HEALTH AND WELLBEING BOARD

4 DECEMBER 2025

Mental Health and Wellbeing - Health and Wellbeing Strategy Update

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SUMMARY REPORT

Purpose of the Report

1. To update members of the Board on work undertaken so far across the Borough in relation to the Mental Health priorities identified in the Joint Local Health and Wellbeing Strategy (2025 – 2029);

2. To facilitate meaningful discussion at the Health and Wellbeing Board in relation to these priorities.

3. To enable members to understand how they, and their organisations, can support action locally and promote continuing improvement of system-level working.

Summary

4. The report is intended to support a review into the thematic priority of mental health, including the opportunity to reflect on:

   (a) Agreed priorities
   (b) Related performance indicators
   (c) Health inequalities
   (d) Stakeholder engagement
   (e) Issues of concern or risk
   (f) Key actions taken and / or planned
   (g) Ask(s) of Health and Wellbeing Board partners.

5. The report describes current performance indicators, inequalities and activity in relation to each priority outcome relating to mental health and wellbeing from the Joint Local Health and Wellbeing Strategy. Issues and recommendations have been combined and presented together, rather than separately for each outcome, reflecting that mental health and wellbeing cannot be addressed in isolation, but must be part of a system-wide approach.

Agreed priorities

6. The agreed priority outcomes considered in this report are:
   a) Reduction in the rate of hospital admissions as a result of self-harm in young people (aged 10-24)

b) Halt the increase in hospital admissions as a result of self-harm in girls and young women
c) Reduction in the rate of hospital admissions for mental health conditions in young people under the age of 18 years
d) Young people who need support for health and wellbeing know what services are available for support and how to access them
e) Through the continued provision of mental health support teams in education settings, a greater number of children and young people will be able to access NHS-funded mental health services
f) Reduce rates of suicide in men and women
g) Support the work of the Darlington Mental Health Network to enable greater collaboration and partnership working, using the learning which emerges to strengthen preventative approaches and inform the future commissioning and delivery of mental health services

Summary of Key issues

7. In preparing the report, a number of key issues, themes and inequalities were highlighted:

(a) Self-reported wellbeing markers (anxiety, feeling that life is worthwhile, happiness and life satisfaction) are not statistically different in Darlington in comparison to the England average (Local indicators for Darlington ONS).

(b) Darlington has worse than England rates for emergency admissions for self-harm in young people, particularly in girls and young women, although the gap is beginning to close.

(c) A recent audit of a sample of young people admitted for self-harm suggested that many of the young people had previously accessed or were currently accessing support services, or had previous episodes of self-harm (not all requiring admission), which offers potential opportunities for early intervention.

(d) Darlington has higher than the England and North East average rates of mental health admissions for young people, particularly for girls and young women.

(e) Darlington has higher than the England average rates for suicide, particularly for men in the 45-64 age group.

(f) There is a wide range of provision for mental health services in Darlington, especially for children and young people, which are provided both by statutory organisations and VCSE/ community providers.

(g) It is recognised that all partners are driven to offer high-quality, effective services that support children, young people and adults to maintain good mental health and wellbeing, and to improve outcomes for all service users.

(h) It is a positive position to have a range of services meeting a variety of needs. However, many providers are not aware of the full suite of mental health service support available in Darlington, or the roles, responsibilities and limitations of

different providers. This reflects what has been highlighted through opportunities such as the Healthy Lifestyle Survey and anecdotally, that young people and their families do not always find it clear to understand where they can go for support.

(i) Data has been identified as a key issue, both in terms of recording and sharing, reflecting the challenges of system working. It has been difficult to bring data together cohesively to fully understand the scale of the issues, and by implication use it in a way that effectively informs service delivery and development.

(j) As well as numerical data, patient outcomes and experiences can add crucial depth in understanding the impact of the service, including learning from those with lived experience about what works, and how services can drive forward to improve outcomes for service-users/ patients.

(k) Proactive opportunities for services to work in partnership and improve communication, such as the mental health network and suicide prevention partnership, have been well-received across the system and have created positive collaborative approaches, maximising impact by sharing skills, expertise and resources.

Recommendations – Broad Principles

8. In order to address the above issues, the report recommends that all members of the board adopt a series of principles in relation to ways of working:

(a) Recognise that mental health and wellbeing are the result of interactions between a wide range of determinants from individual to community and societal influences, and therefore mental wellness is not the responsibility of any single organisation but must be a shared, system-wide priority;

(b) Encourage all organisations to consider actions they could take to develop a more collaborative and cohesive, system-wide approach. This includes data-sharing arrangements, strategic and operational working arrangements, communication between providers, and continuing the development of open dialogue about how systems can better work together to best meet the needs of individuals and the wider population;

(c) Continue to review organisational practice within our own organisations, including reflecting on community, service-user and patient experience, and in dialogue with other partners, to build a culture of ongoing service improvement across the system;

(d) Continue to recognise, promote and invest in prevention and early intervention, so that Darlington people of all ages can access the right support to stay well at the earliest opportunity, thereby improving outcomes whilst also ensuring that intensive specialist resources and clinical interventions are available for those with the greatest and more complex needs;

(e) Consider the impact on mental health and the importance of opportunities for prevention when making decisions about resource allocation across the wider system, not only limited to decisions about mental health provision;

(f) Champion the role of VCSE and community assets when considering the importance of communities in supporting people to recover from mental health issues and to stay well.

Recommendations – Key Actions

9. As well as the above principles, it is recommended that members of the board discuss and agree the following actions:

a) Consider organisational approaches to strengthening patient/ service-user journey in service development, service evaluation and outcome measurement, to provide shared system-wide learning, particularly in relation to identifying those most vulnerable to self-harm and mental health admission and readmission, and the pathways that they follow.
It would be useful for organisations to consider undertaking a deep dive into a sample of patient/ service-user journeys, outcomes and experiences, particularly reflecting on the interface with other services. It may be helpful to review a sample of case studies for young people admitted for self-harm or mental health admissions and share both data and patient stories to support learning about what works well across the system, and what can be improved upon.

b) Actively participate in the Tees Valley I-Thrive steering group, to shape local service provision to meet the needs of Darlington's children and young people. The work of the steering group should also identify opportunities to work together to address some of the issues around data, and how services communicate with each other and with patients/ service-users and families.

c) Engage with the "mapping" of local services which support children and young people's mental health against the I-Thrive model to improve understanding about what provision is available and how people can access it.

d) Encourage the uptake of local training in suicide awareness and prevention, both for professionals and for wider community members and organisations.

e) Continue to challenge stigma and discrimination in relation to mental health and accessing mental health support, by promoting inclusive language, challenging negative stereotypes and assumptions, encouraging open conversations about mental health and by promoting and supporting national and local campaigns related to these priority areas.

