Adults Wellbeing and Health Overview and Scrutiny Committee

Suicide Rates and Mental Health and Wellbeing in County Durham Review Report

September 2018

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Foreword

We have known for some time that the North East of England and specifically areas within County Durham suffer from some of the poorest health and wellbeing measures within the country and that there is a significant gap between the life expectancy of men and women in County Durham and the England average. The rate of suicides within County Durham is higher when compared with the North East region and the England average which has prompted this review.

The Review was undertaken between October 2016 and March 2017 and the Review group examined key national strategies aimed at improving mental health and wellbeing and suicide prevention as well as those local strategies and services provided jointly by the County Council and its key partners across the NHS, the criminal justice system and the Community and Voluntary sector.

The Review Group identified key findings and recommendations which include; the importance of developing an early suicide alert system which is able to flag up those individuals at risk of suicide and which could be used to target preventative mental health services to such individuals in a proactive manner; the importance of a co-ordinated partnership approach to ensure access to preventative mental health services and mental health crisis services is timely and responsive. The need for partners to be able to share information and learning across organisational boundaries has also been highlighted as this is crucial to a co-ordinated approach to the delivery of successful mental health and wellbeing interventions and support services.

The Community and Voluntary sector have a huge role to play in improving health and wellbeing of the population of County Durham and the review has heard evidence from a range of CVS organisations. This highlighted positive practice across the County aimed at suicide prevention and tackling some of the wider determinants of health which can adversely impact upon a person's mental health and wellbeing including relationship breakdown, loss of employment, access to housing, financial hardship and education and training. Their ability to continue to deliver projects, services and interventions during what has been a prolonged period of austerity and funding pressures is a concern.

I would like to thank all those who took part in the review for their time and support especially representatives from the Council's Public Health team, colleagues from the NHS, representatives from the prison service and Durham Constabulary and particular thanks go to the CVS organisations who have given evidence to the Review Group.

Councillor John Robinson
Chairman
Adults Wellbeing and Health Overview and Scrutiny Committee

Executive Summary

1. This review was undertaken between October 2016 and March 2017 following concerns identified by the Adults Wellbeing and Health OSC during consideration of Quarterly Performance Management reports which highlighted that suicide rates for County Durham were above the National and North East average figures. Members examined statistics around suicides and suicide rates during a three year period 2012-14 in more detail rather than wider mental health illness or public mental health statistics. They also assessed the measures that the Council and its partners have put in place to ensure improved mental health and wellbeing and which aim to reduce the incidence of suicides within County Durham. Members considered evidence based on 4 key themes of policies, processes and services of Durham County Council; NHS partners and Safe Durham Partnership together with how the community and voluntary sector is involved in supporting suicide prevention and the promotion of mental health and wellbeing.

2. For the period 2012-14, County Durham had the second highest suicide rate within the North East local authorities and the highest suicide rate amongst its CIPFA nearest neighbour local authority group. The 2012-14 Suicide Audit for County Durham Suicide rates in Durham (2012-14) were 20.6 per 100k population for males and 6.1 per 100k population for females. National figures are 14.1 and 4.0 per 100k population respectively. Durham and Derwentside are the areas with the greatest numbers of suicides although not statistically significantly higher than the County Durham average. The largest number of deaths by suicide occurred in the 40-49 age group with 33% of suicide victims employed at time of death and 31% unemployed. 34% of suicides cases lived alone**.**

3. In September 2012, the Government published “Preventing suicide in England: A cross-government outcomes strategy to save lives”, a new strategy intended to reduce the suicide rate and improve support for those affected by suicide. It set out overall objectives to achieve a reduction in the suicide rate in the general population in England and provide better support for those bereaved or affected by suicide. A national mental health strategy, entitled “No Health without Mental Health” and its implementation framework set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported.

4. The County Durham Joint Health and Wellbeing Strategy 2016-2019 includes a strategic objective to “Improve the mental and physical wellbeing of the population” as well as a key outcome to reduce self-harm and suicides. Key actions set out within the Strategy include a refresh of the Public Mental Health Strategy for County Durham, including the development of a Suicide Prevention Framework and an associated action plan to improve outcomes for people experiencing mental health crises in the community and in custody.

5. The County Durham Public Mental Health Strategy is delivered through a multi-agency partnership involving Durham County Council, NHS Provider and Commissioning bodies, Durham Constabulary, Durham Prisons and a range of Community and Voluntary Organisations which reports to the Health and Wellbeing Board and Children and Families Trust. The County Durham Mental Health Implementation Plan sets out delivery priorities, governance structures and reporting responsibilities.

6. Key milestones within the plan include the implementation of Public Mental Health; Children's Mental Health and Dementia strategies; the delivery of a recovery college (TEWV FT); improved accommodation offers to support inpatient discharge; an improved mental health prevention service and improved crisis response service.

7. As part of the refresh of the Public Mental Health Strategy the Council needs to develop and implement a local suicide prevention strategy which delivers against the Government's suicide prevention strategy and includes key actions aimed at reducing suicides, ensuring the mental health support services are available and accessible to those at risk of suicide and promotes effective partnership working which includes the ability to share data and learning across agencies.

8. In terms of suicide prevention, the existing suicide early alert service promotes early support and interventions for those affected by suicide but should also be able to flag up those individuals at risk of suicide and which could be used to target preventative mental health services to such individuals. This should be explored as part of the development of the suicide prevention strategy and action plan.

9. When examining NHS Policies, processes and services for suicide prevention and the promotion of mental health and wellbeing the working group have received numerous examples of effective partnership working across NHS Organisations including liaison between mental health and acute hospital services, there are improvements that have been identified which could lead to more effective suicide prevention, more timely service provision and interventions for those in crisis and/or at risk of suicide and a clearer crisis pathway and improved accessibility to mental health services.

10. The working group have heard that often those at risk of suicide are known to one or more of the emergency services be that the police or health. Difficulties have been reported in terms of organisations ability to share information across partners in respect of those at risk of self-harm or suicide as well as learning from those incidents of suicide. The working group consider that a multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies.

11. The working group are concerned that there is no diagnosis flag within the A&E system that could give an indication of attempted suicide for patients who present at A&E but who are not admitted. This presents a risk to such patients in that they may not be offered access to mental health services at an early stage which could improve their chance of recovery and prevent potential for suicide.

12. The working group are pleased to note the success of County Durham and Darlington NHS Foundation Trust's work with TEWV NHS FT liaison team in ensuring that those patients who have been admitted and have been identified with an intentional self-harm code are able to access mental health services. However it is noted that this appears to be more effective from 08.00 a.m. until 10.00 p.m. with a liaison gap having been identified when the team handover to the crisis team. It is essential that a consistent level of service should be provided 24/7 to mitigate against risks of potential self-harm and suicide during crisis episodes.

13. The mapping out of services to support individuals escalating towards clinical crisis and averting the crisis or ensuring the person is helped into the right clinical care has been identified as a much needed improvement in current processes. Often individuals are not aware of the services available to them to support their mental health and wellbeing and avoid crisis episodes. They also need guidance to explain how to access these services and whether they can self-refer into services or whether this needs to involve health professionals.

14. The Crisis Care Concordat is a commitment made by all partners to joint working to improve the response to people in mental health crisis across services. Whilst this is to be welcomed, the development of a single point of access to crisis services has been identified as a key gap in current crisis service provision.

15. When examining Safe Durham Partnership policies, processes and services for suicide prevention and the promotion of mental health and wellbeing it was noted that the prison service within County Durham has an effective process known as ACCT (Assessment, Care in Custody and Teamwork) which has been assessed as fit for purpose as an effective mechanism to identify, manage and support those at risk of suicide and self-harm with the prison environment. The process has been reviewed and a series of recommendation s have been implemented which look to improvement communication and awareness amongst staff along with increased training in the process.

16. Work is underway to ensure that there is a greater integration between the criminal justice system and health/social care services particularly around multi-agency casework and information sharing regarding mental health amongst offenders.

17. A similar process has been examined as part of Durham Constabulary's detention and custody process with risk assessments routinely undertaken across their 4 custody suites. As part of this process routine checks are made across a range of databases and records and the group heard evidence of joint working between the Police and Health services including the new street triage service which aims to ensure that Police Officers have access to mental health professionals when detentions under S136 of the Mental Health Act 1983 are being considered.

18. Notwithstanding the above, issues experienced in the past in relation to data sharing between agencies and accessing patients' records/information which may result in delays in accessing treatment need to be addressed by ensuring that a process of case conferencing is in place.

19. Community and Voluntary Sector organisations play a significant role in suicide awareness, prevention and support for mental health and wellbeing. The Rapid Response Suicide Prevention project developed by MIND, CDDFT and Durham CCGs offers a rapid response suicide prevention counselling service which significantly reduces PHQ9 depression test scores and improves mental health and wellbeing. None of the 1649 clients referred into the service between 2011 and 2016 took their own life.

20. The If U Care Share Foundation offers a support after suicide service for those who have lost someone through suicide as well as a prevention referral service. Key areas of work include awareness raising of suicide within education services; shared lived experience of suicide to support those affected by suicide; advice and guidance to mental health support and crisis services.

21. Single Homeless Action Initiative in Durham (SHAID) identifies the wider determinants of health and their impact on mental health and wellbeing. Key groups supported include the homeless, people fleeing domestic violence; ex forces personnel, prison leavers and people with mental health diagnoses.

22. Durham Samaritans deliver listening services to those at risk of suicide, those affected by suicides and also work closely with media outlets to allow for sensitive reporting of suicides. Nationally they have developed teaching materials, including Developing Emotional Awareness and Listening (DEAL) which was used by professionals. Work is undertaken with young people in schools, colleges and youth settings to offer advice on looking after emotional health and a national team of specially trained volunteers work with schools and colleges affected by suicide.

