range of conditions including Attention Deficit Disorders, Autism, Dyslexia and Dyspraxia.[43]

Neurodivergent individuals may also face additional barriers when trying to access mental health support and resources, including the lack of neuro-affirmative practices and challenges in understanding the needs of neurodivergent people.

Neurodivergent individuals may also face barriers in gaining support to access employment or to remain in employment. Such support is available through Access to Work and specifically specialist work-based coaching[44].

There is emerging evidence that ADHD is also significant indicator for suicide risk. Research looking at 372 coroners' inquest records, from 1 January 2014 to 31 December 2017 in two regions of England, found that 10% of those who died by suicide had evidence of elevated autistic traits, indicating likely undiagnosed autism[45]. This is 11 times higher than the rate in people without autism in the UK. ADHD is also associated with significantly elevated risk of suicide[46]. Evidence also indicates that neurodivergent individuals are over-represented in the other high-risk groups - homeless, substance misuse and gamblers.

Neurodivergent individuals can be exposed to certain social and emotional challenges and may struggle with unexpected change, social interactions, communication, and emotional regulation, which can also lead to feelings of isolation, loneliness, and despair. The increased risk may also relate to social stigma, discrimination, bullying, and marginalisation in society.

Neurodivergent individuals may also face obstacles in gaining support to access employment or to remain in employment. Such support is available through Access to Work and specifically specialist work-based coaching.

These problems are especially relevant for the 9,500 (approximately) people on the waiting lists for a diagnostic assessment with the neurodevelopmental services in Sussex.

5.7 Autistic People

Evidence suggests autistic people, including autistic children and young people[47], may be at a higher risk of dying by suicide compared with those who are not autistic.

Undiagnosed or late-diagnosed autism may be a preventable risk factor for suicide[48] and, therefore, earlier identification and timely access to autism assessment services is vital.

Specific factors that further increase the risk of suicide among autistic people include traumatic, painful life experiences[49], barriers to accessing support[50], pressure to 'camouflage' or 'mask' autism[51] (for example, concealing particular traits that are common in autistic people) and feelings of not belonging[52]. Autistic people report difficulties in accessing mental health support[53] because they have an autism diagnosis, are awaiting autism assessment or because of a lack of reasonable adjustments to services.

5.8 Pregnant women and new mothers

In the UK, suicide is the leading cause of direct deaths 6 weeks to a year after the end of pregnancy[54]. In 2020, women were 3 times more likely to die by suicide during or up to 6 weeks after the end of pregnancy compared with 2017 to 2019. Impacts on affected families are devastating and often have lasting effects, particularly on children from a very early stage in their development.

Overall, the level of risk of suicide after pregnancy is not higher than at other times in a woman's life. However, the high risk compared with other causes of maternal death (most of which are rare) and the potential long-term consequences on children's development mean we must take action to prevent suicides in this group. The increasing numbers of teenage maternal suicides, in particular care leavers, in recent years is a significant concern and particular targeted support is needed for this age group.

Perinatal mental illness affects up to 27% of new and expectant mothers[55] and is linked to suicide.

5.9 People with Physical illness

Evidence suggests that a diagnosis of a severe physical health condition may be linked to higher suicide rates[56]. Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition[57].

And, while 2 of 3 people who die by suicide have not been in contact with mental health services within the previous year, evidence suggests that many (49 to 92%) make contact with primary healthcare services in this time[58]. Over 40% of middle-aged men have been in contact with primary care services[59] for either physical or mental health needs within 3 months before taking their own life. It is essential that we support those seeking help for physical illness to meet both their physical and mental health needs.

5.10 People who are economically vulnerable

Financial difficulty and adversity can result in suicidal thoughts or action. Evidence shows an increased risk of suicide for people with debt, and economic recession has been consistently linked to suicide[60]. More recently, evidence from charities such as Money and Mental Health has suggested that rises in the cost of living have been linked to some people feeling unable to cope[61], with some feeling suicidal.

People amongst the most deprived 20% of society are more than twice as likely to die from suicide than the least deprived 20%[62].

History tells us that financial stressors can impact suicide rates-it is estimated that during the recession of 2007 there was an excess of 10,000 suicide deaths in European countries, Canada, and USA[63]. During the same period there was a 0.54% increase in suicides for

every 1% increase in indebtedness across 20 European countries, including the UK and Ireland[64]. Men in mid-life were particularly vulnerable.

There is also a strong relationship between unemployment and suicide in men-during the last recession there was a 1.4% rise in suicide rates for every 10% increase in unemployment in men[65].

Post Covid-19 pandemic, new issues are emerging such as debt linked to fuel poverty and increasing 'cost of living' pressures which may impact those already in financially unstable circumstances, particularly in the poorest areas of the country.

5.11 Victims and witnesses of domestic abuse and violence

Since the 2012 national strategy, more evidence on a link between domestic abuse and suicide[66] has emerged. Research on intimate partner violence, suicidality and self-harm[67] showed that past-year suicide attempts were 2 to 3 times more common in victims of intimate partner violence than non-victims. It highlighted deaths in male and female victims, children and young people in households impacted by domestic abuse, and among perpetrators. Research by the Kent and Medway Suicide Prevention Programme and Kent Police[68] found around 30% of all suspected suicides in that area between 2019 and 2021 were impacted by domestic abuse.

Suicide rates are higher in both the victims and perpetrators of domestic abuse and violence. 50% of those people who have had a suicide attempt in the past year had experienced intimate partner violence at some point in their lifetime[69].

5.12 People with high-risk gambling behaviours

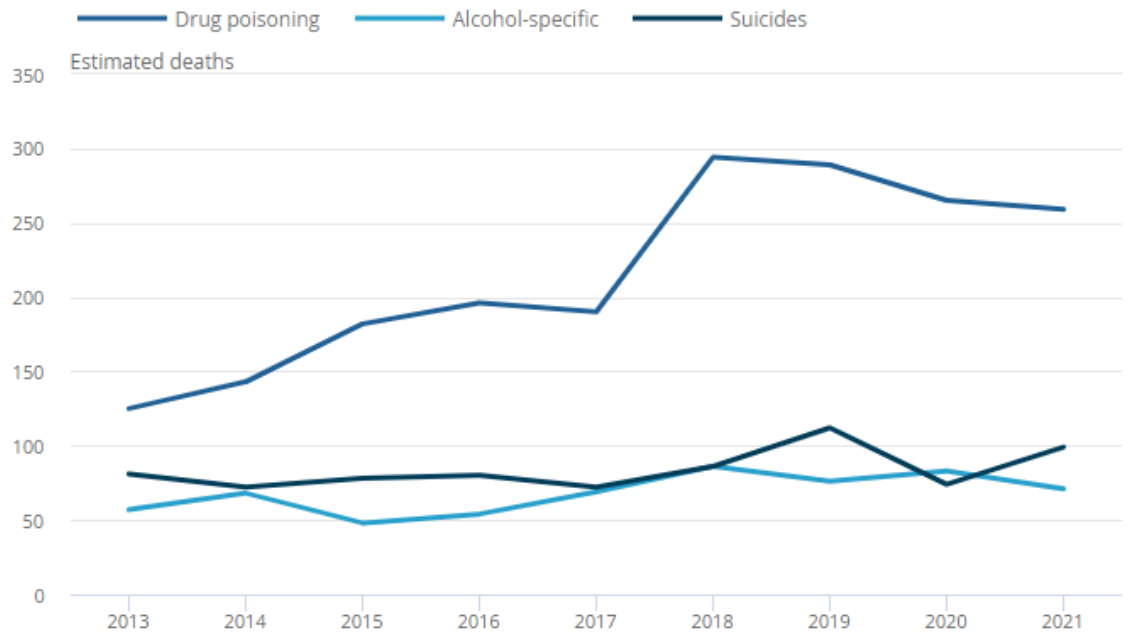
There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people[70]. Although reasons for suicide can be complex, we do know that gambling can be a dominant factor without which the suicide may not have occurred. Action therefore needs to be taken to address the harms of gambling, including suicide, and reach people at risk.

