East Sussex
County Council

East Sussex Suicide Prevention Framework and Action Plan

2024-27

Contents

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1.Introduction

Suicide is defined in this report as 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]. Every suicide is a tragedy that affects families and communities and has long-lasting effects on the people left behind.

Suicide is a serious public health problem; however, suicides can be prevented with timely, evidence-based interventions. For an effective response, local, comprehensive multisectoral suicide prevention strategies are needed[2].

With 5,275 people sadly taking their life in England in 2022, it is of the utmost importance that we do all we can to reduce this number as far as possible. However, it is equally important, that when someone ends their life by suicide, their family, friends and broader community who have been bereaved, have the support they need to manage their loss. Bereavement itself is a risk-factor for suicide[3].

The COVID-19 pandemic has brought new challenges and change across the world, nationally, and locally, to each of our lives, with disruptions to the way we live, work and how we interact with others. Furthermore, cost-of-living pressures in the UK will likely continue to have an impact on people's mental health and wellbeing for some time.

On 11th September 2023, the government published its new national strategy, '*Suicide prevention in England: 5-year cross-sector strategy*, and associated '*Suicide prevention strategy: action plan*'. This updates the previous five-year plan first published in 2012. The government subsequently published 5 progress reports, the last in March 2021.

1.1 Sussex Suicide Prevention Strategy and Action plan (2024-27)

The development of the pan-Sussex strategy began late 2022 and included two main areas of work,

- a review of the latest evidence, including academic research, government policy, public health guidance, and national and local data
- an engagement exercise with key stakeholders from the Sussex Suicide Prevention Partnership in summer 2022, where views were sought on seven proposed action areas. Groups and individuals consulted included community and voluntary sector groups, NHS, Police and local authorities.

The Strategy incorporates evidence of existing priorities and looks at areas where there is increasing evidence, rising concern and new national priorities including: online harms, economic adversity, people who identify as LBGTQ+, trends in children and young people, people who are neurodivergent, domestic abuse and pregnant women. [4]

1.2 East Sussex Suicide Prevention Framework and Action Plan 2024-2027

Work to develop the new East Sussex suicide prevention framework and action plan commenced during summer 2023. It was developed with the help of the East Sussex Suicide Prevention Steering Group and will be reviewed annually. The purpose of the document is to provide a framework and plan for action for multi-agency partners in East Sussex to work together to prevent suicides.

The East Sussex framework and plan should be considered alongside the Sussex Suicide Prevention Strategy and Action Plan (2024-2027), which provides further data and detail of what is effective in preventing suicide. The two documents together are designed to ensure an aligned approach locally and Sussex-wide.

Our East Sussex action plan (Sec.7) highlights the range of strategic approaches, programmes and projects at population level that will help contribute to delivering the ambitions of the Sussex Suicide Prevention Strategy and address local challenges. Where indicated, the plan details actions that will be tackled at a pan-Sussex level, such as surveillance, communications and training.

A significant local challenge for East Sussex is the continuing high level of completed suicides occurring at our coastal cliffs, primarily at Beachy Head. The majority of people completing suicide there travel from out of county, and so options to take 'upstream' preventative action are more limited. A programme of preventative work continues and is led by Public Health.

2. Our Vision

The aim of this framework is to reduce the risk of suicide in East Sussex.

Aligned with the vision of the Sussex Suicide Prevention Strategy and Action Plan (2024-2027), East 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.

2.1 Our Approach

Our approach focuses on the eight key areas outlined in the national strategy:

1. ***Improving data and evidence*** to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. ***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.
3. ***Addressing common risk factors linked to suicide at a population level*** to provide early intervention and tailored support.
4. ***Promoting online safety and responsible media content*** to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. ***Providing effective crisis support across sectors*** for those who reach crisis point.
6. ***Reducing access to means and methods of suicide*** where this is appropriate and necessary as an intervention to prevent suicides.
7. ***Providing effective bereavement support*** to those affected by suicide.
8. ***Making suicide everybody's business*** so that we can maximise our collective impact and support to prevent suicides.