23. The key issue identified across the Community and Voluntary Sector is the funding available to support projects and ensure their sustainability. It is therefore important that an assessment of the effectiveness of CVS services and projects is undertaken to enable resources to be targeted to those which demonstrate the necessary outcomes have been delivered.

Recommendations

24. The review group having considered the findings and conclusions of the review have made the following recommendations:

Recommendation one

That a suicide prevention strategy and action plan be developed and implemented as part of the refresh of the Public Mental Health Strategy for County Durham and that progress against the action plan be monitored by the AWHOSC.

Recommendation two

The existing suicide early alert system, whilst providing excellent support and interventions for those affected by suicide after the event, needs to develop appropriate systems to flag up those at risk of suicide and which could be used to target preventative mental health services and support to such individuals.

Recommendation three

A multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies including adult and children's social care and health services, NHS services and those within the criminal justice system.

Recommendation four

The introduction of an appropriate coding/flagging system for self-harm/attempted suicide across all A&E department attendees should be promoted which identifies those potentially at risk of suicide and allows for proactive offers of access to mental health services and support

Recommendation five

The current processes for referral into mental health services be reviewed to ensure that there is clarity available to potential service users to help them to identify the range of services available, whether the services allow for self-referral as well as referral by health professionals and the associated target timeframes for accessing services.

Recommendation six

The accessibility of the out-of-hours mental health crisis service be reviewed to ensure that individuals suffering from crisis episodes have timely access to support and interventions.

Recommendation seven

An audit of current health and wellbeing support and services within the Community and Voluntary sector be undertaken to evaluate their effectiveness and enable resources to be targeted at those interventions where demonstrable outcomes for improved mental health and wellbeing and reduced suicide risk are evident.

Recommendation eight

That a systematic review of the report and progress made against recommendations should be undertaken after consideration of this report, within six months**.**

MAIN REPORT

Suicide Rates within County Durham – Statistical Analysis

Key Findings

- **For the period 2012-14 County Durham had the 2nd highest suicide rate in the North East and the highest in our CIPFA nearest neighbour group.**
- **Suicide rates in Durham (2012-14) were 20.6 per 100k population for males and 6.1 per 100k population for females – National figures are 14.1 and 4 respectively).**
- **The largest number of deaths by suicide occurred in the 40-49 age group.**
- **33% of suicides were employed at time of death and 31% unemployed.**
- **34% of suicides cases lived alone.**

25. Public Health England in its 2014 guidance for developing a local suicide prevention action plan identified local suicide audits as being an effective way for authorities to identify and respond to high risk groups in their areas, as well as reveal hot spots.

26. An audit of suicides through the systematic collection and analysis of local data on suicides provides valuable information to learn lessons and inform suicide prevention plans. In order to draw together meaningful numbers while still preserving the anonymity of those involved, a three year pool of data is used

27. The rate of suicide per 100,000 of the population is a performance indicator in the Public Health Outcomes Framework (PHOF).

28. Between 2001-03 and 2006-08 the rate of suicide within County Durham although slightly higher, was not statistically different from the England rate. However since 2007-09 the rate for County Durham has risen significantly more than that for England. County Durham has a suicide rate of 13.3 per 100,000 population for the 2012-14 aggregated data. This remains above the suicide rate for the North East (11.0 per 100,000 population) and significantly higher than the suicide rate for England (8.9 per 100,000).

29. For the period 2012-14, County Durham had the second highest suicide rate within the North East local authorities with only Middlesbrough higher. It also had the highest suicide rate amongst its CIPFA nearest neighbour local authority group.

30. The suicide audit considered by the working group showed that in 2012-14 suicide rates for males in County Durham stood at 20.6 per 100,000 population compared with the figures for the North East (17.9 per 100,000 population) and England (14.1 per 100,000 population).

31. In 2012-14 suicide rates for females in County Durham stood at 6.1 per 100,000 population compared with the figures for the North East (4.5 per 100,000 population) and England (4.0 per 100,000 population).

32. There were 198 deaths by suicide or undetermined injury in County Durham between 2012 and 2014. Eight of these deaths were non-County Durham residents and were not included in the suicide audit analysis

33. Of the 190 deaths recorded in County Durham between 2012 and 2014 75% (142) were male and 25% (48) were female.

34. The geographical breakdown of numbers of suicides reveals Durham and Derwentside areas as areas with high numbers of suicides between 2012 and 2014. Removing the cases where the death has occurred in prison identifies the former Derwentside and Durham areas as having the highest numbers and rates across the three years although not statistically significantly higher than the County Durham average.

35. Of the suicides and undetermined injuries 67% of both male and female cases were of people who were under the age of 50 at time of death. The greatest numbers of deaths were seen in those aged 40 to 49 (in part due to the age structure of the county). Whilst suicide is relatively rare in children and young people there were nine deaths recorded in those 19 and younger. At the other end of the age distribution there were eight deaths by suicide or undetermined injury in those aged 70 years or more.

36. When examining employment status amongst suicides, around 33% (63) were employed at the time of death whereas 31% (59) were unemployed, 11% were retired and 7% were long-term sick or disabled.

37. In 34% (65) of cases the person lived alone at the time of death.

Conclusions

38. The statistical analysis shows that County Durham had a relatively high suicide rates with the majority of cases relating to those under 50 and male.

National and Local Strategic Context for Suicide Rates and Mental Health and Wellbeing – Key service strategies, policies and action plans

Key Findings

- **Government policy exists to prevent suicides and includes objectives to reduce suicide rates and provide better support for those bereaved or affected by suicides.**
- **"No Health without Mental Health" national strategy requires organisations to produce a local implementation framework;**
- **House of Commons Health Select Committee into suicide prevention has identified failings in delivering the Government's suicide prevention strategy;**
- **The County Durham Joint Health and Wellbeing Strategy includes a strategic objective to "improve the mental and physical wellbeing of the population" as well as a key outcome to reduce self-harm and suicides. .**
- **The County Durham Mental Health Implementation Plan sets out delivery priorities, governance structures and reporting responsibilities.**
- **Key milestones within the plan include the implementation of Public Mental Health, Children's Mental Health and Dementia strategies; the delivery of a recovery college (TEWV FT); improved accommodation offers to support inpatient discharge; an improved mental health prevention service and improved crisis response service.**
- **The County Durham Public Mental Health Strategy details a summarised action plan against the key objectives of the Public Mental Health Strategy rather than a specific suicide prevention action plan as recommended by the PHE guidance and set out in the Government's national suicide prevention strategy.**

National Policy Context

39. In September 2012, the Government published "Preventing suicide in England: A cross-government outcomes strategy to save lives", a new strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy sets out key areas for action; states what government departments will do to contribute; and brings together knowledge about groups at higher risk, effective interventions and resources to support local action.

40. The strategy sets out overall objectives to achieve a reduction in the suicide rate in the general population in England and provide better support for those bereaved or affected by suicide.

41. There are six key areas for action to support delivery of these objectives

    (i) Reduce the risk of suicide in key high-risk groups;
    (ii) Tailor approaches to improve mental health in specific groups;

(iii) Reduce access to the means of suicide;
(iv) Provide better information and support to those bereaved or affected by suicide;
(v) Support the media in delivering sensitive approaches to suicide and suicidal behaviour, and
(vi) Support research, data collection and monitoring.

42. There is also a national mental health strategy, published in 2011, entitled “No Health without Mental Health”. The strategy implementation framework sets out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported. This is vital, because suicide prevention starts with better mental health for all - therefore “Preventing suicide in England: A cross-government outcomes strategy to save lives” has to be read alongside that implementation framework.

43. The publication of the national mental health strategy “No Health without Mental Health” in 2011 set out at a national level the following high level objectives to improve the mental health and wellbeing of the population:

- More people will have good mental health;
- More people with mental health problems will recover;
- More people with mental health problems will have good physical health;
- More people will have a positive experience of care and support;
- Fewer people will suffer avoidable harm;
- Fewer people will experience harm and stigma.

44. The House of Commons Health Committee Inquiry into suicide prevention produced an interim report in December 2016 which set out a number of key areas that the Government needed to take account of when refreshing its suicide prevention strategy. These included:-

- the refreshed Government strategy must be accompanied by a clear implementation plan, with strong external scrutiny of local authority plans and progress and that local authority suicide prevention plans are mandatory;

- the need for services to support people who are vulnerable to suicide;

- consensus statements on sharing information with families to ensure that there are opportunities to involve families and friends in a patients recovery;

- timely and consistent data is needed to enable swift responses to suspected suicides and to identify possible clusters in order to prevent further suicides;

- greater awareness amongst the media of data breaches regarding the reporting of suicides at national and local level together with restrictions to potentially harmful internet sites and content.

45. The Health Select Committee produced its final report in March 2017 and a response to that by Government was published in July 2017 which included reference to an updated cross-Government suicide prevention strategy.

Local Policy Context

46. The County Durham Joint Health and Wellbeing Strategy 2016-2019 includes a strategic objective to "Improve the mental and physical wellbeing of the population" as well as a key outcome to reduce self-harm and suicides. Key strategic actions set out within the Health and Wellbeing Strategy include a refresh of the Public Mental Health Strategy for County Durham, including the development of a Suicide Prevention Framework and working in partnership through the Crisis Care Concordat an associated action plan to improve outcomes for people experiencing mental health crises in the community and in custody.

47. The County Durham "No Health without Mental Health" local implementation plan 2014-17 is being delivered through a multi-agency partnership and sets out how the Council and its partners will deliver against the national strategy's objectives by developing and improving mental health services covering all ages. The Plan has been developed via the local Mental Health Partnership Board, which is a sub group of the Health and Wellbeing Board and involves a wide range of agencies and stakeholders.