Gamblers who report high-risk gambling behaviours are at increased risk of suicidality. A Swedish study, for example, reported the risk of suicide in a cohort of more than 2000 people with diagnosed gambling disorder was 15 times the rate in the general population[71].

5.13 Homeless People

People who are homeless have a higher proportion of mental disorders than people with stable accommodation, particularly psychotic illness, personality disorders and substance misuse[72]. Suicide is the second most common cause of death among people who are

homeless or rough sleepers in England and Wales, accounting for 13% of deaths among homeless people or rough sleepers in 2018.[73].



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5.14 People who misuse substances

People who abuse alcohol and drugs experience greater than average economic disadvantage, debt and unemployment, social isolation, and other complex needs, and have higher rates of mortality and morbidity.

Collectively, substance use disorders confer a risk of suicide that is 10–14 times greater than that of the general population; deaths related to substance use are highest among people with alcohol use disorders followed by persons who abuse opiates[75].

People who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population[76]. In England, nearly half (45%) of all patients under the care of mental health services who die by suicide have a history of alcohol misuse, accounting for 545 deaths per year on average[77].

Acute intoxication[78], as well as dependence on alcohol and/or drugs, has been consistently associated with a substantial increase in the risk of suicide and self-harm.

Addressing alcohol and drug use may be especially important for supporting particular groups. In a study of middle-aged men that died by suicide in 2017, 49% had experienced alcohol misuse, drug misuse or both[79], particularly where individuals were unemployed, bereaved or had a history of self-harm or violence. Among people in contact with mental health services in England who died by suicide between 2010 and 2020, there were high proportions of both alcohol misuse (45%) and drug misuse (35%)[80].

Mental health trusts that implemented a policy on co-occurring drug and alcohol use observed a 25% fall in patient suicides[81].

5.15 Loneliness and social isolation

Social isolation (having few people to interact with regularly) and loneliness (not having the quality or quantity of social relationships we want, regardless of social contacts) have been closely linked to suicidal ideation and behaviour[82].

Loneliness is also associated with increased suicidality and self-harm. Those with severe loneliness are 17 times more likely to have made a suicide attempt in the past 12 months[83].

One study suggested that social isolation was experienced by 15% of under-20 year olds and 11% of 20 to 24 year olds who died by suicide[84], and qualitative research undertaken by Samaritans[85] found loneliness played a significant role in young people's suicidal thoughts or feelings. A further national study suggested that, of men aged 40 to 54 who died by suicide, 11% reported recent social isolation[86].

We know that loneliness is one of the primary reasons that individuals access crisis services, and that actions to reduce social isolation and loneliness are therefore likely to be key to suicide prevention[87].

5.16 LGBTQ+ Community

People from the LGBTQ+ community are being highlighted as a group at increased risk of suicide in the forthcoming national suicide prevention strategy. Although this risk depends on age, sexual orientation etc, people from LGBTQ+ groups have higher than average levels of mental illness, suicidality[88] [89]and completed suicide as well as facing increased levels of discrimination, stigma, social exclusion, and poor access to bespoke services[90].

In the 2021 Census, 1 in 200 adults aged 16+ in Sussex (0.5%) said that their gender identity was different from their sex registered at birth[91]. Rates varied from 1 in 100 in Brighton & Hove, 1 in 250 adults in East Sussex and 1 in 300 in West Sussex.

A review of several studies found increased suicide risk in LGB+ adults with up to 20% attempted suicide in their lifetimes.[3] 46% of transgender people and 31% of LGB+ cisgender people reported suicidal thoughts in the last year.[92]

5.17 Military Veterans

There are comparatively few international studies investigating suicide in military veterans but a recent study in the UK investigated the rate, timing, and risk factors for suicide in personnel who left the UK Armed Forces (UKAF) over a 22-year period (1996 to 2018)[93]. This found that overall suicide risk in veterans was comparable to the general population but there were important differences according to age, with higher risk in young men and

women. Several factors increased the risk of suicide, but deployment was associated with reduced risk.

5.18 Ethnic Minorities

Black and racially minoritised groups - rates of suicide were highest in the White and Mixed/Multiple ethnic groups for both men and women[94]

Gypsy Roma Traveller communities – the evidence is that Gypsy, Roma, Traveller and nomadic communities are at increased risk. The suicide rate for Irish Traveller women is six times higher than the general population, and seven times higher for Irish Traveller men.[95]

5.19 Occupations

Analysis of 2011[96] Census data demonstrates different risk profiles amongst different occupations for example, men working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average. The risk among men in skilled trades was 35% higher than the average. Individuals working in roles as managers, directors, and senior officials – the highest paid occupation group – had the lowest risk of suicide. Among corporate managers and directors, the risk of suicide was more than 70% lower for both sexes[97].

The risk of suicide was elevated for those in culture, media, and sport occupations for males (20% higher than the male average) and females (69% higher than female average). There is also higher risk in some health professional groups.

6.0 What is effective in suicide prevention?

There are many ways in which services, communities, individuals, and society can help to prevent suicides. A key message from practice and research is that collaborative working is key. Partnership approaches working with, and within local communities, aiming to protect those who are most vulnerable are vital to reducing risk.

An approach that combines mitigating risk factors and enhancing protective factors is more likely to be successful. It is also important to look at suicide prevention across the life stages, from children and young people to adults, and to base any actions on national and local evidence to identify areas of focus to inform the actions that will be needed.

6.1 Addressing Risk Factors

Early intervention is prioritised, with different sectors and government departments addressing risk factors with a strong link to population-level suicide and self-harm rates.

There is strong collaboration within ICSs, building on existing successes that bring a wide range of partners together to address risk factors and wider determinants linked to suicide prevention, such as housing and financial difficulty.

All local suicide prevention plans include tangible actions to address risk factors at a local level.

People who work in relevant public services are supported to identify and support people who might be at risk of suicide or self-harm.

As well as reducing risk factors and enhancing protective factors in the longer term, it is vitally important that we support those at immediate risk.

6.2 Providing Effective and Appropriate Crisis Support

- It is essential that timely and effective crisis support is available to those who need it.
- Only a minority of people who have suicidal thoughts/impulses take their lives.
- Many people in distress don't seek help/support on their own, therefore identify people at risk, reach those in the greatest need, connect them to care/support.
- Empower people to recognise when they need support and help them to find it
- With the right help people can get through a suicidal crisis and recover.
- Recognise that 'hopelessness' is a strong predictor of suicide combined with suicidal ideation without a credible safety plan.
- Anything that delays or disrupts a suicidal act can be lifesaving (including limiting access to the means of suicide), can interrupt suicidal intention, buy time for individual to reconsider and/or be helped.