3. Governance and Accountability

This framework and action plan is monitored and overseen by the East Sussex Suicide Prevention Steering Group (multi-agency) who report into the East Sussex Mental Health Oversight Board and the Pan-Sussex Suicide Prevention Steering Group.

In addition, updates will be shared, as required, with the Health and Wellbeing Board, the multi-agency Children and Young People Health Oversight Board and Children and Young People Mental Health and Emotional Wellbeing Partnership Group.

Appendix 1 presents this information in diagrammatic form.

Governance and accountability structures will be regularly reviewed and updated where required, as we progress implementation of our action plan across the Council and with partners.

In East Sussex, due to the continuing high number of deaths at coastal locations, Public Health East Sussex lead on a related programme of work which is also multi-agency in nature and reports when required to the fora mentioned above.

4. Groups or individuals who have increased 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.

4.1 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[5].

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[6].

A study published in 2021 of men aged 40 to 54 who died by suicide in the UK[7] 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[8].

4.2 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[9]. 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[10] 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.

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[11]

- 52% of suicides in under 20's reported ***previous self-harm.***
- ***Events in childhood*** impact negatively on health in adulthood (physical and mental health), and 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***[12]
- 6% of suicides in under 20's occurred in ***lesbian, gay, bisexual, and transgender (LGBTQI+) 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***[13].
- ***Physical health condition*** were identified in 30% of deaths by suicide in those under the age of 20[14]
- ***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[15].

While ONS statistics suggest that higher education students in England have lower suicide rates[16] 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.

4.3 Family and friend carers

Male and female carers, who look after the people who are sick, elderly and disabled have a higher-than-average risk of suicide[17]. There are an estimated 90,405 unpaid carers of all ages in West Sussex, representing 10.4% of the total population (similar to the England). Around 9 million people in the UK provide unpaid care to family or other relatives.

4.4 People with pre-existing mental illness

Eighty to ninety percent of people who attempt/die by suicide have a mental health condition, but not all are diagnosed.[18] There is approximately an 8-fold increase in risk of suicide for people under mental health care for mental illness[19]. In the case of depression, on average, the risk of suicide is about 15 times higher than the average for the general population[20].

People known to be in contact with mental health services represent around 27% of all deaths by suicide in England[21] – 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[22]. 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.

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[23]
- personality disorders, who accounted for 11% of all patient suicides in England between 2010 and 2020 (and this figure is increasing) [24]
- schizophrenia and other delusional disorders, who accounted for 16% of all patient suicides in England between 2010 and 2020[25]
- eating disorders, where one-quarter to one-third of people diagnosed with anorexia nervosa and bulimia nervosa have attempted suicide. [26]

4.5 Self-harm

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.

Whilst suicide is more common in men, nationally self-harm is more common in women.[27] Approximately 50% of people who die by suicide have previously self-harmed[28][29]. In a large study based on the UK national database of presentations to hospital for self-harm, 45% of presentations to hospital were from the most deprived areas. While unemployment was a high-risk factor, financial problems as a motivation for self-harm were higher in the least deprived areas[30].

Self-harm has high levels of underreporting[31]. As a result, accurate prevalence figures are difficult to determine precisely, with statistics largely focused on those who present to hospital or primary care[32]. These statistics show that the rates of self-harm in children and young people have been increasing over recent decades across a number of comparable countries.

Estimates for the prevalence of self-harm amongst children and young people in England range between approximately 13% and 20%. For example, analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England (2014) found 22% of 15 year olds to report that they had ever self-harmed, with nearly three times as many girls reporting that they had self-harmed (32%) compared to boys (11%).