48. To deliver against the national priorities identified in paragraph 41, a series of local priorities has been developed and will be aligned to a specific group as part of the established governance structure. These are summarised at Appendix 1 of this report.

49. Key milestones in delivering against the County Durham Mental Health Implementation Plan have been identified and progress reported to the review group includes:-

- Public Mental Health, Children's Mental Health and Dementia Strategies being implemented;
- Recovery College (real and virtual) being delivered by Tees Esk and Wear Valleys NHS Foundation Trust;
- Detailed work on accommodation options for people with mental health needs which includes a new service in Bishop Auckland and another being built in Meadowfield;
- Increase in move-on accommodation to support hospital discharge and recovery;
- Strategic review of Mental Health Prevention services with a new operating model to be developed and implemented in 2017;
- Improving crisis responses through the Crisis Care Concordat - funding awarded for a new crisis centre;

- Local Anti-Stigma and Discrimination group in place with a bid made for national funding from 'Time to Change'
- Multi-agency 'Active Durham' partnership to increase levels of physical activity.

50. In considering how to progress work against the Plan further, the local Mental Health Partnership Board has suggested that the Council and partners should:-

- Rationalise the number of strategies and consolidate joint working;
- Develop and deliver the crisis response centre in Durham;
- Improve access to 'talking therapies' with CCGs;
- Ensure the 'Durham Works' programme promotes benefits to people with mental health needs;
- Continue development of specialist accommodation;
- Consolidate the 'Recovery College' and extend its benefits to a wider service user group to include GPs and the ability to self-refer into the service;
- Explore and promote ongoing work with Voluntary and Community Sector
- Explore the potential of Cultural Opportunities to improve mental health and wellbeing through dance, theatre, music, etc.

Suicide Prevention

51. The National Strategy "Preventing suicide in England sets out overall objectives to achieve a reduction in the suicide rate in the general population in England and provide better support for those bereaved or affected by suicide.

52. Guidance issues by Public Health England (PHE) suggests that successful implementation of the national strategy at a local level relies on:-

1. Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations;
2. Developing a suicide prevention strategy and/or action plan that is based on the national strategy and local data, and
3. Completing a suicide audit.

53. The County Durham Public Mental Health Strategy vision states that "Individuals, families and communities within County Durham to be supported to achieve their optimum mental wellbeing". The strategy's key objectives are geared towards promoting mental health and wellbeing; prevention of mental health; early identification of those at risk of mental health and recovery form mental health.

54. Specific objectives related to suicide prevention include:-

Objective 1: Improve mental health and wellbeing of individuals through engagement, information, activities, access to services and education, and

Objective 3: Reduce the suicide and self-harm rate for County Durham.

55. The strategy details a summarised action plan against the key objectives of the Public Mental Health Strategy rather than a specific suicide prevention action plan as recommended by the PHE guidance referenced above.

56. Governance arrangements for the delivery of the Public Mental Health Strategy exist with the performance management framework aligned to the priorities identified within the strategy. The Public Mental Health Strategy group is accountable to the County Durham Mental Health Partnership Board. Progress on the delivery of the strategy objectives and action is reported to the Children and Families Trust and the Health and Wellbeing Board.

57. The Suicide Audit considered by the Suicide Review Working Group covered the three year period 2012-14, the key findings of which are set out at paragraphs 25 to 38 of this report. The Audit involved the collection and collation of data by the Public Health team from a variety of partners including

58. Key services, interventions and programmes have been identified and developed which are aimed at delivering against those actions detailed within the Public Mental Health Strategy specifically related to Suicide prevention. These include:-

- The development of a Suicide early alert system to inform of a death from suicide and emerging trends and which promotes early support and interventions for those affected by suicide;
- Suicide Safer Communities County Durham – a helpline and website resource detailing a range of support services which includes bereavement counselling, relationship advice, suicide bereavement support;
- If U Care Share – a post-bereavement support service for families affected by suicide;
- The County Durham Sheds Programme – a project aimed at tackling loneliness and social isolation; financial and relationship problems initially aimed at men and based on an Australian model but now widened to include women and young people;
- Wellbeing for Life service – Commissioned by Durham County Council and delivered by five partners:- County Durham and Darlington NHS Foundation Trust; County Durham Culture and Sport; the Pioneering Care Partnership; Leisureworks and Durham Community Action. The service aims to empower individuals to say what is important to them and to support them make choices that will benefit them. Specific services available on either a 1 to 1 or group activity basis includes Getting more active; healthy eating/weight loss; smoking cessation; improving one's mental wellbeing; practical cooking; cancer awareness; volunteering; access to training; alcohol and drug awareness and how to access services in the community.

Conclusions

59. The County Durham Public Mental Health Strategy's key objectives are geared towards promoting mental health and wellbeing; prevention of mental health; early identification of those at risk of mental health and recovery from mental health. The strategy also details key objectives related to suicide prevention.

60. However, the strategy details a summarised action plan against the key objectives of the Public Mental Health Strategy rather than a specific suicide prevention action plan as recommended by the PHE guidance and set out in the Government's national suicide prevention strategy. The working group consider it important that a specific suicide prevention strategy and associated action plan be developed and implemented.

61. Whilst recognising the value of the existing suicide early alert system in terms of promoting early support and interventions for those affected by suicide, members of the working group consider that partners should work closely to develop an early alert system that would flag up those individuals at risk of suicide and which could be used to target mental health preventative services to such individuals. Such an early alert system could utilise information gathered from health services and the criminal justice system such as admissions to Accident and Emergency Departments, inpatient mental health services, mental health crisis services, drug and alcohol treatment services and those individuals within the Criminal justice system or released from prison/custodial sentences on parole. This should be explored as part of the development of the suicide prevention strategy and action plan

Recommendation one

62. That the County Council develop and implement a suicide prevention strategy and action plan as part of the refresh of the Public Mental Health Strategy for County Durham and that progress against the action plan be monitored by the AWHOSC.

Recommendation two

63. The existing suicide early alert system, whilst providing excellent support and interventions for those affected by suicide after the event, needs to develop appropriate systems to flag up those at risk of suicide and which could be used to target preventative mental health services and support to such individuals.

NHS Policies, processes and services for suicide prevention and the promotion of mental health and wellbeing

Key Findings

- **Of the 190 suicides in County Durham (2012-14) 80 had been seen by GP services in the last three months of life; 54 had been seen by mental health services in the last three months of life and 39 had contact with A&E hospital services in the last year of life**.
- **Where individuals were seen by mental health services in the last six months of life a known diagnosis existed**.
- **TEWV NHS FT conduct an annual review of all serious incidents occurring within the Trust which when examined found no root cause with multiple factors identified including Post Traumatic Stress Disorder**; **access to mental health services; drug and alcohol abuse and chronic pre-existing health problems which impacted on mental health and wellbeing**.
- **The coding of patients presenting at A&E differs between those treat and discharged and those admitted – there is no diagnosis flag indicating intentional self-harm in the former but a sub code for this exists where patients are admitted.**
- **Coding of self-harm at A&E would potentially enable the identification of patients at risk of suicide and allow for proactive offers of access into mental health services to aid recovery and reduce the incidence of suicide.**
- **A positive element of A&E experience is the excellent relationship with rapid response access to the mental health liaison service between the hours of 08.00 a.m. and 10.00 p.m. There is an apparent gap in service provision between 10.00 p.m. and 08.00 a.m. once the mental health liaison team handover to the crisis team.**
- **A multi-agency "Crisis Care Concordat" is in place to improve the response to people in mental health crisis across services.**
- **The Concordat has introduce a number of initiatives aimed at enhancing access to mental health crisis services which include improving patient conveyance under the Mental Health Act 1983; crisis pathway mapping; the use of Section 136 "Places of Safety suites" and the implementation of a street triage model which allows for closer working between mental health professionals and the police.**

64. During the review, members have been eager to ascertain the level of engagement between health services and those individuals who had committed suicide in order to ascertain the effectiveness of diagnoses, access to preventative service and interventions and how those at risk of suicide could be identified and offered support.

65. Of the 190 suicides in County Durham between 2012 and 2014, a date of last contact with GP services was known in 125 cases. Of these cases 64% (80) were seen within three months of their death. The majority of these consultations may not have been directly related to suicidal ideation or mental health. In nine cases a suicide risk was noted in GP records, with a further 19 people having multiple risks noted. Previous attempted suicides were recorded in eight cases.

Tees, Esk and Wear Valleys NHS Foundation Trust

66. Of the 190 suicides in County Durham between 2012 and 2014, fifty percent of cases (95) had been referred to or were known to mental health services at some point in their lives. Of these individuals 63 had been seen in the 12 months prior to their death, with the majority (54 people, 57%) being seen in the three months prior to death. Of those referred to mental health services seven cases had never been seen.

67. Where cases had been seen by mental health services in the six months prior to death (57) a known diagnoses were:

Mental Health Diagnosis	Cases
Multiple diagnosis	7
Depressive illness	6
Bipolar affective disorder	Suppressed (less than or equal to 5)
Other (including personality disorder; Schizophrenia & other delusional disorders; Adjustment disorder/reaction; Anxiety/phobia/panic disorder/OCD; and drug misuse)	19

Mental Health Diagnosis 2012-14

68. Other and multiple diagnoses include:

- Depression, pathological jealousy, bi-polar and emotionally unstable personality disorder
- Alcohol and drug misuse
- Anxiety and Depression
- Bipolar Affective Disorder & Emotionally Unstable Dependant Personality Disorder
- HIV, Mental and Behavioural Disorder due to multiple drug use & use of other psychoactive substances
- Mixed anxiety, depressive disorder and schizophrenia

- Mixed anxiety and depression
- Alcohol dependence, suicidal idealisation, severe depressive disorder
- Psychotic depression, differential OCD
- Schizoaffective disorder, Personality Issues, Polydrug misuse
- Moderate depressive episode with somatic symptoms, low mood & anxiety
- Autism spectrum disorder (ASD) & Attention deficit hyperactivity disorder (ADHD)
- Mixed Anxiety and Depressive disorder
- Social anxiety & low mood

69. Tees Esk and Wear Valleys NHS FT undertake an annual review of all serious incidents which occur within the Trust to establish and identify areas of learning for the Trust and its staff. Procedures have been revised to ensure greater data reliability and the inclusion of a manual review of narrative issues in each incident. The Trust has identified that there can be flaws in the data due to delays arising from the coroner process and confirmation of verdicts into such incidents.