6.3 Tackling Means and Methods of Suicide

Improving early intervention and tackle the drivers of self-harm and suicidality are vital, but only part of the overall picture, because we know there will still be individuals who may be contemplating and planning suicide. For people at this point, one of the most impactful practical interventions is to reduce access and limit awareness of the means and methods of suicide, providing more time to intervene with effective longer-term actions and preventative support.

Cross-government and cross-sector partnership working continues. There is work to monitor common and emerging methods of suicide and high-risk locations, and ensure that appropriate action is taken in a timely manner as new intelligence becomes available.

First responders and people working on the frontline need to feel equipped to respond appropriately to deaths by potential suicide, no matter the method used, and have the skills necessary to adapt to the situation they find themselves in.

There are continued efforts to ensure that there is responsible reporting of the methods used in suspected or confirmed suicide cases in the media. Information about methods of suicide should be as restricted as possible in the public eye.

Robust reporting systems and mechanisms are in place to enable partners working in high-risk locations to share data and best practice with colleagues to ensure that effective interventions can be replicated across the country.

Around a third of all suicides take place outside the home. High-frequency locations are public sites that are frequently used as a location for suicide. We would encourage those with a role in the planning system to consider the risks of suicide associated with buildings and public spaces and to consult the practice resource 'Preventing suicides in public places'[98] when creating local design policies.

The effectiveness of interventions for reducing access to certain high-frequency locations[99] has been well evidenced. For example, the construction of safety barriers has been shown to successfully reduce suicides on particular bridges. However, these interventions should always go hand in hand with additional measures, including help from others, increasing opportunities for help-seeking, and addressing awareness and reputation of specific locations as a 'suicide site'.

Beachy Head in East Sussex has the highest frequency of deaths at a single location in the UK and presents specific challenges for prevention, most notably its size, remoteness and the fact that the vast majority of those completing suicide there travel from out of county.

6.4 Providing Timely and Effective Bereavement Support

Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to 3 times higher than the general population. Compassionate, effective and timely support for people bereaved by suicide is essential.

Local authorities, police, national government, coroners, the NHS, schools and universities, and VCSE organisations all have an essential role in providing effective and timely bereavement support.

Our ambition and vision is:

- there is widespread recognition that improving bereavement support is an important goal in its own right, and bereavement is a risk factor for suicide among family, friends and acquaintances.
- all individuals bereaved by suicide are offered timely, compassionate and tailored support, wherever they live.
- across workplace, education and health settings, there is recognition of the impact of a suicide bereavement on families, carers, loved ones and the wider community, and actions are taken forward to provide access to support.

- understanding of the impacts of suicide bereavement on groups (including children and young people, people who are LGBT, and ethnic minority groups) is strengthened through research and personal experience insight.

People bereaved by suicide should receive effective support and services following a suicide, regardless of where they live.

Bereavement services and support should consider the needs of different groups and communities to ensure a wide range of people receive the support they need. These different groups include:

- People personally bereaved by suicide.
- University students
- Minority ethnic groups
- Bystanders and witnesses to suicide

6.5 Making Suicide Everyone's Business

Suicide prevention is everyone's business. Every person, organisation and service across the county has a role to play. In recent years, good progress has been made to tackle the stigma surrounding suicide and mental health. However, there is more we can all do to ensure we are all equipped with the skills necessary to potentially save lives.

- every individual across the county has access to training and support that gives them the confidence and skills to save lives. Training is routinely promoted, with significant numbers of people trained in suicide prevention.
- there is no wrong door – when people experiencing suicidal thoughts or feelings reach out, they receive timely support, no matter what service the individual initially accesses. Systems and services are connected around individual's needs.
- employers (especially those in high-risk occupations) have appropriate mental health and wellbeing support in place for their staff – learning from and building on the work the NHS and others are undertaking. This includes members of staff being trained in suicide prevention awareness, particularly those interacting with people who may be more vulnerable.
- we work in partnership so that everyone - from individuals through to organisations and services – feel responsible for ensuring that they are consistently using language that supports people while reducing shame and stigma. This supports everyone to feel able to seek support whenever they need it.

6.6 Improving Skills and Knowledge

Crucial to these ambitions is ensuring everyone has the skills, knowledge and confidence to provide necessary support and intervention. The availability and promotion of easy-to-access guidance and training for everyone is a vital first step.

A range of suicide prevention awareness training courses are already available for both individuals and organisations, including from charities such as Samaritans, and PAPYRUS. This includes free, online courses such as those provided by the Zero Suicide Alliance.

It is also vital that, collectively, we do all we can to reduce stigma. Stigma can be a barrier to people seeking support when they are feeling suicidal or looking for bereavement support. Everyone has a role in creating safe spaces for people to speak up and seek support. Using language that reduces shame and stigma, and encourages people to seek support is an important step everyone can take.

There have been great examples of campaigns, resources and action that support delivering this. Many have been led by people with personal experience of suicide and bereavement, whose bravery and perseverance in making positive change for the good of society, following such a personal tragedy, is incredibly admirable.

As an example of this, If U Care Share is committed to raising awareness of the importance of suicide prevention and postvention, and offering professional support to individuals. As part of this, it has developed resources in collaboration with people with personal experience to dispel the myths surrounding suicide and facilitate open conversations.

Organisations such as the National Suicide Prevention Alliance bring together individuals and organisations from a range of sectors, including people with personal experience. They provide resources and support to help ensure suicide prevention becomes everyone’s business.

6.7 The Role of Employers

Employers have an essential role to play in supporting practices and conversations that help prevent suicides. There are multiple ways this can be done – for example, through employment assistance programmes, line manager training or peer support networks.

While this is imperative for workers engaging with more vulnerable members of the public, every employee should feel supported and every employer should ensure that support is known and available.