Reasons

10. The recommendations are supported by the following reasons: -

(a) They will support in achieving the mental health ambitions of the Health and Wellbeing Strategy.

(b) They will help to address health inequalities, by identifying opportunities for collaboration and strengthening our partnership approach.

Lorraine Hughes, Director of Public Health

Background Papers

Joint Local Health and Wellbeing Strategy (2025 – 2029)
https://www.darlington.gov.uk/media/22428/darlington-health-and-wellbeing-strategy.pdf

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Council Plan	The recommendations and work areas being taken forward address priorities within the council plan.
Addressing inequalities	The report identifies health inequalities across the borough, and this has informed the development of work programmes.
Tackling Climate Change	There are no direct implications arising from this report.
Efficient and effective use of resources	The recommendations support the targeting of resources to areas of need and a focus on evidence-based practice, which will help to achieve best value.
Health and Wellbeing	The proposals will support health and wellbeing outcomes, with a particular focus on mental health and wellbeing across the life course.
S17 Crime and Disorder	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	There are no budget implications
Key Decision	N/A
Urgent Decision	N/A
Impact on Looked After Children and Care Leavers	This report identifies that LAC are a vulnerable group in relation to self-harm admissions.

MAIN REPORT

Content Warning

11. **This report contains information relating to sensitive issues including self-harm and suicide.** Please consider whether today is the right day for you to read the information and prioritise your own safety and mental health. If you need support, please contact Samaritans for free on 116 123 or other sources of support, such as those listed on the NHS help for suicidal thoughts webpage.

Background/ Context

12. Everybody experiences mental health. The World Health Organisation defines mental health as a "state of mental well-being that enables people to cope with the stresses of

life, realise their abilities, learn and work well, and contribute to their community" (WHO: Mental health).

13. Mental health, like physical health, can fluctuate and can be impacted both positively and negatively by many factors, ranging from individual factors and behaviours, to community, social and economic determinants. These factors do not exist in isolation but in a complex, unique and interacting way for individuals.

14. Difficulties in mental health are a common human experience (www.mind.org). As well as the devastating personal impact that mental ill-health can have on individuals and their families, there are also costs to their community and wider economy.

15. A 2024 report by The Centre for Mental Health, commissioned by the NHS Confederation's Mental Health Network, estimated that the total cost of mental ill-health in England was £300 billion in 2022 (The economic and social costs of mental ill health - Centre for Mental Health).

16. These costs are **economic** (sickness absence, "presenteeism", staff turnover and unemployment), **human** (a value assigned to reduced quality of life, and premature mortality in people with mental health difficulties), and **health and care costs** (both provided by public services and informally by friends and family).

17. The Centre for Mental Health promotes **prevention**, **support** and **equality**, by addressing the wider determinants of mental health, as well as ensuring a range of accessible, effective support and treatment for those who need it.

18. **Stigma** continues to play a role in mental health issues, with as many as nine out of ten people with mental health problems reporting that stigma and discrimination have a negative effect on their lives (Stigma and discrimination | Mental Health Foundation).

19. As well as ensuring an effective range of clinical and therapeutic mental health support services when people experience mental ill-health, taking an approach of prevention and early intervention will improve quality of life for individuals and to reduce the demands on local services.

20. Prevention may take the form of staying well, supporting those with greater risk of poor mental health to manage the factors that impact them, and empowering people living with mental ill-health to manage their wellbeing and reduce their chance of relapse.

21. Due to the complex nature of mental health, it is important to recognise the range of roles and responsibilities of different organisations, and therefore a person-centred approach relies on collaboration between organisations and community resources who provide a wide-range of support, which meet different needs at different times, from local engagement and support to intensive clinical treatment.

Information and Analysis

22. The focus of the thematic deep dive is the priority of mental health in Darlington, one of the agreed priority areas within the Joint Local Health and Wellbeing Strategy. The priority

has seven agreed outcomes, across both Early Years and Living Well, and these are considered in detail throughout the report.

23. Updates relating to drug and alcohol treatment services are beyond the scope of this Mental Health and Wellbeing update, and will be presented at a future Health and Wellbeing Board.

24. The report takes a specific deeper dive into current work in relation to serious self-harm and suicide prevention, and higher-level updates are provided for the other priorities.

25. Information and data have been drawn from a range of sources and partner organisations to describe the current mental health and wellbeing landscape in Darlington, to highlight key areas of work being undertaken, and to make recommendations for future actions.

26. These measures are valuable indications of mental health and wellbeing in the borough, and reflect positive steps made in to improve the mental health and wellbeing of people in Darlington, as well as areas for continued development.

27. It must be acknowledged that mental ill-health is not something that can be measured and treated in isolation, and the complexity of interaction of individual factors and wider influences cannot be underestimated. Therefore, while this report reflects specific actions, achievements and ambitions, wider changes in the mental health and wellbeing of the people of the borough will be the result of the interaction of individual factors, community resilience, socio-economic and cultural influences, and commissioned, specialist services.

Outcome One: Reduction in the rate of hospital admissions as a result of self-harm in young people (aged 10-24)

Outcome Two: Halt the increase in hospital admissions as a result of self-harm in girls and young women

28. Outcomes one and two are updated together as the updates below cover both aspects of these priority areas.

29. Darlington's rates of emergency admissions for self-harm in children and young people, particularly for girls and young women, are higher than the England average.

30. In 2023/24, the rate of emergency hospital admissions for intentional self-harm in Darlington, was 121 per 100,000 population. This is a decrease of 57.38% since 2020/21. Darlington is now statistically similar to England (117 per 100,000), and statistically better than the North East (191.3 per 100,000).