A recent East Sussex needs assessment of self-harm in children and young people concluded the following,

- Around a third of secondary school age children report having ever intentionally hurt themselves
- Around 1 in 20 secondary school age children report self-harming regularly.
- Self-harm behaviours are higher in females and increase with age. More males are seen with increasing age.
- For those attending hospital for self-harm, drug overdose or self-poisoning are the main methods of harm. Other methods of harm are higher in males and also in under 15s.
- For those attending hospital, paracetamol is the most common type of overdose followed by antidepressants.
- Self-harm increases with increasing levels of deprivation.
- Repeat hospital attendance for self-harm has been higher in recent years and is higher in females.
- A&E attendances due to self-harm remain fairly stable.
- East Sussex has an increasing and significantly higher rate of self-harm admissions

than England and the South-East, and the most recent data for 2020/21 shows East Sussex has the highest rate in Sussex.
- Within East Sussex, self-harm ambulance call-outs and admissions are highest in Hastings with admissions on an upward trend.
- Available data suggests that the prevalence of self-harm is not increasing. Survey data of secondary school pupils suggests the prevalence of regular self-harming behaviours in 2020/21 is similar to rates in 2017, and A&E attendances appear to be fairly stable. However, the increase in self-harm admissions and repeat self-harm clearly indicates that the severity of self-harming is getting worse.

4.6 LGBTQI+

People from the LGBTQI+ community are increasingly identified as having higher risk of suicide. Nationally 6% of suicides in under 20's occurred in lesbian, gay, bisexual, and transgender (LGBT) people of whom one quarter had been bullied[33]. Higher prevalence of mental health problems among people who are LGBT may be linked to experience of discrimination, homophobia or transphobia, bullying, social isolation, or rejection because of sexuality[34].

4.7 Disability

Nationally, disabled people have higher rates of suicide compared with non-disabled people. This data is from the 2011 Census where disability status was assessed by asking "Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?" [35]

4.8 Neurodivergence

Neurodivergence is the term used for *people whose brains function differently in one or more ways than is considered* standard or typical[36]. The term neurodivergence includes Autism and attention-deficit/hyperactivity disorder (ADHD) conditions.

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.

People with neurodivergent disorders may face 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. They may also face barriers in gaining support to access employment or to remain in employment.

Evidence suggests autistic people, including autistic children and young people[37], may be at a higher risk of dying by suicide compared with those who are not autistic[38]. Undiagnosed or late-diagnosed autism may be a preventable risk factor for suicide[39] 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[40], barriers to accessing support[41], pressure to 'camouflage' or 'mask' autism[42] (for example, concealing particular traits that are common in autistic people) and feelings of not belonging[43]. Autistic people report difficulties in accessing mental health support[44] because they have an autism diagnosis, are awaiting autism assessment or because of a lack of reasonable adjustments to services.

There is emerging evidence that ADHD is also significant indicator for suicide risk[45]. Evidence also indicates that neurodivergent people are over-represented in the other high-risk groups - homeless, substance misuse and problem gamblers.

4.9 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[46]. The impact 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[47] and is linked to suicide.

4.10 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)[48]. 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 and those with shorter lengths of service. Contrary to popular perceptions, the study also found that those who have served in a conflict had a reduced risk of suicide.

4.11 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.[49] 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.

4.12 People with Physical illness

Evidence suggests that a diagnosis of a severe physical health condition may be linked to higher suicide rates[50]. Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition[51].

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[52]. Over 40% of middle-aged men have been in contact with primary care services[53] 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.

5.13 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[54]