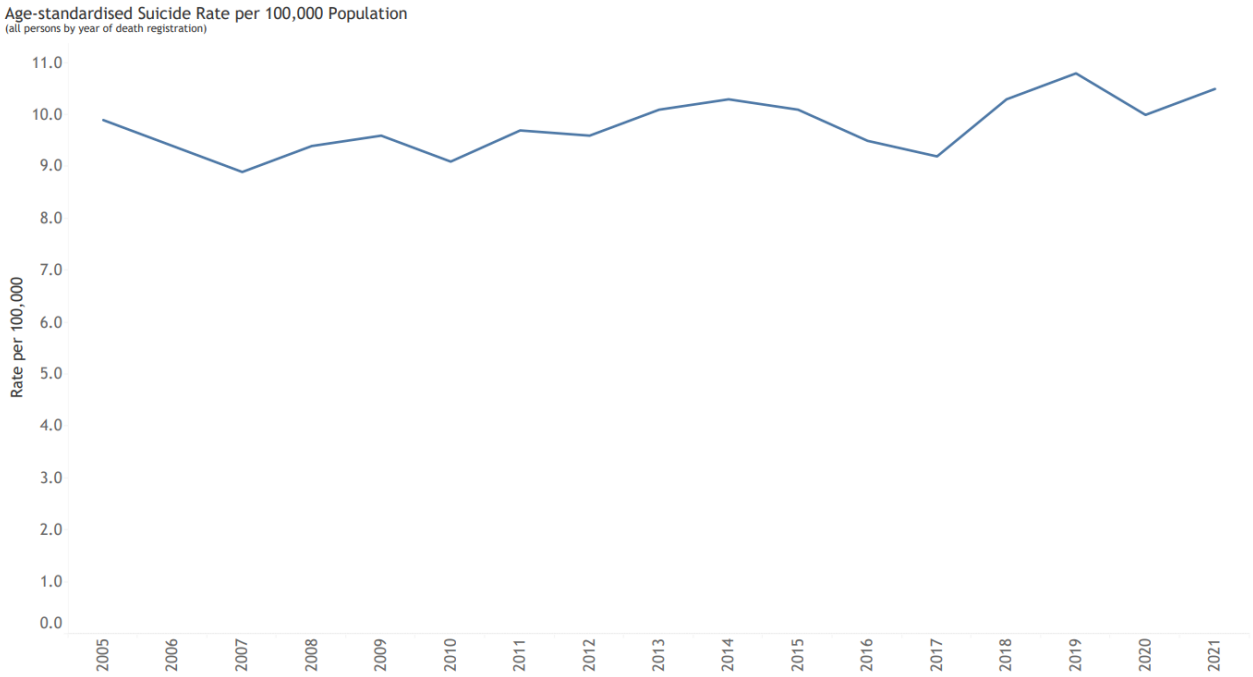
We strongly encourage all employers to have adequate and appropriate support in place for employees, such as people trained in mental health first aid, mental health support and suicide prevention awareness. Employers should also encourage employees to take the time to look after their mental health, focusing on prevention as well as providing support.

7.0 Data

7.1 The National Picture incl. National Data:

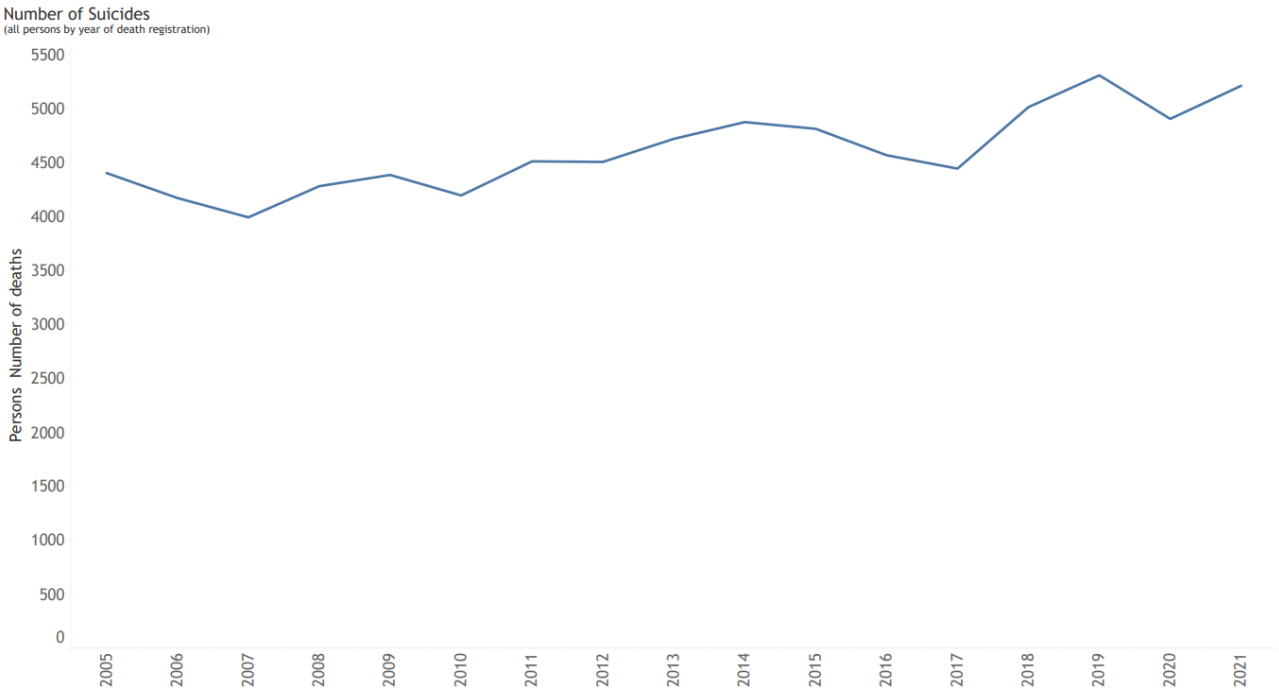
Between 2013 and 2018 suicide rates in England had been steadily reducing and although now rising again are low in comparison to those of most other European countries. Prior to the Covid-19 pandemic there were already concerns about the rising rate of suicide in 2018 and 2019 (see **Figures 1 and 2**). The high rates in middle age and after self-harm were also noted as national priorities[1]. Suicide in the under 20s has seen increases for a decade.

Figure 1: Number of suicide deaths registered in England.



[1] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)

Figure 2: Age-standardised rate for registered suicide deaths in England



While the exact reasons for the 2018 increase are unknown and could include changes to the recording of deaths by suicide, the latest data shows that the rise was largely driven by an increase among men-who have continued to be most at risk of dying by suicide. In recent years, there have also been increases in the rate among young adults, with females under 25 reaching the highest rate on record for their age group. Overall, people aged 10 to 24 years, and men aged 45 to 64 years have seen the greatest increases in suicide rates.

In 2022, 2 years on from the COVID-19 pandemic, provisional data suggested there were 5,275 deaths by suicide registered[100], a rate of 10.6 per 100,000 people. And while, overall, the current suicide rate is not significantly higher than in 2012, the rate is not falling.

7.2 Suicides in Mental Health Inpatient Settings

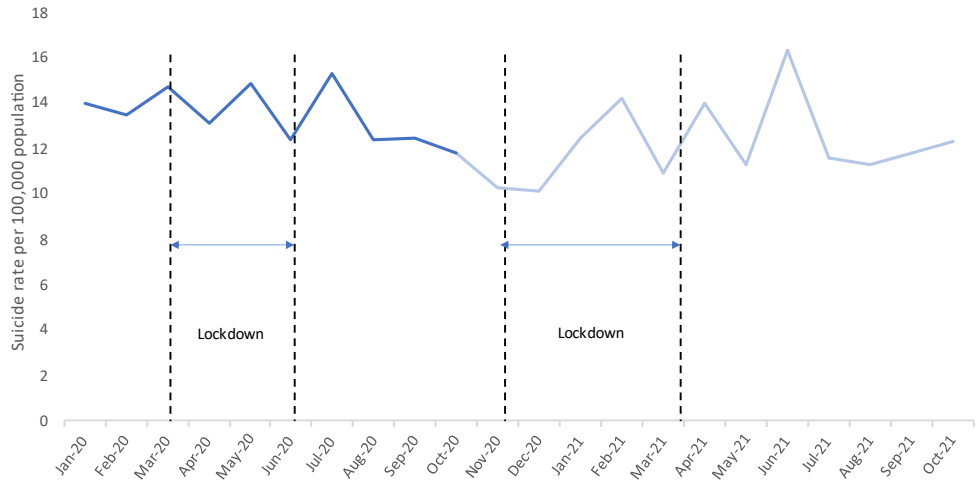
Collective efforts to improve patient safety led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020[101].