Fig 1: Emergency Hospital Admissions for Self-Harm (all ages)

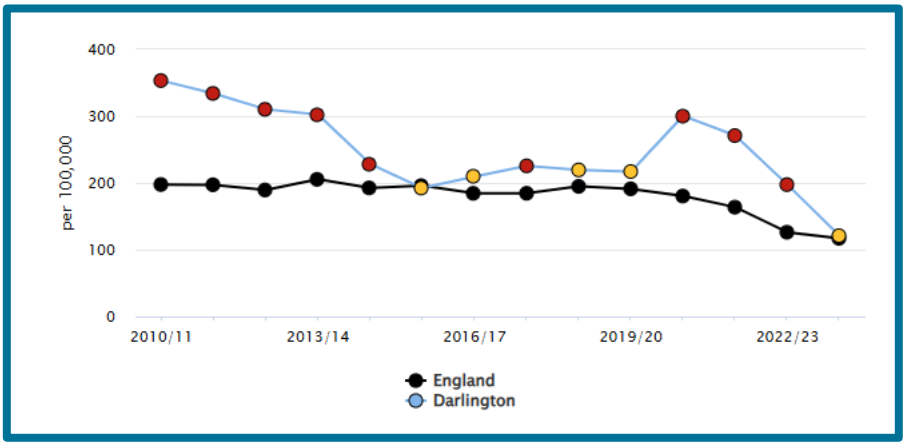


Fig 1: Graph showing rates for Emergency Hospital Admissions for Intentional Self-Harm in Darlington and in England per 100,000 (all ages). Source: www.fingertips.phe.org.uk

Inequalities by age

31. Rates of self-harm emergency admissions in young people in Darlington have been significantly higher than the England average since 2020/21.

Fig 2: Emergency Admissions for Self-Harm in young people

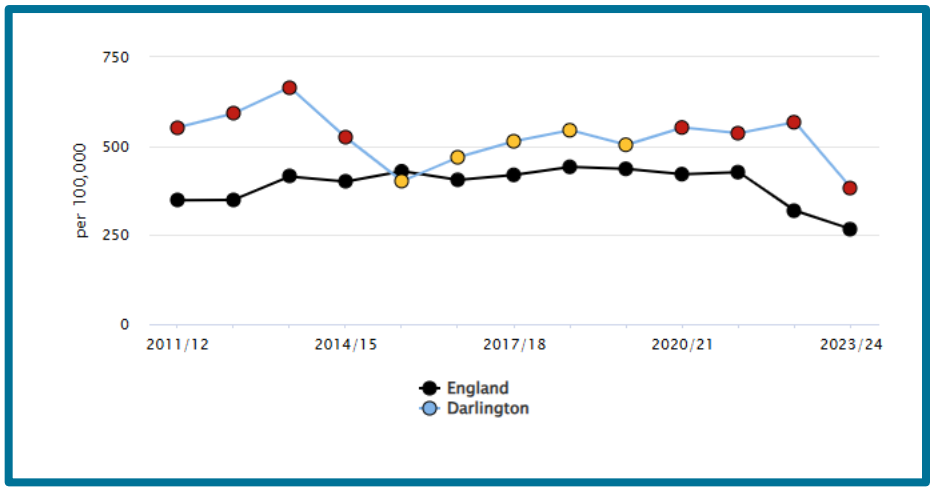


Fig 2: Graph showing total Emergency Hospital Admissions for Intentional Self-Harm in children and young people (10-24) Darlington and in England. Source: www.fingertips.phe.org.uk

32. In the period 2023/24, the rate in children and young people under 24 in Darlington (382.1 per 100,000 population) declined faster than the England rate. While the gap is closing, the rate in Darlington has remained statistically higher that the rate across England (266.6 per 100,000), and is similar to the average rate across the North East (397.0 per 100,000).

Inequalities by sex

33. Fig 3 below shows that admissions for females across all ages remain consistently higher than admissions for males.

Fig 3: Emergency Hospital admissions for self-harm by sex

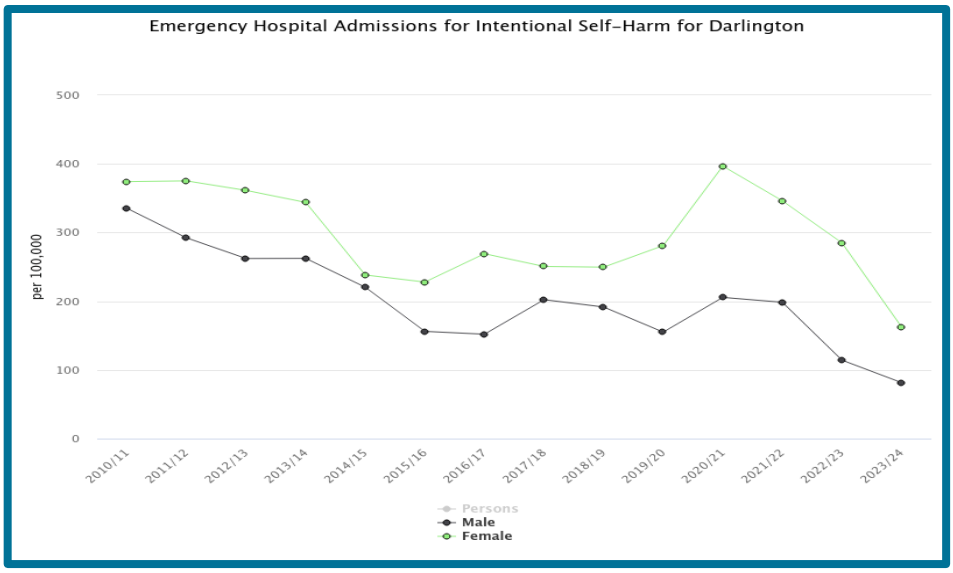


Fig 3: Graph showing total Emergency Hospital Admissions for Intentional Self-Harm for Darlington by sex (all ages). Source: www.fingertips.phe.org.uk

34. The count of emergency hospital admissions for intentional self-harm among females, has more than halved in four years. In 2020/21, there were 205 admissions, whereas in 2023/24, there were 90 admissions. This is a decrease of 56%. This is similar for males, in 2020/21, there were 100 admissions, whereas in 2023/24 there were 40. This is a decrease of 60%.

35. The gap between the rates for each sex is narrowing, with a rate for males at 81.5 per 100,000 population and the rate for females decreasing to 162.6 per 100,000 population.

Inequalities by age and sex

36. Fig 4 (below) demonstrates the impact of the interaction of inequalities by age and sex, with young women and girls (10-24) having significantly higher rates of self-harm emergency admissions than young men and boys.