70. The data in respect of suicides and drug/substance related deaths requires further examination and any attempts to correlate the two should be treat with a degree of caution as it is often not known whether death was intentional.

71. The months of February, March, July and October have the highest numbers of serious incidents with the most common methods being hanging and overdose.

72. When the Trust looked for any key trends and issues arising from the investigation of serious incidents it found that:-

- No single identifiable root cause could be established;
- Improvements needed to be made in the documentation kept in respect of risk assessment and management of patients as well as the effectiveness and timeliness of record keeping;
- The involvement of family in the care of individuals could be considered;
- A number of incidents occurred when individuals were on leave from inpatient services and that the Trust were currently undertaking a thematic review of this issue;
- In a number of cases, patients have disclosed traumatic events that adversely impact upon their mental health and wellbeing and this has resulted in an identified need to reflect trauma questioning/counselling in staff training and development;
- A series of socio-economic factors including benefits, service reductions and access to social care and mental health services impacted on incidents;
- Mental health issues coupled with drug and alcohol misuse and the ineffectiveness of drug and alcohol treatment services could be linked to some incidents;

- Some individuals had pre-existing chronic physical health problems which often impacted on their mental health and wellbeing.

73. TEWV NHS Foundation Trust has reviewed these trends and embarked on a programme of actions at a Trust wide and locality level which aims to address some of the shortcomings identified during the examination of serious incidents. Actions across the Trust have been focussed on improving the existing Serious Incident review processes through enhanced governance arrangements; greater effectiveness in identifying improvement and learning from SI cases and also utilising learning from the National Confidential Enquiry into Suicide Harm and the Care Quality Commission's "Learning, candour and accountability" benchmarking.

74. Actions taken at a locality level have built on the Trust-wide learning through speciality level governance meetings within adult mental health services which includes quarterly adult mental health clinical incident reviews using "Plan, Do, Study, Apply" tools which promote change management based on learning from incidents. This process involves senior nurses, consultants and psychologists. The establishment of a Children's and Adolescent Mental Health Services (CAMHS) Crisis team has also enhanced the service provided to that age group.

75. The Working group examined the availability and accessibility of current mental health services involving TEWV. Concerns had been expressed by the working group regarding the accessibility of services, particularly whether there was open access to services or whether a referral process into the service was followed.

76. Across primary and secondary care the following services were available:-

- Community Intervention Teams – Open Access
- Crisis Teams – Open Access
- Mental Health liaison services – Accessed via Acute Trusts/A&E
- Veteran's services – Open Access
- Inpatient mental health services – Accessed through Crisis team referral
- Talking Changes (Accessing psychological therapies) – Open access

77. Members noted that these were supplemented by a range of "third sector/Community and Voluntary sector" services including links with crisis teams and MIND.

78. TEWV has identified a number of challenges facing the service, not least of which involve the current socio-economic climate and the stigma still attached to mental health conditions. The Trust is working to improve assurances that required changes identified within the Trust and its services are embedded at individual staff level. Pressures associated with capacity and demand across services must be managed alongside service user expectations as well as engaging those groups identified as hard to reach including LGBT and the Gypsy/Traveller Groups.

79. The Trust recognises the importance of continues and improved joint working across partners citing the work of the Crisis Care Concordat; the recovery college project, CVS support and ongoing work with the police which are all aimed at addressing current failings within the system including enhanced engagement across all partners; improved information sharing protocols and greater patient and family involvement in service developments.

County Durham and Darlington NHS Foundation Trust

80. Between 2012 and 2014, there were 39 cases of suicide which had contact with A&E/hospital services in the year prior to their death. While 10 were associated with overdose (of which we do not know the proportion which were intentional or indeed attempted suicide), the majority were from a range of conditions not necessarily associated with suicidal ideation or mental ill health.

81. Treatment for general medical conditions was the next most common cause of an A&E/hospital contact (six cases) followed by gastrointestinal (five cases). There were fewer than five cases per each of the remaining categories, including contact for reasons of mental illness or alcohol problems. 6 cases were known to have a psychological assessment prior to discharge.

82. The working group are aware of a range of services delivered either in partnership or directly by County Durham and Darlington NHS Foundation Trust (CDDFT) related to suicide prevention.

83. The wellbeing for life service adopts a model similar to the recovery model principles adopted by TEWV in respect of mental health and wellbeing improvement. Provided in partnership with the Pioneering Care Partnership, DCC Culture and Sport, Leisureworks and Durham Community Action, the wellbeing for life service follows the NICE stepped care model for the treatment of depression.

84. Since 1 April 2016 there have been over 2000 one-to-one contacts with the wellbeing for life service and CDDFT staff have received suicide ideation training and applied suicide intervention skills training.

85. CDDFT are also involved in the Talking Changes service commissioned by County Durham and Darlington CCGs and delivered jointly by TEWV, CDDFT and Mental Health Matters. This a self-help and talking therapies service designed to help anyone living in the County Durham and Darlington area to deal with common mental health problems such as stress, anxiety or depression, as well as panic, phobias, obsessive compulsive disorder (OCD) and post-traumatic stress disorder.

86. Offering a range of talking therapies, this free, confidential service is open to people aged 16 or over who live in County Durham or Darlington and whose mental health is causing them concern and is affecting an individual's

employment, health or home life. The service is not available if an individual is already accessing adult mental health services.

87. The service is part of the national improving access to psychological therapies (IAPT) programme and offers psychological interventions that include talking therapies and supported self-help programmes. Treatments currently include:-

- Step 2a Telephone Guided Self Help
- Step 2a Psycho-Education Groups
- Step 2b Face to Face Guided Self Help
- Step 3 Face to Face Cognitive Behavioural Therapy
- Step 3 Interpersonal Therapy
- Step 3 Eye Movement Desensitisation Therapy
- Step 2 / Step 3 Long Term Conditions Pathway
- Employment Support

88. Members were advised that around 10000 people per year access these services.

89. The Primary Care Psychology service delivered by CDDFT received 308 referrals during 2015/16 with 177 patients discharged in the first 2 quarters of 2016/17. The service treat patients including those with enduring trauma and personality disorder with the complexity and risk associated with their conditions assessed using a variety of mental health assessment tools. Patient's condition and outcomes are assessed pre and post treatment with success gauged by securing a reduction in the appropriate rating scores.

90. The working group were advised that the service was to be de-commissioned on 30 June 2017 and members were extremely concerned at the risk to patients' mental health and wellbeing and chances of securing improvements in their conditions with the cessation of this service as well as what replacement services were proposed.

91. There is a view that suicide is only associated with a person's mental health and that they relate to an associated mental health illness. The review heard evidence that within clinical (health) psychology, patients whose physical health condition deteriorates or who may have a physical disability can trigger thoughts about taking their own life. In such circumstances, the physical state of a patient is such that their quality of life may be poor and they feel unable to lead a "normal" life.

92. Several factors have been identified which may trigger such thoughts including:-

- not wanting to be a burden on their family and services as their disease/condition progresses;
- not wanting their family/spouse to witness them suffer;
- avoidance of experiencing deteriorating symptoms as their prognosis worsens;
- fear of increased pain;

- anxiety over financial implications especially if a person cannot work or has to move home due to their illness/disability;
- feeling in control about the end of their life when there has been little control or predictability in their health.

93. Many of these patients have never previously suffered with serious mental health problems and would simply view their suicidal thoughts as logical and as a way to lessen further suffering

94. CDDFT also provides a small clinical health psychology service aims to provide support to people who may experience such circumstances around a chronic physical illness.

95. Members heard evidence that with more publicity in recent years about assisted suicide, or people travelling to clinics such as Dignitas when they have a terminal condition, society in general may be more accepting of suicide when there is a physical illness perhaps because of this there is less stigma.

96. When a person has a physical condition/illness where the course is medically known to deteriorate (or an event where the person has been left with debilitating effects) these patients are perhaps more likely to have suicidal thoughts, so it is vital to ensure good support is in place. For example, in stroke, heart failure, Parkinson's disease, terminal cancer, COPD, uncontrolled diabetes, MS, HIV, motor neurone disease, and also in early stages of dementia.

97. Research suggests that patients are more likely to report suicidal thoughts soon after a diagnosis of a chronic or terminal condition. Often support is not available then, and the person's distress is not responded to appropriately. It is therefore vitally important for services like health psychology to be involved in the care of these patients, consulting with non-psychology healthcare staff to offer support and intervene in a timely manner.

98. In considering the role played by CDDFT in respect of suicide prevention and improving mental health and wellbeing, the working group have examined the procedures that exist within the Trust's Accident and Emergency Departments in Darlington Memorial Hospital and University Hospital North Durham and how these are used/able to identify suicide attempts and self-harm and highlight potential patient need for access to mental health services.

99. There is currently no relevant diagnosis flag within the A&E system that can give an indication of attempted suicide. What is coded is effectively the condition of the patient, for example overdoses would be covered by a poisoning diagnosis code but it would not be possible to tell from the data whether this was accidental or deliberate.

100. However, for inpatient clinical coding (where A&E patients are admitted) there is an intentional self-harm code that is used as a sub code alongside an eventual diagnoses.