7.3 Impact of Covid Pandemic on National Suicide Rates and Trends

After increases in the national suicide rate in 2018 and 2019, there were additional concerns relating to Covid-19, centred on potential risks to mental health-from anxiety, isolation, loss of support and disruption to care. However, the overall national rate in 2020 decreased to 10 per 100,000 from 10.8 in 2019 and there were no rises over lockdown

(Figure 3). This also tallies with international data, which can provide us with some confidence that UK analysis is accurate.

Figure 3: Suicide rates over covid-19 lockdowns



No rise in the number of suspected suicides

This finding is **reflected** in ONS findings

The cross-government report on preventing suicides in England and the 2022 National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[102] annual report indicated that whilst the pandemic did indeed cause concern, some of the actions taken may have had some protective elements. More support for crisis services, more community engagement, family time and support specifically at the beginning of the pandemic, may have provided some element of protection.

> 'Perhaps the explanation is social cohesion, mutual support, a sense of getting through it together. Perhaps friends and families have rallied around those who are vulnerable. Perhaps the pandemic brought out the best in us'-Louis Appleby.

Nevertheless, continued vigilance and targeted actions are vital as COVID-19 has exposed fault lines in society where risk of suicide is also found - inequalities based on deprivation, ethnicity, disability, and stigma worsened during the pandemic.

The post Covid-19 period may be particularly challenging times for vulnerable individuals and the impacts may be longer term: particularly in those for whom the pandemic has exacerbated existing problems, and for those for whom the pandemic has resulted in significant and specific new issues, that we know are potential drivers of suicide, for example, job loss, unmanageable or mounting debts because of reduced income, bereavement and loneliness or social isolation.

Groups that have been flagged nationally as needing additional vigilance include those who have experienced a negative financial impact, children, and young people, specifically those who self-harm, witness domestic abuse, experience bereavement, bullying and academic pressures; and those with existing mental health problems.

Post-Covid-19 we also need to monitor certain occupational groups that may have experienced significant trauma throughout the pandemic, such as those working in health and social care. They risk experiencing the negative enduring consequences of this trauma, including burnout.

Children's experience of Covid-19/lockdowns:

In the early stages of the Covid pandemic, NHS England alerted clinicians and services to a possible increase in children and young people suicides, including potential risks for those with autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD).

Due to the pandemic, education and employment opportunities changed and many young people reported feeling overwhelmed with the pressure to maintain the high standards of their work whilst adapting to a new way of learning and working. For those coming out of education in particular, the prospects of finding a job and long-term employment have also been identified as a particular risk factor.

Amongst the likely suicide deaths in young people reported after the lockdowns, restriction to education and other activities, disruption to care and support services, tensions at home and isolation were found to be potentially contributing factors.

7.4 Local Data

Sussex has a combined population in the region of approximately 1.5 million, and ranges from very affluent areas to some of the most deprived in the country. There are inner city areas, coastal and rural communities, and everything in between.

Sussex is made up of three local government areas, East Sussex, West Sussex and Brighton and Hove, each with its own demographic and political make-up.

Table 1: numbers of suicides and rates of suicide across local authorities in Sussex

Location	Numbers (average over past 5 years)	Rate	Population
Brighton and Hove	36	14.1	277k
East Sussex	63	12.1	455k
West Sussex	75	11.5	843k
Total	174		

The rates of suicide in Brighton and Hove and in East Sussex consistently exceed the England average (Table 1 and Figures 4,5 and 6). The rate of suicide in West Sussex mirrors the England average:

Figure 4: Suicide rate (Persons) for Brighton and Hove

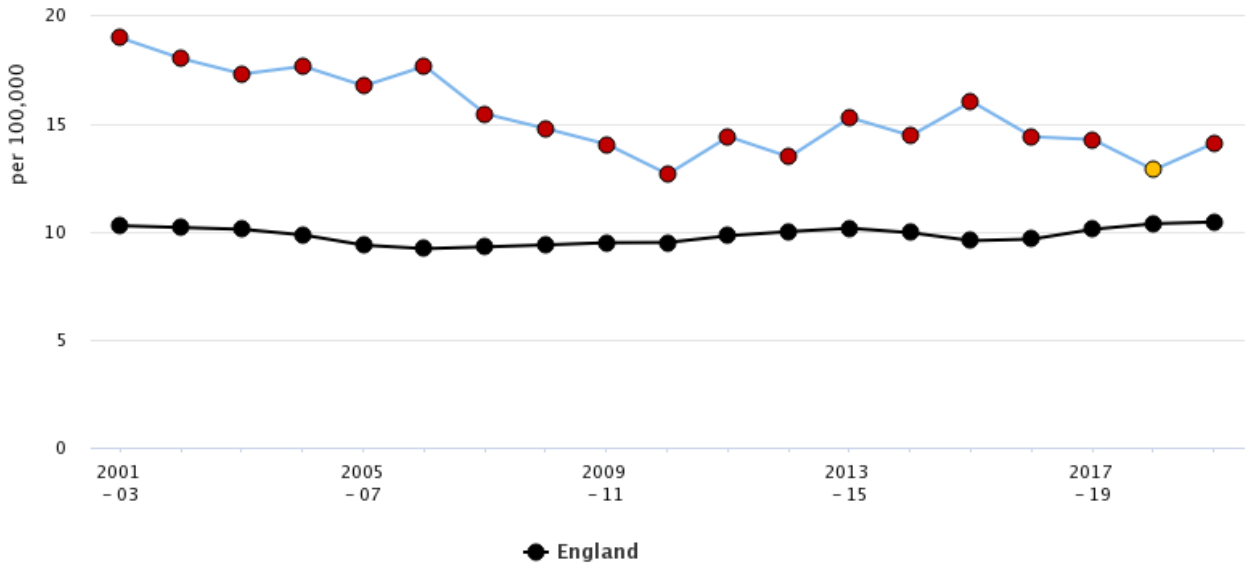


Figure 5: Suicide rate (Persons) for East Sussex

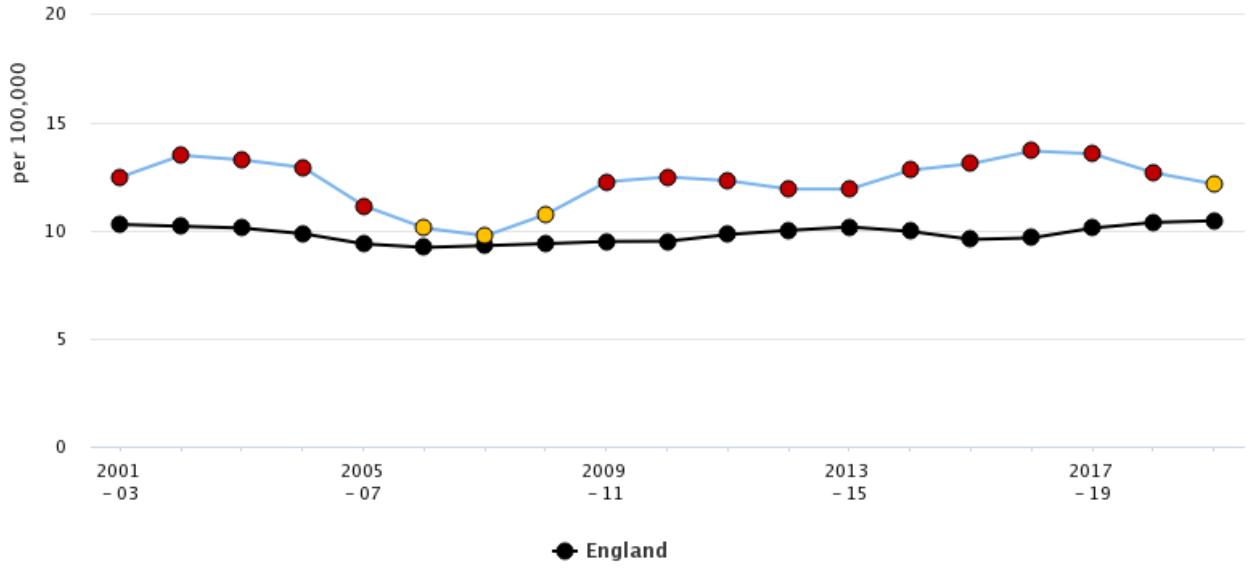
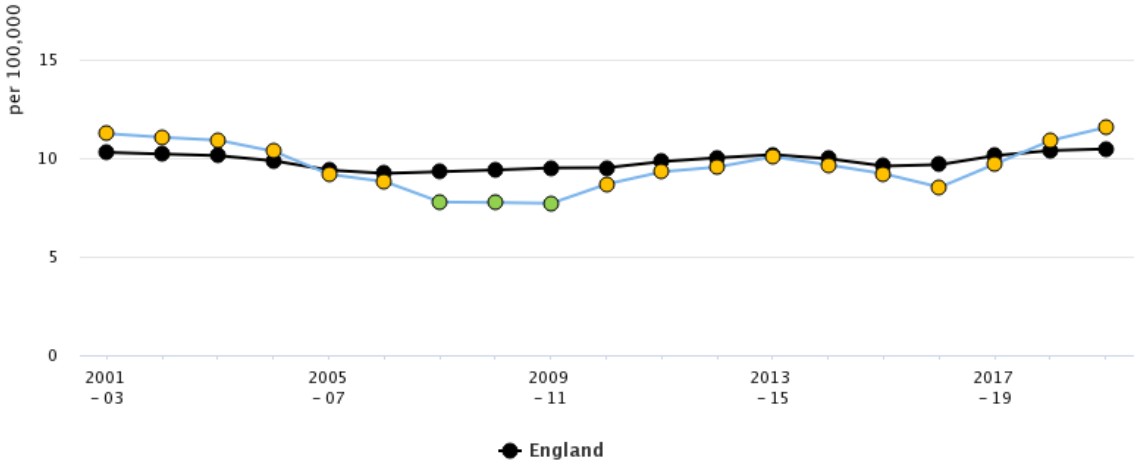


Figure 6: Suicide rate (Persons) for West Sussex



7.5 Surveillance (Real Time Surveillance)

Real-time surveillance is now available in Sussex. This is information gathered via police colleagues at the scene of an unexpected death which may be due to suicide. These suspected suicides have not yet gone through the coronial system, but they present important and timely information on local suicides.

The advantage of real time surveillance is it allows us to respond quickly to emerging trends that point to particular risk factors or high-risk groups locally. We can put in place prompt mitigations and the data also allows us to provide timely support to those who have been recently bereaved or affected by suicide.

8.0 Sussex Suicide Prevention Action Plan

8.1 How Do We Get There?

A key issue now is to ensure that our planning, partnership building, and data collection turn into action. The Action Plan, summarised below, covers the first year (2024). It will be updated and amended in response to the changing nature of risk factors for suicide and the continuous evaluation of our progress.

The Action Plan sets out areas for actions for key partners that will be best delivered at pan-Sussex level; some can be tackled immediately, others phased in over the lifetime of the strategy. It should be noted that progress with some is dependent on the availability of resources to do so.

The Action Plan will be monitored quarterly by the Sussex (ICS) Suicide Prevention Steering group.

8.2 How Will We Measure Success?

Ultimately, we want to see a reduction in Sussex's suicide rate. However, due to the relatively low numbers of suicides it is difficult to quickly show a statistically significant improvement in suicide rates across a local area. Therefore additional (proxy) measures will be used to assess the Plan's success. These measures include for example, levels of self-harm in the population and levels of activity across the action areas.

8.3 Sussex Suicide Prevention Strategy – One Year Action Plan 2023/24

*******Dependent on programme support capacity

Action Area	Key Actions	Lead(s)	Timescale
Working with Sussex-wide partners	Commitment of partners to Sussex Suicide Prevention Strategy Group and sub-groups	Director of Public Health, East Sussex County Council	Ongoing
	Endorsement of Sussex SP Strategy by 3x Health and Wellbeing Boards		
	Publication of Sussex SP Strategy		Nov 2023 – Jan 2024
	Publication of SPFT Suicide Prevention Strategy		Feb 2024
Suicide Response / Postvention	Establish 'postvention' working group to oversee,	Consultant in PH/ Programme Lead	***
	Develop system capacity to identify and support those affected by suicide in real time	Consultant in PH/ Programme Lead	***
	Continued development of RTS analytical/surveillance capability, dashboard and inclusion of self-harm, suicidal behaviour and drug related deaths	Consultant in PH	Ongoing
	Deliver Sussex Workforce Wellbeing Project		Ongoing
	Scope potential to expand GP based 'After Death Reviews'(ADR) capacity beyond Brighton and Hove	Clinical Director, NHS Sussex	March '23 – Sept '24

Action Area	Key Actions	Lead(s)	Timescale
	Undertake a Pan-Sussex bereavement health needs assessment (not limited to suicide bereavement) and develop business case for future bereavement support based on need.	Consultant in PH/ Programme Lead	***
Training / learning	Establish 'training/learning' working group to oversee,	Consultant in PH / Programme Lead	
	Undertake training needs analysis – with aim of scoping potential to organise and commission training across Sussex.		***
	Develop system capacity to share learning from statutory and non-statutory incident reviews, including CDOP, serious incidents, inquests and ADRs		***
Communications, Engagement with media and online safety	Co-ordinate communications, campaigns and working with media across Sussex	ICS Comms team	Ongoing
	Scope need for a web-based central resource and campaign portal		***
	Complete communications strategy relating to Coastal Suicides		Nov 2023
	Evidence reviews of online harms and develop recommendations for action		June 2024
Lived Experience	Establish 'lived experience' working group to oversee,	SPFT / Consultant in PH / Programme Lead	***
	Development of proposals to ensure a meaningful and sustainable approach to involving those with lived experience, in the design and delivery of suicide prevention activity		