Fig 4: Emergency admissions for self-harm for children and young people

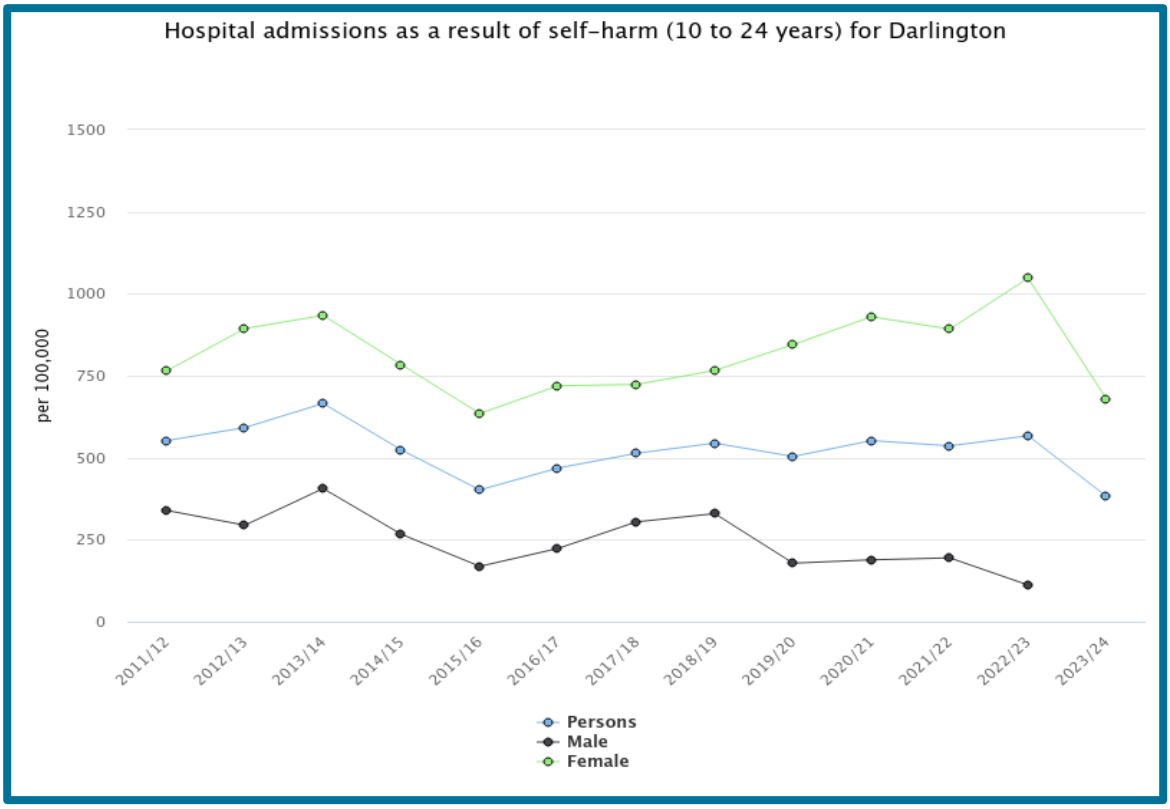


Fig 4: Graph showing total Emergency Hospital Admissions for Intentional Self-Harm in children and young people (10-24), split by sex in Darlington. Source: www.fingertips.phe.org.uk

37. Rates in males have steadily reduced since 2018/19. The upward trend in young women and girls has been halted, and in 2023/24 showed a marked reduction from 1,047.5 per 100,000 population in 2022/23 to 679.4 per 100,000 population in 2023/24.

CDDFT Self-Harm Audit 2023-24

38. An audit was undertaken by **County Durham and Darlington NHS Foundation Trust (CDDFT)** looking at hospital admissions for self-harm in children and young people. The audit reviewed hospital admission data for 2023/24, for children and young people aged under 18 years who were admitted to hospital (Darlington Memorial Hospital or University Hospital of North Durham) for self-harm.

39. The audit focused on the NICE standard NG225: Self-harm: assessment, management and preventing recurrence. It should be noted that this audit focused on children and young people who were admitted to hospital and therefore did not include those who attended Accident and Emergency and were then discharged home.

40. Key messages and trends from the 2023/24 self-harm admission data for children aged under 18 years who were admitted to CDDFT included the following:

    (a) In 20023/24 there were 181 admissions to University Hospital of North Durham and Darlington Memorial Hospital (a small number of these were for children living outside of the County Durham and Darlington areas).

    (b) 83% of those admitted were female and 17% were male.

    (c) The median age for admissions was 15 years, with a range from 11 -17 years old

(d) Patients tend to have relatively short hospital stays, with the median length of time being 19 hours, within a range of 11.5 – 35 hours.

(e) Some children had more than one admission to CDDFT for self-harm in 2023/24 (approx. 17% of admissions were repeat admissions).

(f) Just over 40% of children admitted lived in the most deprived quintile (CORE 20) as measured by the Index of Multiple Deprivation.

41. Data for self-harm admissions to CDDFT between 2018 and 2025 were also mapped as rates per 1,000 children aged 11-17. This showed that rates of injury admission varied by geographical areas (using Middle Super Output Areas).

42. The audit included a deep dive into the patient records for a sample of 60 admissions (30 at Darlington Memorial Hospital and 30 at University Hospital of North Durham). The deep-dive audit identified the following:

(a) The majority of admissions for self-harm were a result of an overdose.

(b) 64% had previous episode of self-harm recorded

(c) 80% had previous contact with CAMHS prior to their self-harm admission.

(d) 43% had previous contact with Children's Social Care recorded.

(e) 100% were referred to CAMHS as a result of the self-harm episode.

(f) 63% had a full HEEADSSS assessment undertaken and recorded (This includes detail around: Home, Education, Eating, Activities, Drugs, Sexuality, Suicide, Safety).

(g) Reported reasons for the self-harm episode included issues at school, relationship difficulties, issues at home, Adverse Childhood Experiences (ACE) and bullying. It should be noted that the reasons were very individual and usually a complex interaction of a number of factors.