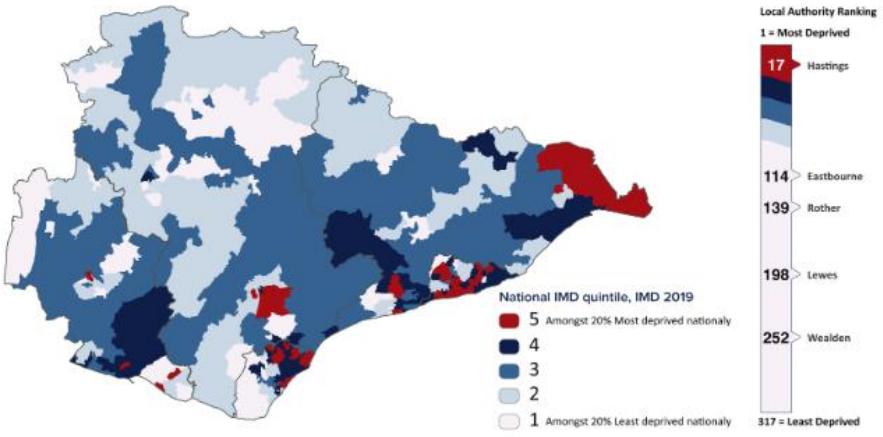
Gypsy Roma Traveller communities - the evidence for Gypsy, Roma, Traveller and nomadic communities is limited but suggests that the suicide rate for Irish Traveller women is six times higher than the general population, and seven times higher for Irish Traveller men.[55]

5. Risk factors linked to suicide at population level

5.1 Socio-economic deprivation

Suicide rates are higher among men and women living in the most deprived areas of England. Middle-aged men have higher suicide rates in the most deprived areas – up to 36.6 per 100,000 compared to 13.5 per 100,000 in the least deprived areas. The effect of social deprivation on risk of suicide impacts more on working-age people, but not on those aged under 20 or those aged over 65 (it is likely that risk factors other than deprivation are more significant at these ages)[56].

East Sussex is the 5th most deprived of the 26 county councils, although deprivation varies significantly within the county, with Hastings being the 17th most deprived of the 317 local authorities nationally, and Wealden being the 65th least deprived.



5.2 Occupation and unemployment

Analysis of 2011[57] 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[58].

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.

People with a mental health condition are three times more likely to have a 'long term' period of sickness, and this can reduce the likelihood of them returning to work and increase their likelihood of future unemployment. Whilst there are more people at work with mental health conditions than ever before, 300,000 people with a long-term mental health problem lose their jobs each year, a much higher rate than people with physical health conditions[59].

Unemployment is a key risk factor for all, particularly men between 40 and 60, along with other causes including unmanageable debt, and social isolation[60]. In the last recession there was a 1.4% rise in suicide rates for every 10% increase in unemployment in men[61].

People experiencing serious mental health problems are also less likely to be in work than those without them. The gap in employment rate between people in contact with secondary mental health services and people who are not is 69.1% in East Sussex, which is marginally worse than the England gap at 67.2%[62]

The gap in the employment rate between those with a long-term health condition and those without in East Sussex is 9.5%, this is slightly lower than that of England at 10.6%[63]

5.3 Economic adversity, debt, gambling and the cost of living

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[64]. 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, with some feeling suicidal[65].

People amongst the most deprived 20% of society are more than twice as likely to die from suicide than the least deprived 20%[66].

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[67]. 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[68]. Men in mid-life were particularly vulnerable.

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.

There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people[69]. 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.

5.4 Bereavement

Suicide has a broad impact, not only on immediate family and close friends, but also on colleagues and wider society. Those bereaved by suicide have an increased risk of suicide and are more likely to experience poor mental health[70]. There is increasing recognition that those significantly affected by suicide extend beyond those known to the deceased, including witnesses, frontline professionals and others working in suicide prevention.

5.5 Domestic abuse

Since the 2012 national strategy, more evidence of a link between domestic abuse and suicide[71] has emerged. Research on intimate partner violence, suicidality and self-harm[72] 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[73] 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[74].

5.6 Substance misuse

People who misuse 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].

5.7 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]. 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].

5.8 Homelessness

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[88].

People who are homeless have a higher proportion of mental disorders than people with stable accommodation, particularly psychotic illness, personality disorders and substance misuse[89]. Nationally 45% of people experiencing homelessness have been diagnosed with a mental health issue, compared to an estimated rate of 25% in the general population[90]. This rises to 8 out of 10 people who are sleeping rough.