101. Experience across the two A&E departments indicates that patients arrive via ambulance or the Police and that the department is seen as a place of safety even though this is not the best environment for a patient who is experiencing an acute crisis. With the ongoing pressures placed on the service, treatment is often seen as “patching up” rather than offering longer term mental health support that patients might need. Patients are also often keen to “just go” following their initial acute ED treatment although patients often end up staying overnight where a required mental health assessment is required.

102. The positive element of the A&E experience appears to be in respect of the excellent relationship with rapid response access to the mental health liaison service between the hours of 08.00 a.m. and 10.00 p.m. Unfortunately there is an apparent gap in service provision between 10.00 p.m. and 08.00 a.m. once the mental health liaison team handover to the crisis team.

103. CDDFT have effective liaison follow on arrangements with TEWV staff to deal with patients who need mental health support. For those patients at A&E who have experienced an identifiable self-harm event or where they feel that there is nowhere else to turn, a risk based assessment is made which can result in an offer of up to six follow up sessions as a brief intervention and solution focussed therapy.

104. For those patients who are admitted with for example delirium or dementia up to six weeks of community support post discharge can be made. There is also a potential onward referral to community psychiatric nurses/community mental health teams and mental health secondary care.

105. CDDFT acknowledges that there is an identified need to enhance the Trust’s role as an organisation in educating general medical staff in respect of mental health and wellbeing, suicide risk identification and prevention and associated mental health and wellbeing services.

106. Data collected from the Trust’s Safeguard incident management system in respect of serious untoward incidents for 2014/15; 2015/16 and 2016/17 (to December 2016) shows that there were 64 incidents over that period of which 2 were deemed to be suspected suicide. Both of these incidents were the subject of a root cause analysis and subsequent action planning.

107. The working group are concerned that there is no diagnosis flag within the A&E system that could give an indication of attempted suicide for patients who present at A&E but who are not admitted. This presents a risk to such patients in that they may not be offered access to mental health services at an early stage which could improve their chance of recovery and prevent potential for suicide.

108. The working group are pleased to note the success of the Trust's work with TEWV NHS FT liaison team in ensuring that those patients who have been admitted and have been identified with an intentional self-harm code are able to access mental health services. However it is noted that this appears to be more effective from 08.00 a.m. until 10.00 p.m. with a liaison gap having been identified when the team handover to the crisis team. The working group feel that it is essential that a consistent level of service should be provided 24/7 to mitigate against risks of potential self-harm and suicide during crisis episodes.

109. The working group also acknowledged the work being done within the Trust to train employees on mental health awareness and suicide prevention and suggested that this needed to be systematic throughout the Trust.

Mental Health Crisis Care Concordat

110. The Mental Health Crisis Care Concordat is a partnership consisting of Durham Constabulary, Durham County Council, Darlington Borough Council, Tees, Esk and Wear Valleys NHS Foundation Trust, North East Ambulance Service, North Durham CCG, DDES CCG, Darlington CCG and voluntary and community sectors. The concordat is a commitment made by all partners to joint working to improve the response to people in mental health crisis across services.

111. The working group received information regarding three initiatives aimed at improving patient experiences during crisis episodes :-

- Patient conveyancing – the conveying of a patient who has been detained under the Mental Health Act 1983 and needs to go to hospital;

- Crisis pathway mapping – the mapping out of services to support individuals escalating towards clinical crisis and averting the crisis or ensuring the person is helped into the right clinical care;

- Section 136 suites – usually called a place of safety, this is somewhere that a patient in crisis can be taken, usually by the police for assessment.

112. Improvements implemented for patient conveyancing involved the commissioning of a private ambulance provider to focus solely on attending mental health crisis incidents thus removing the risk which had been previously evident of NEAS ambulances being diverted to attend "blue light" calls which delays attendance at the mental health crisis incident. Whilst this has been commissioned by Durham and Darlington CCGs, it is possible that such a service could be commissioned regionally and thus benefit from economies of scale.

113. For crisis pathway mapping, work has been undertaken to map current mental health crisis services to establish what services need to be improved, what is working well and any gaps in services identified. Following this work, a

refreshed 2 year action plan for the Crisis Care Concordat has been developed focussing on prevention actions that avoid crisis episodes.

114. Nationally it has been accepted that the use of police cells as Section 136 suites (Places of Safety) is inappropriate and CCGs are required to reduce their use of police cells for this purpose and eliminate their use for those under 18 years of age.

115. The Crisis Care Concordat developed health based places of safety, one in Lanchester Road Hospital, Durham and one in West Park Hospital, Darlington which were staffed from the hospital wards. TEWV were given additional funding to enable them to staff the hospitals to a level where people could come off the wards into the s136 suite when required. The suites are used mainly by the police when they have picked someone up under s136 of the Mental Health Act and they need assessment in a place of safety.

116. Working jointly with the Police and TEWV, commissioners found that this model was ineffective in that it was not as easy as hoped to get a member of staff from a ward to the s136 suite quickly.

117. Consequently, the Concordat has developed a street triage model which involves TEWV staff (a mental health professional) working in the police force control room and out on the street in the car to provide support in cases where mental health issues may be a factor in a crisis incident.

118. The other major implication of the Policing and Crime Bill (which includes the prohibition of the use of Police Cells as Places of Safety for under 18s) is the reduction of time an individual can be held on a s.136 from 72 hours to 24 hours. This may have implications when someone under 18 has been assessed as needing admission but there is difficulty finding a bed. Also, there is a potential issue in obtaining an opinion from a second doctor should admission be required because there is a national shortage of doctors who are able to assess and admit. TEWV are working these issues through with commissioners.

119. Ongoing areas of development reported to the working group include the need to identify high intensity users of all emergency services. In mental health, these individuals invariably also use other emergency services (police, social services) frequently and the theory is that the response they are receiving is not helping them. If it were, they wouldn't ring back. People behave in this manner for a variety of reasons and the response they need will need to be individualised.

120. The Crisis Care Concordat aims to identify these individuals who are common to us all, then work out what they need to support them personally. We will then need to agree a way of identifying people who start to behave in this way and work out how we are going to support them as they become known to the services.

121. This will involve all statutory bodies working together and sharing information. This is complicated because of the laws surrounding information sharing and patient confidentiality.

122. The development of a single point of access to crisis services has been identified as a key gap in current crisis service provision. In a crisis scenario it has been suggested that currently patients are expected to work out if they are in a social crisis (and need social services support); an emotional crisis (and need support for that such as bereavement support or relationship counselling) or a clinical crisis (and are in need of support from the TEWV crisis team). This often leads to patients accessing services that are inappropriate to their crisis needs.

123. Crisis Care Concordat partners agree that one point of access is needed where patients can go and say they need help, then be given the time to talk through the help which they need so that they can be directed to the right place. This could be the patient themselves, or a third party. The service would receive self-referrals as well as referrals from other professionals (GPs could refer someone they are seeing for sleep problems but are concerned that there is a different underlying cause) as well as from the community and voluntary providers.

Conclusions

124. Whilst the working group have received numerous examples of effective partnership working across NHS Organisations including liaison between mental health and acute hospital services, there are improvements that have been identified which could lead to more effective suicide prevention, more timely service provision and interventions for those in crisis and/or at risk of suicide and a clearer crisis pathway and improved accessibility to mental health services.

125. The working group have heard that often those at risk of suicide are known to one or more of the emergency services be that the police or health. Difficulties have been reported in terms of organisations ability to share information across partners in respect of those at risk of self-harm or suicide or alternatively learning from those incidents of suicide. The working group consider that a multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies.

126. The working group are concerned that there is no diagnosis flag within the A&E system that could give an indication of attempted suicide for patients who present at A&E but who are not admitted. This presents a risk to such patients in that they may not be offered access to mental health services at an early stage which could improve their chance of recovery and prevent potential for suicide.

127. The working group are pleased to note the success of the Trust's work with TEWV NHS FT liaison team in ensuring that those patients who have been

admitted and have been identified with an intentional self-harm code are able to access mental health services. However it is noted that this appears to be more effective from 08.00 a.m. until 10.00 p.m. with a liaison gap having been identified when the team handover to the crisis team. It is essential that a consistent level of service should be provided 24/7 to mitigate against risks of potential self-harm and suicide during crisis episodes.

128. The mapping out of services to support individuals escalating towards clinical crisis and averting the crisis or ensuring the person is helped into the right clinical care has been identified as a much needed improvement in current processes. Often individuals are not aware of the services available to them to support their mental health and wellbeing and avoid crisis episodes. They also need guidance to explain how to access these services and whether they can self-refer into services or whether this needs to involve health professionals.

129. The Crisis Care Concordat is a commitment made by all partners to joint working to improve the response to people in mental health crisis across services. Whilst this is to be welcomed, the development of a single point of access to crisis services has been identified as a key gap in current crisis service provision.

Recommendation three

130. A multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies including adult and children's social care and health services, NHS services and those within the criminal justice system.

Recommendation four

131. The introduction of an appropriate coding/flagging system for self-harm/attempted suicide across all A&E department attendees should be promoted which identifies those potentially at risk of suicide and allows for proactive offers of access to mental health services and support.

Recommendation five

132. The current processes for referral into mental health services be reviewed to ensure that there is clarity available to potential service users to help them to identify the range of services available, whether the services allow for self-referral as well as referral by health professionals and the associated target timeframes for accessing services.

Recommendation six

133. The accessibility of the out-of-hours mental health crisis service be reviewed to ensure that individuals suffering from crisis episodes have timely access to support and interventions.