(h) 11% of the children in the deep-dive audit were living in children's residential homes

(i) 22% of the children in the deep-dive audit self-reported drug use

(j) 24% of the children in the deep-dive audit had SEND/ Neurodivergence recorded

43. The audit has supported work within CDDFT to continue to improve pathways and care for young people admitted for self-harm. For example, work to improve the recording of HEEADSSS assessments and improve education around the risk factors identified.

44. The key findings from the audit have also been shared with partner organisations through a number of partnership groups across County Durham and Darlington to help inform their work on preventing self-harm. These include the Darlington Borough Council Public Health Team, Darlington Safeguarding Partnership, CAMHS Clinical Network Away Day, Durham

County Council Public Health Team and County Durham Children and Young Peoples Mental Health Partnership. These partnerships are using the audit data to help inform their work on preventing self-harm in children and young people.

45. The **ICB** are reviewing follow-up within 48 hours for those discharged from mental health in-patient admissions, in line with NICE guidance. As part of the review, the ICB has expressed a commissioning intention for 2026/27 for providers to deliver 48-hour follow-up for all ages following admission for self-harm, to ensure that appropriate further support is identified and offered, including crisis or community support.

Mental Health Services for Children and Young People

46. **TEWV Children and Adolescent Mental Health Services** offer a range of support in relation to admissions for self-harm for children and young people. All young people have immediate access to Crisis Teams via 111 select mental health. The crisis teams will triage calls and assess those young people who are in need of an assessment urgently within 4 hours. There is also an additional target of a 24-hour assessment for those requiring treatment first. The crisis teams will liaise with families and any other service such as Local Authorities, Community CAMHS teams, schools or other health teams as needed.

47. In Darlington, waits for triage, needs assessment and commencement of support through SPA (single point of access), Getting Help and Getting More Help teams compare favourably with national benchmarks:

    - Average length of time children and young people have waited for an assessment in Q4 24/25 is 46 days (this average skewed by those also waiting for a neurodevelopmental assessment)
    - Majority of referrals receive an assessment with 28 days
    - Waits for treatment vary depending on support required
    - Typically, appointments to commence support start within 6-12 weeks of referral
    - Longest waiters are for young people waiting to start on medication for ADHD – up to 6 months
    - Factors impacting this include workforce/clinical capacity for demand and national medication supply issues
    - Specialist eating disorders performance against national access standards, in a 4-week period in Q4 24/25
        - 100% of routine referrals seen within 4 weeks
        - 100% of urgent referrals seen within 1 week

48. The crisis teams also provide liaison services to the paediatric wards and support young people who contact them before they self-harm which aid early and preventative intervention. If a face-to-face appointment is needed, this is arranged for a convenient time and place for that young person. They also provide detailed safety planning with YP and families/wider services.

49. The crisis teams, in conjunction with community mental health teams, work with Mental Health Intensive Home Treatment teams who will work with young people and families 2-3 times or more per week to reduce risks, keep young people close to home and promote

connections that already exist as part of recovery. They will work in conjunction with any wider system around a child.

50. Data from Q4 of 24/25 demonstrates Crisis and IHT teams performing well
    - 98% of calls to CAMHS crisis are triaged by a clinician
    - 90% of urgent referrals were seen within 4 hrs
    - Majority of standard breaches are for CYP within an acute hospital setting and who are not medically fit to be seen for assessment

Outcome Three: Reduction in the rate of hospital admissions for mental health conditions in young people under the age of 18 years

51. The rate of hospital admissions for mental health conditions in young people (under 18 years) in 2023/24 for Darlington was 200.8 per 100,000 population. The rate of young people admitted to hospital for mental health conditions in Darlington has risen sharply since 2019 and is statistically worse than both the England and North East averages. Darlington is ranked 4th in England, and 1st in the North East. Darlington is statistically worse than England (80.2 per 100,000 population) and the North East (88.7 per 100,000).

Fig 5: Hospital admissions for mental health in young people

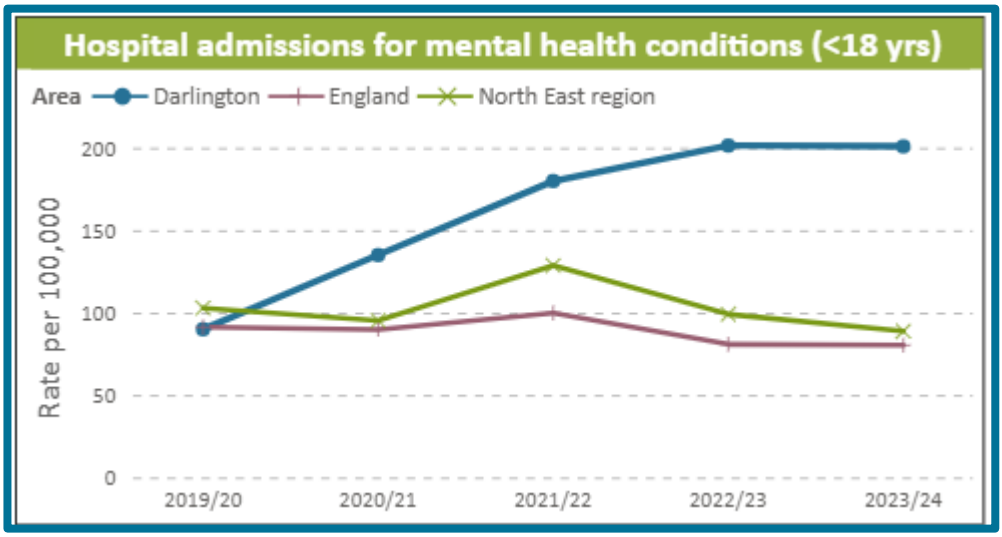


Fig 5: Graph showing total hospital admissions for mental health conditions (<18 years) in Darlington, the North East and in England. Source: www.fingertips.phe.org.uk

Inequalities by sex

52. Fig 6 (below) demonstrates that since 2018/19, rates for females have been consistently higher than that for males. In 2023/24, rates in females were significantly higher in females under 18 than for males at 273.4 per 100,000 population and 87.4 per 100,000 population respectively.