Action Area	Key Actions	Lead(s)	Timescale
	Engage National Suicide Prevention Alliance (NSPA) to support local organisations and action develop Sussex lived experience local network.		
Self-harm	Continue Sussex Self-harm Learning Network and scope potential for Pan-Sussex strategic approach.	Consultant in Public Health	Dec 2023
	Develop self-harm prevention framework for children and young people, using the findings from local needs assessments		Jan -June 2024

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27.7.23

Amendments

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20.10.23

Appendix 1- National frameworks, evidence, and resources

- Suicide prevention in England: 5-year cross-sector strategy (Department of Health and Social Care, 2023)
- Suicide prevention strategy: action plan (Department of Health and Social Care, 2023)
- Preventing suicide in England: A cross-government outcomes strategy to save lives, (Public Health England, 2012)
- Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)
- Preventing suicide in public places (Public Health England, 2015)
- Identifying and responding to suicide clusters and contagion (Public Health England, 2015)
- Suicide Prevention (House of Commons Health Committee, 2016).
- Government response to the Health Select Committee's Inquiry into Suicide Prevention (Department of Health, 2017)
- National Confidential Inquiry into Suicide and Safety in Mental Health (Healthcare Quality Improvement Partnership, 2019)
- National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report (Healthcare Quality Improvement Partnership, 2023)
- Prevention concordat for better mental health (Public Health England, 2020)
- Support after a suicide: A guide to providing local services (Public Health England, 2016)
- Suicide Prevention, Resources and Guidance (Public Health England, 2019)
- Suicide Prevention, Cross Government Plan (Public Health England, 2019)
- Five Year Forward View for Mental Health – One year on (NHS England, 2017)
- Preventing Suicide in England: Fourth Progress Report of the Cross-Government Outcomes Strategy to Save Lives (Public Health England, 2019)
- Suicide prevention: A guide for local authorities (Local Government Association, 2014)
- Local Suicide Prevention Resources: Case Studies & Information Sheets (National Suicide Prevention Alliance in association with Public Health England, 2017)
- Local Suicide Prevention Planning in England (Samaritans and University of Exeter, 2019)
- Public Health England advice for local suicide prevention planning
- Local suicide prevention planning, A practice resource, Public Health England, 2020
- January 2019 the national suicide prevention strategy refresh (Fourth Annual Progress Report
- Suicide prevention action plans NICE NG105
- Cross-Government Suicide Prevention Workplan

- Overview | Preventing suicide in community and custodial settings | Guidance | NICE (2018)
- History | Suicide prevention | Quality standards | NICE
- Kirklees suicide and self-harm prevention action plan 2020-2023
- file (bristol.gov.uk)
- LGBT Action Plan 2018: Improving the lives of Lesbian, Gay, Bisexual and Transgender people - GOV.UK (www.gov.uk)
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- Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)
- A Closer Look at Substance Use and Suicide | American Journal of Psychiatry Residents' Journal (psychiatryonline.org)
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- Summary of Core Standards – SASP (supportaftersuicide.org.uk)
- Adult Psychiatric Morbidity Survey - NHS Digital
- £29 million Know Your Neighbourhood Fund confirmed - GOV.UK (www.gov.uk)
- DAPB4066: Social Prescribing Information Standard - NHS Digital

Appendix 2 - Sussex ICS Suicide Prevention Programme (2019-2023

What has been achieved:

Sussex ICS received £1.5m over three years from, beginning in March 2019, to develop, implement and run a three-year suicide prevention programme. The funding was part of the NHS England/Innovation £25m national transformation funding for suicide prevention. Sussex ICS received £623k per annum for the first 2 years and £337,692 in the final year of the programme.

The national programme was supported by the Royal College of Psychiatrists and the National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) led by Professor Louis Appleby. In receiving the funding local areas were encouraged to be innovative in their thinking and work in partnership. This stimulated the development of a range of collaborative programmes, overseen by a multi-agency working group, chaired by the East Sussex Director of Public Health.

Sussex ICS received further funding of £120k p.a. for 4 years, starting in April 2020, to support the development of a pan-Sussex suicide bereavement service. Bereavement support is the one key initiative that the NHS long term plan has determined should be in place in all ICS areas across England.

RTS and bereavement support
Training – 2 phase approach (1) needs assessment (2) bespoke training
Comms. – continue to use Warning Signs but much more targeted bursts; also focus on promoting bereavement service
GP MH fellowship
SPFT work/serious MH – also SCFT who run IAPTs – much more about reaching out to different orgs. post covid – me to be much more closely aligned to SPFT.

Real Time Surveillance

An analyst has been recruited to 3 days per week post. They are developing the surveillance system and drawing together various data sources which will inform work on clusters and contagion as well as highlighting geographic areas and population groups at risk for more focused interventions. In time the dashboard will include data relating to self-harm and drug related deaths.

Bereavement support

Evidence suggests that timely bereavement support, appropriate to the particular nature of suicide, plays a key part in suicide prevention activity.

Providing support for people bereaved by suicide is a key objective of the national suicide prevention strategy for England[ciii]. Through the Long-Term Plan (LTP), NHSE/I committed to expanding funding for post-vention bereavement services to all areas of the country. Sussex received 4 years of recurrent funding, totalling £480K and is just coming to the end of the second year of funding.

A condition of the funding is that we have a centralised service. The model configured in Sussex relies on a single point of access (SPOA) triaging calls to one of three bereavement support service, for adults based in the local authority areas and a pan-Sussex service commissioned for children and young people up to the age of 25.

The model is working well however a recently completed evaluation of the service highlighted areas that needed developing further and these will be the focus for the service in the coming year.

Training

Equipping our workforces with knowledge of suicide and self-harm prevention is helpful. Particularly amongst the emergency services who often feel ill prepared when they are faced with people with mental health and suicidal issues. The approach up to now has been very piecemeal and is generally reliant on 'off the shelf' training that is not always fit for purpose. A more focused, bespoke approach to training for each workforce, particularly the emergency services is proposed. I have developed bespoke training for SSOS & SOBS on autism & suicide, as well as for Beachy Head Chaplaincy. Also developed and trained urgent care teams for SPFT on autism. All this training was well-received. This should be rolled out more widely.

A pan-Sussex service brings consistency of training, economies of scale and fits in well with the organisational structures of our blue light services such as the ambulance service (SECAMB) and the police (Sussex Police) which are configured at Sussex level rather than by local authorities.

It is envisaged that this work takes place in two stages. The first stage is to carry out a needs assessment to understand the scale of work. The second stage is to develop and implement a plan for identifying key workforces and developing bespoke training across Sussex. One approach could be to procure an experienced training partner to support this work.

Communications

Communications support is needed to increase local knowledge and awareness to the wide range of national and local resources that are available. Alongside this support is needed to ensure local campaigns are coordinated and funding isn't wasted duplicating campaigns that already exist.

The locally developed 'Warning Signs' campaign has been a significant success in reaching out to middle aged men, and those concerned about middle aged men in distress. However much more could be done to promote this campaign and use it in a more targeted way to respond to local concerns.

There is an urgent need for there to be a more co-ordinated communications approach to ensure all those that need them are made aware of the resources available, to ensure consistency of messaging and maximise impact. A pan-Sussex approach also ensures value for money whilst avoiding duplication.