Safe Durham Partnership - Policies, processes and services for suicide prevention and the promotion of mental health and wellbeing

Key Findings

- **Of the 190 suicides in County Durham (2012-14), 9 occurred in prison with a further 5 within a year of release from prison; 27 were known to the probation service and 97 were known to police prior to death with 24 having their last contact with police in the last three months of life.**
- **The prison service has reviewed and improved its Assessment, Care in Custody and Teamwork (ACCT) process which identifies, supports and manages those at risk of suicide or self-harm.**
- **Issues of prison officer staffing, the availability of psychoactive substances and an increase in prison violence have been suggested as reasons behind an increase in self-harm in prisons nationally.**
- **Whilst nationally suicides in or following custody are higher now that before 2012, there have been no deaths in police custody during 2012-14 and 2 following police custody.**
- **Durham Constabulary have an established detention and custody process which safeguards against suicide risk.**
- **The new street triage process is welcomed by Durham Constabulary although some issues are experienced regarding data sharing protocols between partners.**

134. As part of the review, the working group examined the extent to which those individuals who had committed suicide were known to the various parts of the criminal justice system.

135. Between 2012 and 2014 there were 9 deaths from suicide in prison. A further five suicides took place within a year of release from prison.

136. Only a minority of 14% (27) of suicide cases had ever been known to the Probation Services. Eight people had their last contact with the probation service within three months prior to their death and a further four people had contact a year prior to their death.

137. A small majority of cases (51%, 97) were known to the police prior to death. A quarter (24) had their last police contact within three months of death. A

further 18% (17) had their last contact with the police within a year of their death.

Suicide and Self Harm in Prisons

138. The Safe Durham Partnership Board undertook a prison suicide audit in 2016 specifically examining deaths by suicide at Low Newton Remand Centre; HMP Frankland and HMP Durham across the period January 2009 to December 2015. During this period there were 20 deaths by suicide within County Durham prisons, the highest number occurring in HMP Durham.

139. The Audit aimed to identify key areas within prisons where pathways may be improved to reduce the suicide risk within prisons

140. By utilising four case study reviews, findings showed that in these cases suicide risk factors were noted but that the prison emergency procedure (Code Black) was not implemented immediately.

141. Across the prisons, the emergency procedure has been changed and all staff are now trained in this procedure as well as receiving suicide prevention training also. All prisoners now have a suicide assessment upon entry to prison.

142. Additional recommendations from the audit included the inclusion of probation data within future audits; a transfer from prison to community pathway to be established; consent from individuals must be requested and medical information and suicide risk shared with GPs and probation within 24 hours of discharge.

143. Members noted the many vulnerable groups in prison populations including those with drug/alcohol issues, financial crisis, mental health problems and abuse all of which contribute to the risk of suicide. The prison service's own Assessment, Care in Custody and Teamwork (ACCT) process is considered to be fit for purpose as an effective system to identify, manage and support those at risk of suicide or self-harm, when it is applied properly.

144. Members note that for the last five years 35-40% of self-inflicted deaths within prisons have been of people within the ACCT process which indicates that the quality of care and supervision that is provided for prisoners on ACCT needs to be improved. The prison service also acknowledged their need to improve the identification of prisoners at risk.

145. A review of the ACCT process resulted in several recommendations being made in areas such as communications, national policies, process improvements and increase training all of which have been referenced in the Director of Public Sector Prisons' Suicide and Self Harm project. The project's objectives are:-

- Implementation of the ACCT review recommendations;

- Delivering improvement in the prison service early weeks in custody work;
- Improving identification of individuals at risk of self-harm and / or suicide;
- Addressing repeat Prison and Probation Ombudsman recommendations;
- Enhancing staff and partner involvement in supporting those at risk, providing clear operational guidance and information and by improving training packages;
- Developing appropriate interventions for male and female offenders;
- Increasing the evidence base and understanding of what drives self-harm and self-inflicted deaths.

146. Extensive work has been done to establish whether reasons for the increase in self-inflicted deaths can be identified. The National Offender Management Service's (NOMS) continuing work with partners and academics through the National Suicide Prevention Strategy Advisory Group and the Ministerial Board on Deaths in Custody is important in ensuring that the prison service learns from experience in other sectors.

147. There are also difficulties in quantifying the effect of other changes and challenges facing prisons and prisoners. Operational experience suggests that there is less predictability and familiarity in the prisoner experience with the reductions in overall prison officer headcount combined with vacancies and the use of detached duty. Other known challenges include the increase in the use of new psychoactive substances, which may have health implications for users, and relate to problems of indebtedness and violence which may increase feelings of despair or vulnerability. Violence in prisons has increased and feeling less safe in prison could also heighten fear or despair. Extensive programmes of work are tackling both these issues.

148. Analysis suggests that the reasons for the increase in self-inflicted deaths are complex and involve an interplay between heightened levels of vulnerability amongst prisoners as a cohort, and factors which may affect the way in which NOMS is managing these risks amongst prisoners. For example, operational feedback frequently identifies the challenges of convening timely case management conferences with all relevant partners, the challenges of releasing staff for training, and the need to support prisoners through key periods of vulnerability such as the first month in custody.

149. Work is underway to ensure that there is a greater integration between the criminal justice system and health/social care services particularly around multi-agency casework and information sharing regarding mental health.

Durham Constabulary

150. Deaths in or following police custody include deaths that happen while a person is being arrested or taken into detention. It also includes deaths of people who have been arrested or have been detained by police under the

Mental Health Act 1983. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

151. This also includes deaths that happen:

- during or following police custody where injuries that contributed to the death happened during the period of detention;
- in or on the way to hospital (or other medical premises) following or during transfer from scene of arrest or police custody;
- as a result of injuries or other medical problems that are identified or that develop while a person is in custody;
- while a person is in police custody having been detained under Section 136 of the Mental Health Act 1983 or other related legislation

152. This does not include:

- suicides that occur after a person has been released from police custody;
- deaths that happen where the police are called to help medical staff to restrain individuals who are not under arrest.

153. Apparent suicides following Police Custody include apparent suicides that happen within two days of release from police custody. This category also includes apparent suicides that occur beyond two days of release from custody where the time spent in custody may be relevant to the death.

154. In examining the national picture in respect of deaths in or following police custody and apparent suicides following police custody, members found that the number of deaths in or following police custody had decreased to 14, similar to the levels observed in the three years before 2014/15.

155. The number of recorded apparent suicides following custody has decreased to 60 compared to 70 recorded in the previous year. This is the lowest figure recorded since 2012/13 when there was a notable increase in this category. However, it remains considerably higher than the average before 2012/13.

156. Reporting of these deaths relies on police forces making the link between an apparent suicide and a recent period in custody. The overall increase in these deaths over the 11 year period may therefore be influenced by improved identification and referral of such cases.

157. Of the 60 apparent suicides following police custody, 56 were male and four were female. More than half of the individuals (33) had known mental health concerns. Twenty-eight people were reported to be intoxicated with drugs and /or alcohol at the time of the arrest, or it featured heavily in their lifestyle. Eighteen apparent suicides occurred on the day of release from police custody, 24 occurred one day after release, and 16 occurred two days after release.

158. Twenty-two of those who died had been arrested for a sexual offence. Of these, 17 were in connection with sexual offences or indecent images involving children.

159. There were no deaths in custody within Durham Constabulary and 2 apparent suicides following police custody.

160. When examining the impact of mental health upon police activity within County Durham, out of an average of 15000 calls per month to Durham Constabulary's force control over 800 (5%) have a mental health need or component identified which equates to around 27 calls per day. Whilst this may not appear high, such calls take up an estimated 15 to 20% of an officer's time on duty, each requiring the attendance of 2 police personnel.

161. The use of police to convey individuals to places of safety designated under Section 136 of the Mental Health Act 1983 has been examined as part of the work of the Crisis Care Concordat referenced at Paragraph of this report. As stated earlier, the Policing and Crime Bill includes the prohibition of the use of Police Cells as Places of Safety for under 18s. There has been no such use of a police cell for under 18s since 2014 in County Durham.

162. In examining Durham Constabulary's detention and custody processes, members were advised that all persons arrested and detained in one of Durham Constabulary's 4 Custody Suites are risk assessed on arrival or as soon as practicable after arrival depending on that person's presenting behaviour. This covers questions around the following:-

- How are you feeling in yourself now?
- Do you have any illness or injury?
- Are you experiencing any mental ill health or depression?
- Would you like to speak to the doctor/nurse/paramedic (as appropriate)?
- Have you seen a doctor or been to a hospital for this illness or injury?
- Are you taking or supposed to be taking any tablets or medication? If yes, what are they and what are they for?
- Are you in contact with any medical or support service? If yes, what is the name of your contact or support worker there?
- Do you have a card that tells you who to contact in a crisis?
- Have you ever tried to harm yourself? If yes, how often, how long ago, how did you harm yourself, have you sought help?

163. Answering "Yes" to any of the questions will result in more detailed questioning around that area.

164. As part of the process the checks are made of the PNC, previous custody records, risk assessments and other parties such as the Arresting Officers, relatives, friends, legal representatives and medical professionals including Liaison and Diversion services.

165. All these as well as the answers from the detainee and their behavior/ demeanor affect the risk assessment. Key elements are those highlighted around alcohol/drug misuse and dependency as well as mental ill health including depression, and medical conditions and ailments.

166. If necessary formal assessments by trained health care practitioner's or force medical examiners take place, available 24/7. In addition there is access to criminal justice liaison nurses from Liaison and Diversion services who work within custody suites 7 days a week. Children and Adolescent Mental Health Services are also contactable 7 days a week as are the crisis team for advice/referrals. This helps to reduce the likelihood of suicide or self-harm both while detained and in preparation for release.

167. Pre-Release of a detainee is considered at an early stage in the process so that a suitable care plan, post release, is in place prior to release of the detainee. The custody officer is required to complete a pre-release risk assessment. They do not leave this until the point of release. Instead it is an ongoing process throughout detention and concluded at the point of release. This is in line with approved professional practice for detention and custody.