Fig 6: Mental Health hospital admissions for young people

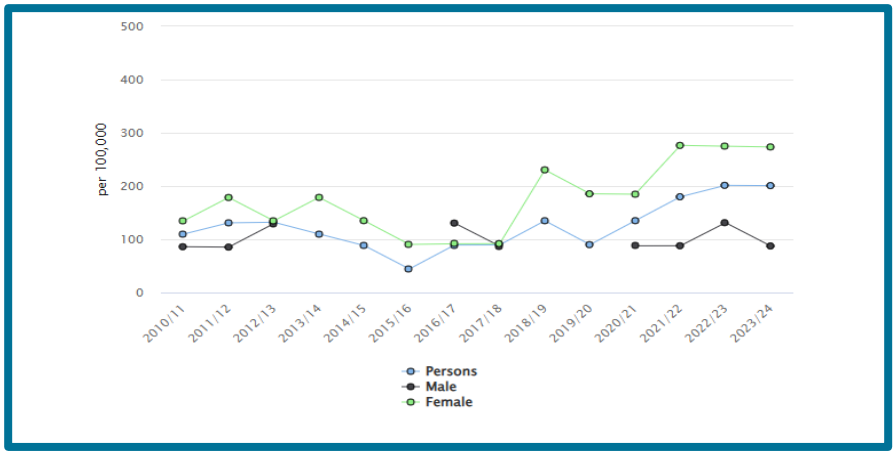


Fig 6: Graph showing total hospital admissions for mental health conditions (<18 years) in Darlington, split by sex. Source: www.fingertips.phe.org.uk

53. As above, **TEWV CAMHS** team provide mental health services for children and young people for mental health conditions. Please refer to update above for detail on CAMHS approach.

54. The crisis teams, in conjunction with community mental health teams, work with Mental health Intensive Home Treatment teams who will work with young people and families 2-3 times or more per week to reduce risks and keep young people close to home and promote connections that already exist as part of recovery. They will also work in conjunction with any wider system around a child. If a young person is receiving Intensive Home Treatment, regular MDT meetings are arranged with partner services and families to review any intervention plan and ensure services dovetail and not duplicate to meet need.

55. To support children with complex developmental trauma, joint commissioning arrangements and recurring funding have been agreed with the **ICB and all 5 Local Authorities** (Darlington, Stockton, Hartlepool, Middlesbrough and Recar and Cleveland) across Tees Valley (with Stockton Local Authority as the agreed host organisation) as part of an integrated approach to supporting those who experience multiple placements moves or care breakdowns, face challenges with engagement with services, generally exhibit risk taking behaviours and where there are high-cost care packages a dedicated team will be developed.

56. This Multi-Disciplinary Team and approach is expected to mobilise before the end of 2025/26. Following the I-Thrive model (see Fig 7 below) we would expect that this sits in the Getting Risk Support element of the framework, supporting a small number of children with high levels of need.

Outcome Four: Young people who need support for health and wellbeing know what services are available for support and how to access them

Children's Voice:

57. The Healthy Lifestyles Survey (HLS) is undertaken by the Public Health Team every year with children and young people who attend primary and secondary schools in Darlington. This anonymous online survey asks about their experiences, attitudes and behaviours

across a range of topics related to health and wellbeing, including emotional wellbeing, substance use, online activity, relationships and sexual health, diet and exercise, safety and antisocial behaviour.

58. The results are collated by primary and secondary aged pupils, providing an insight into the common themes and issues that affect children and young people living in Darlington, as well as painting a picture of their attitudes and beliefs to help young people and professionals challenge preconceptions and make informed decisions about their own lifestyle choices and risk-taking behaviour. Results are also fed back to each school, enabling them to use the responses from the survey to build an understanding of the needs of young people in their year groups and respond with an action plan for the following academic year.

59. The below graphs show the answers to the question "If you were worried or had a problem, who would you talk to or get support from?"

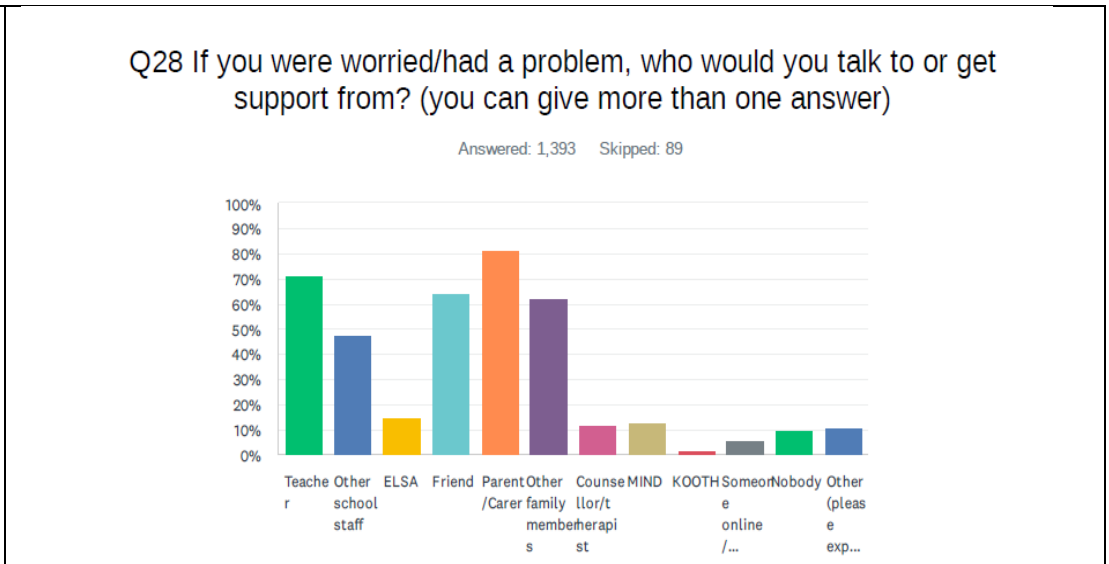
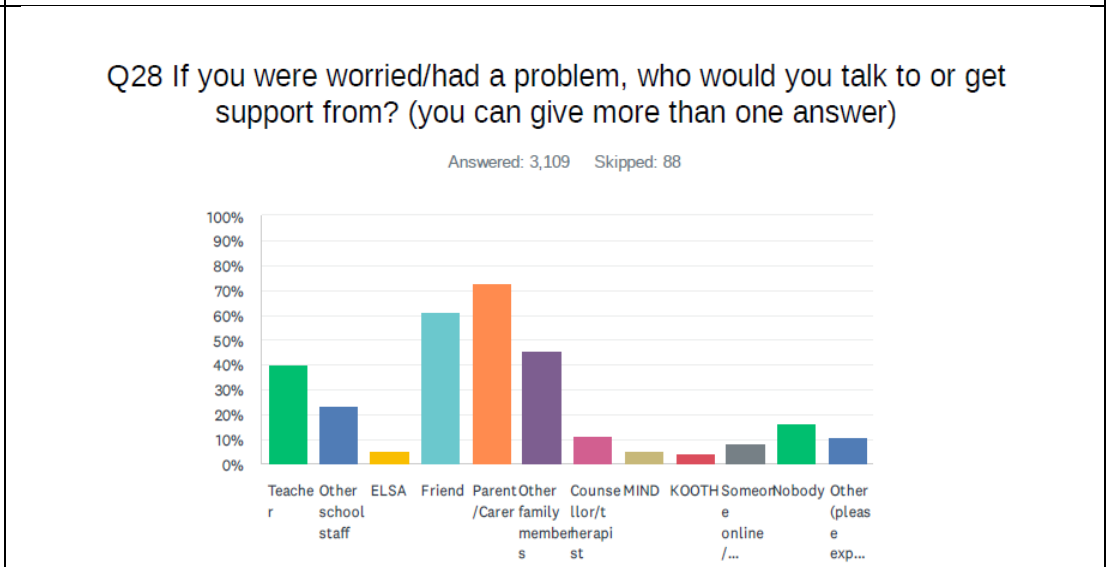
HLS 2024 Y5/6 cohort	
HLS 2024 Secondary Age cohort	