6.Data

6.1 National Data

In 2022, there were 5,275 recorded suicides in England, equivalent to an age-standardised mortality rate of 10.6 deaths per 100,000 people. This rate was similar to 2021 but statistically significantly higher than 2020. However, 2020 saw a decrease in suicide rates because of the impact of the coronavirus (COVID-19) pandemic on the coroner's inquests, and a decrease in male suicides at the start of the pandemic[91].

Based on 2019 data, numbers of suicides began to increase in England in 2018, after four years of decline. 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[92].

Of the suicides recorded in England in 2021, just under 74% were completed by men, at 15.8 per 100,000 compared to 5.5 per 100,000 women.[93] In recent years, nationally 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 cartNational Child Mortality Database shows that Suicide and Deliberate Self Harm remains one of the leading causes of deaths for the reviews of children in England aged 15-17 years[94].

6.2 East Sussex Profile

East Sussex has a population of approximately 558,900. The rate of suicides in East Sussex of 12.1 per 100,000 people (approximately 68 people per year) exceeds the England average of 10.4 but is between other parts of Sussex (Brighton and Hove,14.1 and West Sussex, 11.5). These rates are measured over a 3 year period, 2019 – 2021[95]. The chart below compares the East Sussex rates with England and local authority areas in the South-East.

Chart 1: Comparison of East Sussex suicide rates with England, the Southeast region and local authorities in the South-East[96]

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	15,447	10.4	10.3	10.6
South East region	–	2,558	10.6	10.2	11.0
Brighton and Hove	–	113	14.1	11.4	16.8
Isle of Wight	–	48	13.8	10.0	18.4
Milton Keynes	–	91	12.9	10.4	15.8
East Sussex	–	179	12.1	10.3	14.0
Reading	–	49	12.0	8.8	16.0
West Berkshire	–	48	11.9	8.7	15.8
Kent	–	479	11.7	10.6	12.7
West Sussex	–	265	11.5	10.1	12.9
Buckinghamshire UA	–	157	11.0	9.3	12.7
Medway	–	76	10.6	8.4	13.3
Surrey	–	316	10.1	9.0	11.2
Oxfordshire	–	181	10.0	8.6	11.5
Portsmouth	–	56	9.9	7.4	13.0
Southampton	–	63	9.5	7.2	12.3
Hampshire	–	321	8.9	8.0	9.9
Slough	–	31	8.7	5.8	12.5
Bracknell Forest	–	28	8.4	5.6	12.1
Windsor and Maidenhead	–	31	8.2	5.5	11.7
Wokingham	–	26	6.0	3.9	8.8

Source: Office for National Statistics

The rates of suicide amongst men are far higher than women, accounting for approximately 70% of deaths, which is similar to England as a whole. The suicide rate in East Sussex has consistently tracked higher than the national average See chart 2. Of the 5 district and boroughs in East Sussex, rates are highest in Eastbourne (19.6), and the lowest is Rother (9.4). See chart 3.

Chart 2. Suicide rate (persons) 2001-2021. East Sussex.

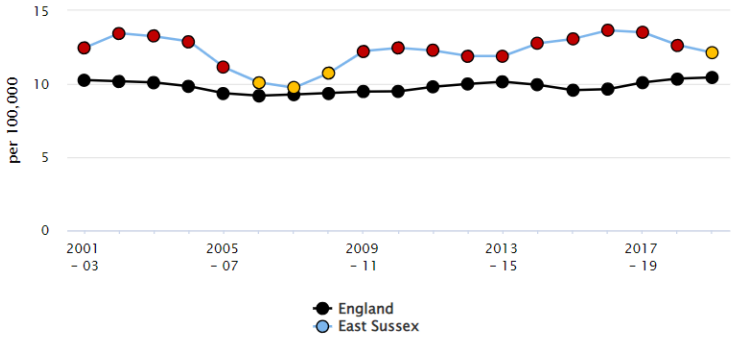


Chart 3. Suicide rate (persons) 2001-2021. East Sussex District and Boroughs 2019-21