168. Custody officers refer to all existing risk assessment information for the detainee. They speak to all detainees prior to release to confirm suitable processes are in place prior to release to reduce the risk of suicide or self-harm. They then need to decide what action, if any, is appropriate to support vulnerable detainees upon release. This can be anything from making sure there are suitable transport arrangements and clothing available to release the detainee to ensuring there is the required support of parents, carers, or indeed referrals to Community Mental Health Teams, Alcohol or Drug dependency support schemes, local authorities regarding homelessness, GP services or hospitals for medical issues and referrals for service veterans.

169. Custody Officers are encouraged to reduce the risk of re-offending by actively considering alternatives to charge or formal Out of Court Disposals such as a caution where appropriate. An approach such as the Checkpoint program or restorative justice approaches, can also help address the issues that might be the root cause of that offending or behaviour such as alcohol, drugs, homelessness or dealing with mental health issues such as Post Traumatic Stress Disorder.

170. All Custody Sergeants receive training prior to being in post. This training received is approved by the College of Policing and forms part of the Detention and Custody Learning Program for Custody Sergeants. Custody Sergeants continue in post to receive 2 additional Continuous Professional Development days training each year as in addition to mandatory training refreshers around PST and First Aid. Training also covers mental health issues, risk assessment and Pre-Release.

171. Reference has been made within this report to the introduction of street triage service as a partnership between Durham Constabulary and Tees, Esk and Wear Valleys NHS Foundation Trust which aims to assist police officers in

accessing mental health professionals where s.136 detentions are being considered/carried out. This is particularly welcomed by Durham Constabulary in view of the demand being placed upon their service for such instances and the importance of appropriate access to mental health/crisis services.

172. The importance of joint working between Durham Constabulary and mental health practitioners cannot be overstated as problems have been experienced in the past regarding the protocol for data sharing between agencies and accessing patients records/information which may result in delays in accessing treatment.

173. Durham Constabulary are also key partners within the suicide and attempted suicide early alert process which commissions “If you care, share” to provide support to the families of suicide victims.

Conclusions

174. The prison service within County Durham has an effective process known as ACCT (Assessment, Care in Custody and Teamwork) which has been assessed as fit for purpose as an effective mechanism to identify, manage and support those at risk of suicide and self-harm with the prison environment. The process has been reviewed and a series of recommendations have been implemented which look to improvement communication and awareness amongst staff along with increased training in the process.

175. Work is underway to ensure that there is a greater integration between the criminal justice system and health/social care services particularly around multi-agency casework and information sharing regarding mental health amongst offenders.

176. A similar process has been examined as part of Durham Constabulary’s detention and custody process with risk assessments routinely undertaken across their 4 custody suites. As part of this process routine checks are made across a range of databases and records and the group heard evidence of joint working between the Police and Health services including the new street triage service which aims to ensure that Police Officers have access to mental health professionals when detentions under S136 of the Mental Health Act 1983 are being considered.

177. Notwithstanding the above, the problems experienced in the past in relation to data sharing between agencies and accessing patients’ records/information which may result in delays in accessing treatment needs to be addressed by ensuring that a process of case conferencing is in place.

Recommendation three

178. A multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies including adult and children’s social care and health services, NHS services and those within the criminal justice system.

Suicide prevention and the promotion of mental health and wellbeing – Community and voluntary sector involvement and support networks

Key Findings

- **The Community and Voluntary Sector play a significant role in suicide awareness, prevention and support for mental health and wellbeing.**
- **The Rapid Response Suicide Prevention project developed by MIND, CDDFT and Durham CCGs offers a rapid response suicide prevention counselling service which significantly reduces PHQ9 scores and improves mental health and wellbeing. None of the 1649 clients referred into the service between 2011 and 2016 took their own life.**
- **The If U Care Share Foundation offers a support after suicide service for those who have lost someone through suicide as well as a prevention referral service. Key areas of work include awareness raising of suicide within education services; shared lived experience of suicide to support those affected by suicide; advice and guidance to mental health support and crisis services.**
- **Single Homeless Action Initiative in Durham (SHAID) identifies the wider determinants of health and their impact on mental health and wellbeing. Key groups supported include the homeless, people fleeing domestic violence; ex forces personnel, prison leavers and people with mental health diagnoses.**
- **Durham Samaritans deliver listening services to those at risk of suicide, those affected by suicides and also work closely with media outlets to allow for sensitive reporting of suicides.**
- **The Samaritans have developed teaching materials, including Developing Emotional Awareness and Listening (DEAL) which was used by professionals. Work is undertaken with young people in schools, colleges and youth settings to offer advice on looking after emotional health and a national team of specially trained volunteers work with schools and colleges affected by suicide.**
- **The key issue identified across the Community and Voluntary Sector is the funding available to support projects and ensure their sustainability.**

179. In examining the extent and effectiveness of community involvement and support networks in identifying the risks and potential root causes associated with suicides, the working group received evidence from:-

- Darlington MIND

- If u Care Share Foundation
- Single Homeless Action Initiative in Durham (SHAID)
- Central Durham Samaritans

Darlington MIND – Rapid Response Suicide Prevention project (RRSSP)

180. The RRSSP was developed in response to a significant increase in the number of suicides within County Durham around 2010. The partnership project involved three local MIND associations (Darlington; Derwentside and Hartlepool and East Durham) together with County Durham and Darlington NHS Foundation Trust. The project was funded initially by NHS County Durham and Darlington (PCT) and more recently North Durham CCG and Durham Dales, Easington and Sedgefield CCG.

181. The project offers a rapid response suicide prevention counselling service for residents of County Durham or those registered with a County Durham GP. Referrals are received from the TEWV NHS FT Crisis or access teams only and aim to help those identified as at risk of or have attempted suicide but who do not need inpatient care.

182. Each referral is triaged within 24 hours with each client seen by a psychotherapist or counsellor within 5 working days of receipt of the referral, although in practice this is often quicker than that.

183. Clients are seen in either local MIND counselling rooms or in GP surgeries in their locality. The MIND facilities are in Stanley, Consett, Peterlee, Darlington, Newton Aycliffe or Durham City.

184. Clients are offered an initial assessment and up to six counselling sessions which can be weekly, monthly or more frequent depending on need with BACP registered psychotherapists or counsellors. A report is submitted back to the client's GP upon completion of the sessions and aim to provide an assessment of what longer term interventions may be necessary.

185. The project has a management board and robust governance arrangements.

186. Members learned that from July 2011 to December 2016, 1649 referrals had been made into the service with 818 referrals from North Durham CCG and 831 from the DDES CCG. Of the referrals, 56% were male and 44%were female which is quite different from the incidence of suicides across the gender groups.

187. The PHQ9 depression test scores for clients are taken at the start and end of the course of counselling with dramatic and positive results. Members noted that none of the clients referred to the service took their own lives during therapy with satisfaction levels above 95%. In terms of PHQ 9 scores, the most severe is 27 and after these sessions 90% of clients have scores under 10.

188. The project has been funded on an annual basis with the current contract running until March 2019. Whilst funding has not increased over the duration of the project, the number of referrals into the service is increasing with the largest number of referrals in a single month being 44.

189. Members note the concerns around the funding of the project and the success of the rapid response suicide prevention counselling service. Key risks identified by members include the importance of rapid referral into specialised mental health services following counselling where this is identified as necessary. Members have heard anecdotal evidence from service users about the pressure that existing mental health crisis teams are facing, the ability to access crisis services and the impact that this has on the timeliness of required interventions.

190. Reference has been made to the funding crisis in mental health services and the government promise for further investment in these services. However an integrated service is needed that addresses not just mental health but also contributing factors such as debt, housing need, social care, pain management, social isolation and employment.

If u Care, Share Foundation

191. The If U Care Share Foundation was established as a campaign in 2005 after the loss of a young man to suicide aged 19. It aims to provide prevention services, intervention and support after suicide. The service is linked to Durham Constabulary who offer referral into the service to those affected by suicide with services having grown due to an increase in demand for these services.

192. As at March 2017, 658 people had been referred into the Foundation's support after suicide service within County Durham after the loss of a loved one through suicide with 443 of these being female and 215 male. A further 172 prevention referrals have also been made.

193. The Foundation works at national and international level to raise awareness of suicide and suicide prevention. The Foundation provided evidence to the Government Health Select Committee on suicide prevention and this featured within the Committee's interim report into Suicide Prevention published in December 2016.

194. Key evidence provided to the parliamentary select Committee suggested that health professionals should consider how information about those who feel suicidal can be shared with families. Whilst acknowledging the importance of patient confidentiality, it has been suggested that encouraging the option to involve a trusted family members or friend could improve support and aid recovery.

195. The Foundation are members of the:-

- National Suicide Prevention Strategy Advisory Group

- All-party Parliamentary Group on Suicide and Self-harm prevention
- Support after Suicide Partnership
- International Association for Suicide prevention
- The Alliance of Suicide prevention charities.

196. The Foundation is a small organisation of 10 staff and volunteers who have been affected by suicide and have worked with over 14000 young people in respect of suicide prevention and mental health. Key issues identified by the Foundation during their work include:-

- The importance and need for education services to highlight/promote the availability of mental health crisis and support services to children and young people;
- The value of sharing lived experience stories with young people to encourage them to seek support and to increase awareness of the support that is available;
- The need to provide mental health support and access to interventions at an early stage;
- Concerns about the availability and sustainability of suicide prevention and support services in the ongoing climate of public sector funding cuts and government austerity measures;
- The availability of IAPT (Improved Access to Psychological Therapies) services and the long waits to access these services.

Single Homeless Action Initiative in Durham (SHAID)

197. During the course of the Review, members of the working group have commented on the wider determinants of health and wellbeing, noting the importance of employment, housing accommodation and social interaction as contributing to positive mental health and wellbeing. This report has previously identified that of the 190 deaths recorded in County Durham between 2012 and 2014, around 31% (59) were unemployed and in 34% (65) of cases the person lived alone at the time of death.