Fig 8: Responses to the question from the Healthy Lifestyle survey conducted by Darlington Borough Council's Public Health team.

60. In the 2024 survey, 133 out of 1393 (9.55%) Y5 and Y6 primary school children who took the survey, identified that they felt they had nobody to talk to if they were worried or had a problem.

61. For secondary school children across Y7-11, this number was higher, with 513 of 3,109 respondents (16.5%) answering that they had nobody to get support from if they were worried/ had a problem.

62. Fewer than 15% of children and young people in either age group identified mental health support services such as Kooth, counsellors or therapists as a source of support for a problem they were worried about.

63. Positively, most children and young people answering this question felt that they had at least one source of support, however, there is still opportunity to continue to improve access to support and reduce stigma around asking for help.

64. In both groups, parents, teachers and friends were the main sources of support, followed by other school staff and family members. There is, therefore, great importance on ensuring that pathways for support are clear both for children and young people, and for the adults they trust, so that family, schools and organisations are able to access appropriate information to provide young people with the support they need in the way that they are able to access it.

Adopting the I-Thrive Approach

65. The ICB has established a Tees Valley-wide steering group across the sectors. The Steering Group will focus on the I-Thrive model and its implementation across Tees Valley.

66. The I-Thrive model is an approach to delivering mental health services for children, young people and families. The model places emphasis on promoting good mental health and wellbeing, early intervention and active involvement of children and young people and their families in decisions about their care (from https://implementingthrive.org/about-us/).

67. This approach has been endorsed in the NHS Long Term Plan (www.longtermplan.nhs.uk/) and has been adopted as a multi-agency approach across the Tees Valley.

68. The I-Thrive model is an integrated, person-centred and needs-led approach which describes need according to five groupings: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help and Getting Risk Support (Fig 7, below).

69. The Steering Group aims to drive forward on overseeing reforms to ensure children, young people and their families receive the support they need, when they need it, underpinned by the values, principles and components of getting it right for every child, and responsive to local needs and systems from early intervention to crisis/risk support.

70. The Steering Group will provide strategic leadership and oversight for mental health initiatives targeting children and young people, ensuring alignment with national, in particular the NHS 10-year plan, and local policies, programs and organisational goals. The Steering Group ensures that partners/agencies work together, provide strategic direction, share information, jointly commission services, monitor performance and agrees priorities.

Fig 7: The I-Thrive model. Source: [i-THRIVE | Implementing the THRIVE Framework]

71. Following a competitive tendering process, the ICB have awarded **TEWV** and 5 local Partner organisations (Alliance Psychological Services, Changing Futures, Teesside Mind, The Junction and The Link) a contract for a Single Tees Valley wide "**Getting Advice & Signposting and Getting Help' Mental Health and Wellbeing Service for Children and Young People."**

72. This Service will go live on 1st January 2026 with funding committed for an initial 7 years to enable sustainable approaches to integrated care and support.

73. The Service will offer advice, digital innovations, support through a newly created website and 'digital front-door' and provide a range evidence-based mental health and trauma focussed interventions across communities and schools. A mobilisation plan is now in place, which includes communications with key stakeholders across the system and the development of new marketing materials. The Service will work in collaboration with the Mental Health Support Teams, ensure reasonable adaptations are in place for children presenting with neurodiversity and aims to provide a consistent and seamless approach to early access and support and when young people, parents, carers and professionals want advice and support they can easily access this.

Outcome Five: Through the continued provision of mental health support teams in education settings, a greater number of children and young people will be able to access NHS-funded mental health services

74. Mental Health Support Teams (MHST) were established from the "Transforming children and young people's mental health provision: a Green Paper, 2017", which recognised that

providing support in school would improve children & young people's access to early mental health and wellbeing support.

75. **North East and North Cumbria ICB** are responsible for commissioning Mental Health Support Teams (MHSTs) in schools. As part of the governments ambition of 100% schools' coverage by 2029/30, a local ICB review of all existing MHST's, across Tees Valley is now underway. This will aim to understand what's working well and what could be improved for Darlington and to gain feedback to help shape and develop existing provision against national guidance alongside local need in preparation for expansion across the area. Recommendations from this review will be reflected into the local delivery of teams and any expected changes anticipated by 1st April 2026.

76. **Tees, Esk and Wear Valley Foundation Trust** (TEWV) provide Darlington's MHST provision.

77. TEWV reports that MHSTs have demonstrated having a positive impact across the Tees Valley and Darlington is the first local authority in the Tees Valley to achieve 100% coverage of all mainstream schools.

78. In the school year from Sept 24 to Aug 25, the MHST team delivered a total of 505 group sessions in Darlington Schools.

79. TEWV report that in the 12 months to the end of 24/25, 11,152 young people within the Tees Valley accessed NHS-funded mental health services. This is on track to meet required national access trajectories

Other Children and Young People's Mental Health Support

80. While access to MHSTs has proven to be a valuable addition to education-based mental health support, they do not operate in isolation and a wealth of other mental health provision is in place in schools and educational institutions in Darlington. This is described below.