Area	Value	95% Lower CI	95% Upper CI
England	10.4	10.3	10.6
East Sussex	12.1	10.3	14.0
Eastbourne	19.6	14.6	25.9
Hastings	11.9	8.0	17.1
Lewes	10.7	7.2	15.4
Wealden	9.9	7.1	13.3
Rother	9.4	5.8	14.3

Source: Office for National Statistics

7. Suicide Prevention Action Plan 2024-2027: Year 1 Actions

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Ongoing development and implementation of the Real Time Surveillance (RTS) system and response, analysis of data to inform action to limit the impact of a suicide, including contagion.	RTS monthly reporting Systems in place to identify clusters ***Pan-Sussex Collaboration***	Public Health (East Sussex, West Sussex, Brighton and Hove)
Development of RTS dashboard to include self-harm and drug related death data.	New system capacity to monitor self-harm attendance/admissions and drug related deaths. ***Pan-Sussex Collaboration***	Public Health (East Sussex, West Sussex, Brighton and Hove)
2. 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		
Action	**Success measures / Outputs and Outcomes**	**Lead Agencies**
Improving mental health of men, through • Men in Mind Project- Training and Skills Programme • VSCE Mental Health Network – Insights gathering • FE/College – future workforce project	• A successful programme, informed by ongoing evaluation • A clear understanding of how local communities and VSCE organisations can be supported to develop more projects to support mens' mental health. • The development of a college based educational programme to	Public Health East Sussex

	promote mental health of young men entering male dominated workplaces.	
Reducing the prevalence and impact of self-harm in children and young people through, • Implementing the recommendations of the East Sussex Children and Young People Self-Harm Needs Assessment	Formation of CYP Self-harm Task and Finish Group reporting to the CYP Mental Health and Emotional Wellbeing Partnership Group.	CYP Mental Health and Emotional Wellbeing Partnership Group, East Sussex County Council (ESCC)
Roll out of the Sussex Toolkit for Unexpected Deaths in Schools	Extend local training to support promotion and implementation of the toolkit. ***Pan-Sussex Collaboration***	Education East Sussex, ESCC
Don't Brush it Under the Carpet – MH Campaign for older peoples mental health	Successful campaign launched Autumn/Winter 2023 ***Pan-Sussex Collaboration***	Sussex Partnership NHS Foundation Trust
Supporting the mental health of pregnant women and new mothers through, • Family Hub Programme and Start for Life Offer – Parents in Mind (PIM) peer support services for women and non-birthing partners • Effective pathways of support for peri-natal mental health problems	• Successful evaluation of PIM (mothers) and commencement of PIM (fathers) • Multi-agency pathway review	Children Services (Early Help) and Public Health, ESCC

3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Establishment of 'stewardship approach' to ***tackling loneliness and social isolation***, through the 'Connecting People and Places' project. Annual Public Health Report 2022/23 - Connecting People and Places | (eastsussexjsna.org.uk)	Commencement of stewardship group and engagement activity with VCSE, local authority and NHS partners.	Sussex Community Development Association (SCDA) and Public Health, ESCC
Ongoing work of the Multiagency Financial Inclusion Steering Group (MFISG) to support to those experiencing financial stress and vulnerability, including • Up-to-date central 'cost-of-living' support web page • a 'plan on a page approach' to connect financial inclusion and mental health networks, to better understand the impact of mental health on financial stability (and vice versa).	• Widely available resources promoted through multiple agencies and staff training • Completion of network and engagement project to identify opportunities for action by the MFISG.	Adult Social Care and Health (ASCH), ESCC
Undertake a 'gambling heath needs assessment', to identify opportunities for harm avoidance and reduction.	Publication of needs assessment and a plan for implementing recommendations.	Public Health East Sussex
Ongoing implementation of the East Sussex Alcohol Harm Reduction Strategy 2021-26. • Establishment of Alcohol Care Team	• Commencement of secondary prevention service aimed at	Public Health East Sussex