Primary care work

Most people who die by suicide have seen their GP in the previous year. Although this may provide an opportunity for prevention, identifying patients who are at particular risk is difficult and scope to intervene meaningfully is limited within a typical consultation.[civ]

As part of the NHSE/I transformation programme, GP Mental Health fellowships were introduced and currently 3 practising GPs are part of this fellowship attending a series of masterclasses and studying for a PG certificate in healthcare leadership at Canterbury Christ Church University. They will then use this knowledge to identify areas where they can support GP practices and PCNs with increasing their knowledge and response to those at risk of suicide. The GPs already report far greater awareness of the causes of suicide and self-harm and that this has enhanced their current practice.

Debriefing sessions in practices where a patient suicide has taken place should also be carried out as the norm. The effect of a patient suicide on the mental health of those practitioners involved in the care of the patient can be devastating. Debriefing sessions in practices where a patient suicide has taken place, allowing primary care staff the opportunity to talk through the events should be carried out as the norm. Currently this only takes place in practices in Brighton and Hove.

Developing future cohorts of the fellowship and ensuring consistency of debriefing sessions are more efficiently organised at a pan-Sussex level, freeing up staff time and reducing running costs.

Coastal cliffs work

Parts of the southern side of the Sussex geography in East Sussex and Brighton & Hove have high chalk cliffs. In East Sussex a notorious site of public suicide attracts people from all over the country and abroad and is sadly the most frequented public place of suicide in the country. Much work has already taken place over the years to understand the reasons people in distress are drawn to the cliffs and to develop solutions to make it less accessible as a place of suicide.

At a local level people from all three local authorities travel to the cliffs at East Sussex to take their lives but arguably this work needs more traction at a national level, given the significant numbers who travel from outside Sussex who take their lives at the cliffs.

It is imperative that this work continues to maintain a high profile. It should also be recognised that, whilst not as notorious as the East Sussex cliffs, there are cliffs at Brighton and Hove and for these reasons coastal suicide needs to be part of a Sussex wide strategy. It is proposed that the format of meetings that specifically look at coastal suicide, start by focusing on what is already working well at place and moving on to discuss which areas of work need more impact to achieve their aims by becoming a pan-Sussex strategic objective.

Toolkit for Schools in the Event of an Unexpected Death

Toolkit launched in B&H and being adapted for East and West Sussex

- £40k allocated for training for school staff across Sussex on use of toolkit and general suicide prevention training.
- £10k allocated for training of youth workers in B&H as above.

Grassroots commissioned to provide training for approx. 570 staff across Primary, Secondary, SEND and College staff across Sussex.

Self harm and learning network

10 workshops developed for parents, teachers and carers to help with understanding what self-harm is, how to spot the signs and provide support and signposting.

A one-day on-line conference in November was extremely well attended.

Workshops were delivered by the Self-Harm Learning Networks in West Sussex, East Sussex, Brighton and Hove, and by the Allsorts Youth Project (a project supporting LGBTQIA+ youth in Brighton and Hove). Workshops were delivered online and were specifically aimed at teaching staff, and parents and carers.

Warning Signs campaign www.preventingsuicideinsussex.org

The purpose of the campaign is:

- To increase awareness amongst men (and their influencers) of where they might access help if they are finding it difficult to cope with their stress/depression.
- To improve recognition of suicide risk and of how to help, among the influencers in men's lives.
- Consequently, to help contribute towards reducing the stigma associated with help-seeking in men.

The website has received over 24,450 visits since its inception.

Sussex A&E Compassionate care call

This involves a follow-up by compassionate care call, after assessment after an episode of self-harm or suicidal distress in A&E.

Innovation Fund

Small grant fund for voluntary sector organisations across Sussex.

Appendix 3- Risk and Protective Factors for Suicide

Risk Factors

Individual Risk Factors

Previous suicide attempt, depression, other mental illnesses, serious illness e.g., chronic pain, criminal/legal problems, job/financial problems or loss and debt, substance use, Adverse Childhood Experiences (ACEs), violence victimization and/or perpetration, gambling

Relationship Risk Factors

Bullying, domestic abuse, bereavement, relationship breakdown, social isolation and loneliness

Community Risk Factors

Lack of community cohesion, community violence, discrimination, lack of access to healthcare including crisis care

Societal Risk Factors

Stigma associated with help-seeking and mental illness, unsafe media portrayals of suicide, online harms, easy access to lethal means of suicide among people at risk.

Protective Factors

Individual Protective Factors:

- effective coping and problem-solving skills,
- reasons for living (for example, family, friends, pets, etc.),
- strong sense of cultural identity,
- educated and equipped with knowledge and skills for healthy and safe usage of online platforms,
- high-quality signposting and support are prevalent across a range of platforms,
- care provided is person-centred and considers the mental health, physical health, and social needs of those in suicidal crisis,

Relationship Protective Factors:

- support from partners, friends, and family,
- feeling connected to others,
- compassionate, effective and timely support for people bereaved by suicide is essential,
- safe spaces for people to speak up and seek support,
- employers

Community Protective Factors:

- feeling connected to school, community, and other social institutions,
- availability of consistent and high quality physical and mental healthcare,
- support both for substance misuse but also for any mental health or self-harm concerns, with a ‘no-wrong-door’ policy that makes every contact with services count,
- support programmes for people facing difficulties over jobs and benefits,
- action to support people facing financial difficulty,
- tackle the link between suicide and alcohol or drug use, and especially alcohol and drug misuse and dependency,
- take action to support people who feel lonely,
- encourage the voluntary sector and online platforms to continue to ensure that appropriate online signposting and resources reach the right people.

Societal Protective Factors:

- suicide prevention is everyone’s business,
- cultural, religious, or moral objections to suicide,
- reduced access to lethal means of suicide among people at risk,

- first responders and people working on the frontline feel equipped to respond appropriately to deaths by potential suicide, no matter the method used, and have the skills necessary to adapt to the situation they find themselves in,
- encourage those with a role in the planning system to consider the risks of suicide associated with buildings and public spaces and to consult the practice resource Preventing suicides in public places when creating local design policies,
- reducing references to, and limiting awareness of, emerging methods,
- reducing excessive alcohol consumption at a population level and instances of acute intoxication,
- engagement with people with personal experience of substance misuse should inform the development of appropriate treatment practices.
- build a more connected society where everyone is able to build meaningful relationships,
- tackling domestic abuse and identifying victims, including children who witness abuse.
- every individual across the country has access to training and support that gives them the confidence and skills to save lives.

Crisis Care - Protective Factors:

- timely and effective crisis support is available to those who need it,
- people are able to access crisis support in the most appropriate environment for them, when they need it, whether that is through statutory health, VCSE or social care services.
- people can access support in the way that feels most suitable for them,
- information-sharing processes are implemented and strengthened. This includes sharing information about suicide risk with families and carers, pathways between services and sectors are stronger, and uphold a person-centred, joined-up approach to crisis prevention and response, including through timely follow-up and aftercare processes,
- there should be appropriate support and processes in place for responding to a suicidal crisis, including following appropriate risk management, discharge and aftercare processes.

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