198. SHAID has worked with a number of priority groups identified as at risk of suicide including homeless people of all ages; women fleeing domestic violence; ex-Armed Forces homeless of all ages; LGBT clients; prison leavers; people with diagnosed mental health issues.

199. Key support services offered by SHAID, include: pre-tenancy advice; social isolation navigation; floating support; Plan 4 Life / DurhamWorks; St Peter's Court Armed Forces; Support Groups; Police, Crime and Victims' Commissioner (PCVC) recidivism housing programme.

200. The Working Group learned that 127 people had been helped with pre-tenancy advice and other interventions such as negotiations with landlords to stop tenancies ending. Other support included: access to furniture; securing energy suppliers; help in terms of accessing Housing Benefit and; challenging decisions from statutory services.

201. Councillors were reminded of the issue of social isolation, with SHAID having set up a social isolation navigator which looked to help any people who were lonely or isolated within the Derwentside area. It was explained that 187 people were supported face-to-face, above the target of 100, and it was added that the service was not a wellbeing service rather it looked to help individuals enrich their lives. Members noted many referral routes to the navigator with good buy-in from GPs, Pharmacists and the Police and Fire Service.

202. SHAID were a partner in the DurhamWorks programme and have set up their "Plan 4 Life" programme which provides personal development training to 16-24 year olds living in County Durham. It aims to help individuals broaden their aspirations and explore career prospects.

203. SHAID have also assisted 175 ex-Armed Forces individuals to access accommodation at the St. Peter's Court apartments, Sacriston. Tenants can stay for up to 2 years during which SHAID can offer tenants support and advice on issues such as funding avenues for training and employment as well as housing support to allow a tenant to more on to their own accommodation.

204. Councillors learned of the work with LGBT clients, and how their specific group had integrated with the youth group and they have an excellent rapport, there being no stigma amongst the group.

Central Durham Samaritans

205. Members of the working group noted the vision of the Samaritans was that fewer people died by suicide and to bring about this vision they worked to make an impact through:-

- Reducing the feelings of distress and despair that can lead to suicide
- Increasing access to support for people in distress and crisis
- Reducing the risk of suicide in specific settings and vulnerable groups
- Influencing Governments and other agencies to take action to reduce suicide

206. Notwithstanding the resilience of some people affected by thoughts of suicide, the Samaritans received a call every 6 seconds, and every 30 seconds from someone with suicidal feelings. It was added that talking to someone and being listened to can help to give a sense of perspective and find solutions to problems. Two-thirds of people did not like to burden others with their problems and the Samaritans were trained listeners available 24 hours a day, every day of the year and were confidential and listen without judging.

207. Anyone could contract the Samaritans, by telephone, e-mail, text, letter or face-to-face and that encouraging people to talk about what was bothering them contributed to good mental wellbeing. People could speak to the Samaritans anonymously and even if they had given details, the Samaritans

would not pass on their information to anyone else or intervene against their wishes.

208. The Samaritans ethos was that a reduction in suicide comes from the actions of many different organisations working together and that they would provide information on other services that offered further support and help. It was noted that certain groups had a heighten vulnerability to suicide and that certain settings contributed to an increased suicide risk and therefore these situations required a tailored range of interventions. The Samaritans offered training for those working in contact with vulnerable people and also to editors and journalists from national and local newspapers in terms of how to sensitively report suicides and sensitively depict the issue within television dramas.

209. The Samaritans also work in partnership with Network Rail and the wider rail industry to help reduce suicide on the railways, post-vention advisors were also made available post-incident at stations to support passengers and staff.

210. The work of the Samaritans in prisons, supporting and providing training for the last 25 years, including for “Listeners”, inmates that provided emotional support for fellow inmates was highlighted. The Samaritans had many respected teaching materials, including Developing Emotional Awareness and Listening (DEAL) which was used by professionals. The organisation also delivered talks to young people in schools, colleges and youth settings to offer advice on looking after emotional health and had a national team of specially trained volunteers that could go into schools and colleges affected by suicide.

211. Samaritans worked to support those bereaved by suicide through “Facing the Future”, in partnership with Cruse Bereavement Care. The Samaritans also work with the Police in terms of a missing people partnership, to reach out to those who are missing at risk of suicide. Samaritans also work to support those from the Armed Forces with issues such as Post-Traumatic Stress Disorder (PTSD) and that the Samaritans had worked with politicians to drive policy change, including the “Five Year Forward View for Mental Health” by the Mental Health Task Force, a key report outlining recommendations for the NHS and Government to improve mental health in England.

Conclusions

212. The Community and Voluntary sector have a huge role to play in improving health and wellbeing of the population of County Durham and the review has heard evidence from a range of CVS organisations. This highlighted positive practice across the County aimed at suicide prevention and tackling some of the wider determinants of health which can adversely impact upon a person’s mental health and wellbeing including relationship breakdown, loss of employment, access to housing, financial hardship and education and training.

213. Their ability to continue to deliver projects, services and interventions during what has been a prolonged period of austerity and funding pressures has been identified by the CVS organisations engaged in the review as a concern.

214. It is therefore important that an assessment of the effectiveness of CVS services and projects which addresses suicide prevention and improved mental health and wellbeing is undertaken to enable resources to be targeted to those which demonstrate that the necessary outcomes have been delivered

Recommendation seven

215. An audit of current health and wellbeing support and services within the Community and Voluntary sector be undertaken to evaluate their effectiveness and enable resources to be targeted at those interventions where demonstrable outcomes for improved mental health and wellbeing and reduced suicide risk are evident.

No Health without Mental Health Objective	**Local Priorities**	***APPENDIX 1*** **Lead Group**
1. More people will have good mental health *More people of all ages and back grounds will have better wellbeing and good mental health. Fewer people of will develop mental health problems – by starting well, developing well, working well, living well and ageing well.*	1.1 Undertake and assessment of the mental health needs of the population of County Durham	Public Mental Health Strategy Implementation Group
	1.2 Develop and implement programmes to increase resilience and wellbeing through practical support on healthy lifestyles	Public Mental Health Strategy Implementation Group
	1.3 Develop an Integrated Primary Care Model for Access to talking therapies	Mental Health Care Delivery Working Group
	1.4 The development and implementation of the Children and Young People's Mental Health and Emotional Wellbeing Plan	Children and Young People's Mental Health and Emotional Wellbeing Group
	1.5 Implement the multi-agency Public Mental Health and Suicide Prevention Strategy for County Durham	Children and Young People's Mental Health and Emotional Wellbeing Group
2. More people with mental health problems will recover *More people who develop mental health problems will have a good quality of life – greater ability to manage*	2.1 Work together to find ways that will support the armed services community who have poor mental or physical health	Mental Health Care Delivery Group
	2.2 Ensure that people using mental health services who are in employment have a care plan that reflects the additional support needed to help them retain this employment	Mental Health Care Delivery Group

their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.	2.3 Implement the Recovery College to offer training opportunities for people with mental health difficulties to gain a better understanding of their difficulties and how to manage them as well as providing opportunities to learn from others with similar experiences	New Recovery Working Group
	2.4 Ensure that all services adopt a Recovery orientated approach and use validated recovery measure to evaluate outcomes. By using relevant recovery related Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) enables service providers and service users to evaluate progress	New Recovery Working Group
	2.5 Explore opportunities to embed co-production and peer support models within contracts	All Groups to contribute
	2.6 Ongoing monitoring and awareness of the financial challenges and how the welfare reforms impact on the ability to access services	Public Mental Health Strategy Implementation Group
	2.7 Ensure service users and their carers have access to NICE recommended guidance and evidence based interventions	All Groups to contribute
3. More people with mental health	3.1 Develop a more integrated response for people with both mental and physical health conditions	Mental Health Care Delivery Group

problems will have good physical health *Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health*	3.2 Provide a wide range of physical activity opportunities across County Durham to support more active lifestyles	Public Mental Health Strategy Implementation Group
	3.3 Ensure that people with mental health conditions have their physical health needs actively addressed	Mental Health Care Delivery Group
4. More people will have a positive experience of care and support *Care and support, wherever it takes place, should offer access to timely, evidence based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.*	4.1 Continue to improve access to psychological therapies and other interventions	Mental Health Care Delivery Group
	4.2 Improve the experience of hospital discharge processes	Mental Health Care Delivery Group
	4.3 Through co-production involve individuals and carers more closely in decisions about the shape of future service provision	All Groups to update
	4.4 Work together to give people greater choice and control over the services they purchase and the care that they receive	All Groups to update
	4.5 Improve awareness of the range of service provision available to General Practices and improve the accessibility and uptake to these services	Mental Health Care Delivery Group
	4.6 Development and Implementation of the County Durham Dual Needs Strategy	Dual Needs Strategy Implementation Group

5. Fewer people will suffer avoidable harm *People receiving care and support should have the confidence that the services they use are of the highest quality and at least as safe as any other public service*	5.1 To co-ordinate a local response to the Crisis Care Concordat	Mental Health Crisis Care Concordat Task Group
	5.2 To develop a more extensive, accessible crisis team	Mental Health Care Delivery Group
	5.3 To ensure close working with all Co. Durham partnership groups that have an impact on mental health issues	Public Mental Health Strategy Implementation Group
6. Fewer people will experience stigma and discrimination *Public understanding of mental health will improve and , as a result, negative attitudes and behaviours to people with mental health problems will decrease*	6.1 Work with the voluntary and community sector to develop opportunities for early identification of those people at risk of social isolation	Public Mental Health Strategy Implementation Group
	6.2 Undertake local campaigns to raise awareness as well as taking an active part in any regional or national campaigns	Public Mental Health Strategy Implementation Group