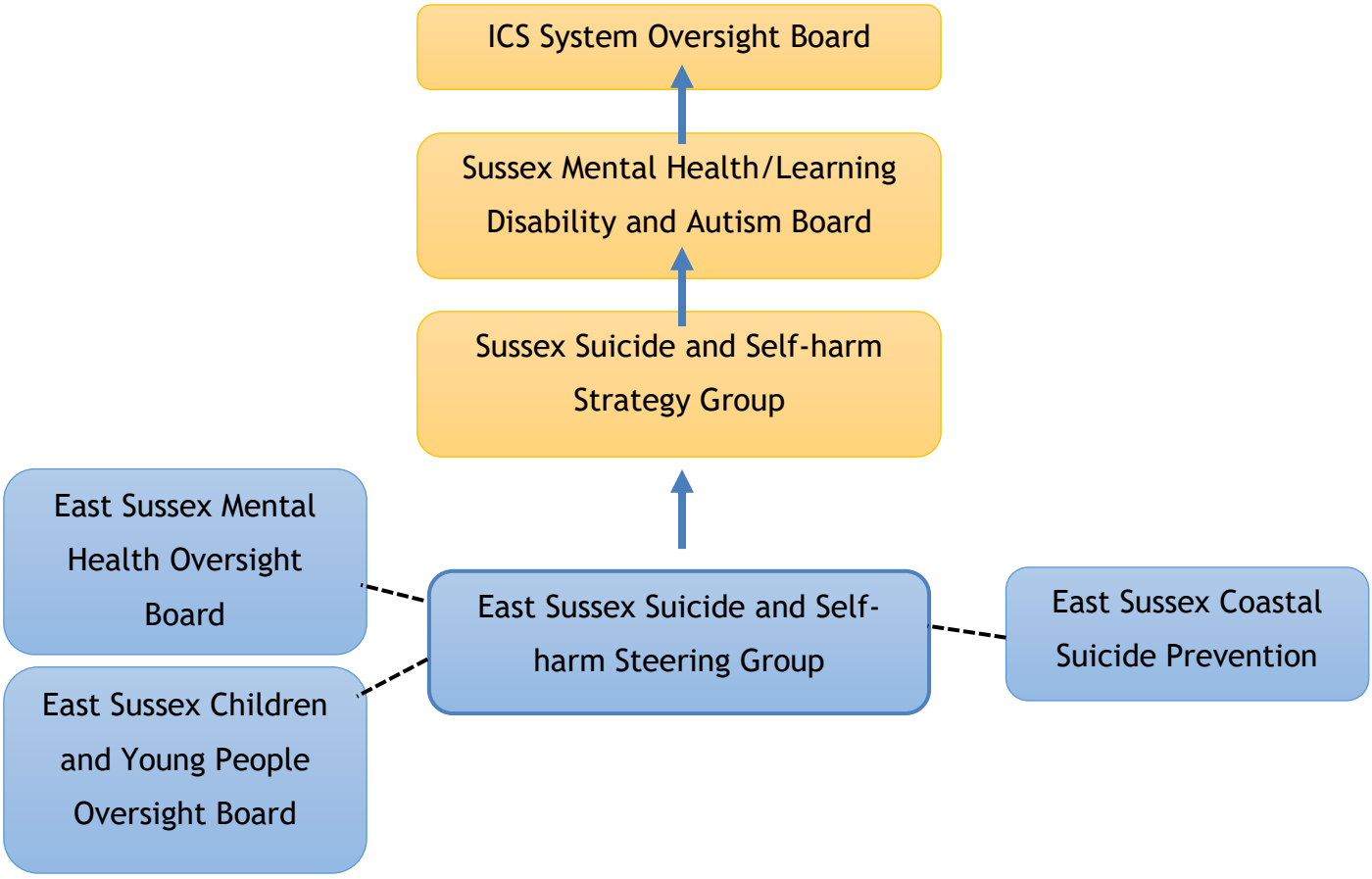
• Reducing supply in targeted areas (licensing and enforcement)	those attending hospital due to risky levels of drinking. • Reduce proliferation in alcohol selling outlets and licensing hours, in areas with higher deprivation and alcohol harm	
Supporting the aims of the East Sussex Safer Communities Partnership Plan through the prevention of domestic and sexual violence and abuse, against women and girls. • Theatre in Education Programme. Sexual relationships, harmful behaviours and consent	Successful education programme reaching Year 9 secondary school pupils (ages 13/14yrs), including curriculum component and teacher support.	Public Health East Sussex
4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Development of suicide prevention communications plan	• promote services to improve communities', individuals' emotional/mental wellbeing • promote mental health support services for people with escalating concerns • encourage communities' self-support *Pan-Sussex Collaboration*	Sussex Health and Care, Sussex Partnership NHS Foundation Trust, Public Health (East Sussex, West Sussex, Brighton and Hove)

Development of a 'Coastal Suicide Prevention Communications Plan'. Including. 1.Media Monitoring and Advice 2.Proactive Media 3.Resilience/good news network and stakeholder engagement 4.Communications resources 5.Digital landscape analysis and intervention	A multi-agency plan identifying opportunities for preventative action.	**Samaritans,** Public Health East Sussex
5. Providing effective crisis support across sectors for those who reach crisis point.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Implementation of the Sussex Mental Health Urgent and Emergency Care Improvement Plan, including • Improving access to crisis cafes • Continued development of SHOUT Sussex text service for those needing 24/7 immediate support.	• Pilot of open access service in collaboration with Sussex Partnership Foundation Trust - Hastings and Brighton • Increased uptake of service (25% Dec 2022 to Dec 2023) ***Pan-Sussex Collaboration***	Sussex Health and Care, Sussex Partnership NHS Foundation Trust VSCE mental Health Network/Southdown Housing
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**

Continue with the Coastal Suicide Prevention Programme including, • Natural barriers feasibility study • Engagement Rangers/Ambassador Project • Communications strategy	• Completion of ecological survey • Commencement of project • Launch of strategy	Public Health East Sussex
Contribute to the ongoing work of the Safe Public Spaces (SPS) Network which seeks to share learning and good practice regarding locations with frequent suicides.	Continued membership and collaboration amongst national partners.	Public Health East Sussex
7. Providing effective bereavement support to those affected by suicide		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Work with partners to ensure continued support is available for those bereaved and affected by a suicide.	Development of common standard multi-agency operating procedure for identifying and supporting those affected. ***Pan-Sussex Collaboration***	Public Health (East Sussex, West Sussex, Brighton and Hove)
Deliver the 'Suicide Response & Prevention Workforce: Support & Supervision Project Workforce Wellbeing Project', which aims to establish support for non-frontline workers involved in suicide prevention work.	Completion of Phase 1: Exploration: Secure an academic partner to identify the target population, their needs and proposed interventions. ***Pan-Sussex Collaboration***	Sussex Health and Care, Public Health East Sussex
Undertake a Sussex wide 'bereavement needs assessment' [not limited to bereavement through suicide]	A report describing the nature and impact on residents and identify areas for improvement and development of support.	Public Health (East Sussex, West Sussex, Brighton and Hove)

	Pan-Sussex Collaboration	
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Through the 'Men in Mind Project- Training and Skills Programme' encourage businesses, community interest groups and members of the public to play a part in recognising and helping people in difficulty.	A successful programme, informed by ongoing evaluation	Public Health East Sussex
Provide a free or low-cost training programme to anyone in a caring role, including VCSE staff and volunteers.	Full uptake of available training from a broad range of organisations and individuals.	Public Health East Sussex
Develop a sustainable approach to meaningfully involve those with lived experience across Sussex to develop and improve prevention activity* *(includes those who have made suicide attempts and those bereaved by suicide)	Pan- Sussex and East Sussex plans are implemented, through involvement of people with lived experience. *Pan-Sussex Collaboration*	Public Health (East Sussex, West Sussex, Brighton and Hove)

Appendix 1 - Governance structure East Sussex and Pan-Sussex



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