81. **Harrogate and District NHS Foundation Trust** (HDFT) are commissioned to provide the Darlington 0-19 service. The 5-19 Emotional Resilience Team work with children, young people and families to empower and enable them to make informed decisions about their emotional health and to support them in transitioning safely and happily into adult life. The Darlington Growing Healthy 5-19 Team works in the home and community settings to deliver universal and targeted interventions designed to meet public health outcomes. The team can provide 1:1 support for low level short term emotional health concerns whilst offering a universal approach to schools with the Decider in year 6. Children and young people can directly access the service via school drop ins.

82. HDFT provide a service to all children and young people of school age, and their families, whether or not they are attending school. The service is based on the Healthy Child Programme from 5-19 years old, offering advice and information and assess health needs for any child referred into the service. The service is the first point of contact for schools when there are concerns regarding a child's health and wellbeing.

83. Between January and October 2025, 445 referrals were accepted into the 5-19 service. Referrals may be for general school nursing or emotional resilience. However, all children referred in are observed for emotional health concerns.

84. **Darlington Mind's Children and Young People's service** receives referrals from ten Darlington secondary schools and has supported 28 people aged 11 to 18 years with specialist counselling in overcoming self-harm, suicidal ideation, self-esteem, anxiety, bullying, body image and social disconnection. Darlington Mind's team also collaborates closely with Mental Health Support teams in schools.

85. **Education Partnerships Team** In addition to specialist clinical provision from CAMHS and commissioned services such as MHST and the 0-19 service, schools promote an integrated approach to wellbeing in schools, and all schools have different pastoral systems in place to support the emotional development and wellbeing of children and young people. While schools are not clinical experts, they are an important part of the early identification process of meeting needs. Schools also play a key role in working with clinical and social care partners once a child or young person is open to their services.

86. All schools in Darlington have a Senior Mental Health Lead, and the Education Partnerships Team support this programme through the Mental Health Leads Network. Many schools have invested in training staff in ELSA (Emotional Literacy Support Assistant) or have commissioned their own school counsellor.

87. The Education Partnerships Team is actively involved in representing education through attendance at several oversight and implementation groups. This includes the Tees Valley Neurodevelopmental Oversight Group, and the Children and Young people's Tees Valley Mental Health Steering Committee (described above).

88. The Education Partnerships Team is also currently working on several projects including Emotionally Based School Avoidance at the Y6/Y7 transition and are supporting our ICB (Integrated Commissioning Board) as they undertake a full review of the MHST service.

89. The Education Partnerships Team has worked with schools and other agencies to produce guidance tools to support the sector in working with children with wellbeing and mental health needs. The guidance and tools below outline consistent approaches and increase confidence in working with children and young people who may face SEMH challenges in schools and the wider community. Guidance topics include:
    - EBSA – Emotionally Based School Avoidance
    - Critical Incident, loss and bereavement
    - Self-Regulation across the ages and phases
    - Darlington Inclusion charter
    - Workforce Development Programme – CPD session on Social and Emotional and Mental health

90. **Darlington Borough Council's Building Stronger Families** service supports children through their growth and development. Young people and their families are referred from a range of services in health or education, or may self-refer for support.

91. Building Stronger Families' *Looking After Me Programme* is a preventative and early intervention approach which equips children with essential life skills—such as building self-esteem, confidence, and resilience—by exploring topics like body image, relationships, problem-solving, and responsibility. This proactive approach helps reduce risk factors for poor mental health and promotes emotional wellbeing.

92. The outcomes recorded include:

- Improved confidence and resilience among children and young people;
- Greater awareness of how to make informed choices that positively impact wellbeing;
- Strengthened social and emotional skills leading to better peer relationships and reduced isolation;
- Building skills that support positive decision-making into adolescence and adulthood;
- Reduction in risky behaviours linked to poor mental health;
- Increased engagement with Early Help and other support services when needed.

93. Positive outcomes reported by Practitioners:

- *"Often the children in the group form peer friendships and share how they will keep in touch with each other."*
- *"The programme gives children the opportunity to explore their relationships in a safe space, helping them to realise who is there for them and which relationships are true and healthy."*
- *"We are often asked by parents if their child can do something else or complete it (the programme) again. This is because they have noticed a difference in their child."*

94. Children attending the programme have reported:

- *"Getting to know other people and speak about situations I have been in, hearing that other people have been in these situations too, I am not alone. We worked together to think about solutions"*
- *"It's OK to not always feel your best, I can learn to deal with this in the right ways."*
- When asked 'what have you learned?', *"Self-confidence and not feeling alone. Some people have been through the same stuff I have."*

95. In addition to commissioned services, there are a number of charities and community organisations, such as The Listening Post, offering school-based support.

96. The wide range of services in Darlington indicates a real need for local provision to support children and young people's mental health, and highlights the importance of collaboration and communication between services and the people they serve in order to best meet the needs of the children and young people.

<u>Outcome Six: Reduce rates of suicide in men and women</u>

97. Every life lost to suicide is a tragedy. In 2024, 5717 suicides were registered in England, and increase of 61 since 2023.

98. Men in England are three times more likely to die by suicide than women, and males age 50-54 have the highest suicide rate at 26.8 per 100,000 population (Office for National

Statistics (ONS) data, collated by Latest suicide data | Suicide facts and figures | Samaritans).

99. Suicide rates are reported by the ONS as a three-year pooled average per 100,000 population in each Local Authority area. For the period 2022-24, Darlington's overall suicide rate (persons) has decreased slightly to 18 per 100,000, down from 19.6 per 100,000 in 2021-23 population (see Fig 9, below).

100. The current rate in Darlington is statistically higher than England (10.9 per 100,000 population), but similar to the North East (14.1 per 100,000 population).

101. Darlington's rate is the 6th highest in England and the 3rd highest in the North East.

102. It should be noted that while the rates in Darlington are high, the numbers of lives lost to suicide remain relatively small. This does not lessen the impact of these tragic losses, but it means that caution is exercised when sharing local data to ensure that anonymity is protected. Where data is not shown on the below graphs, it is due to data being suppressed as a result of small numbers.

Fig 9 Suicide rates in England and Darlington

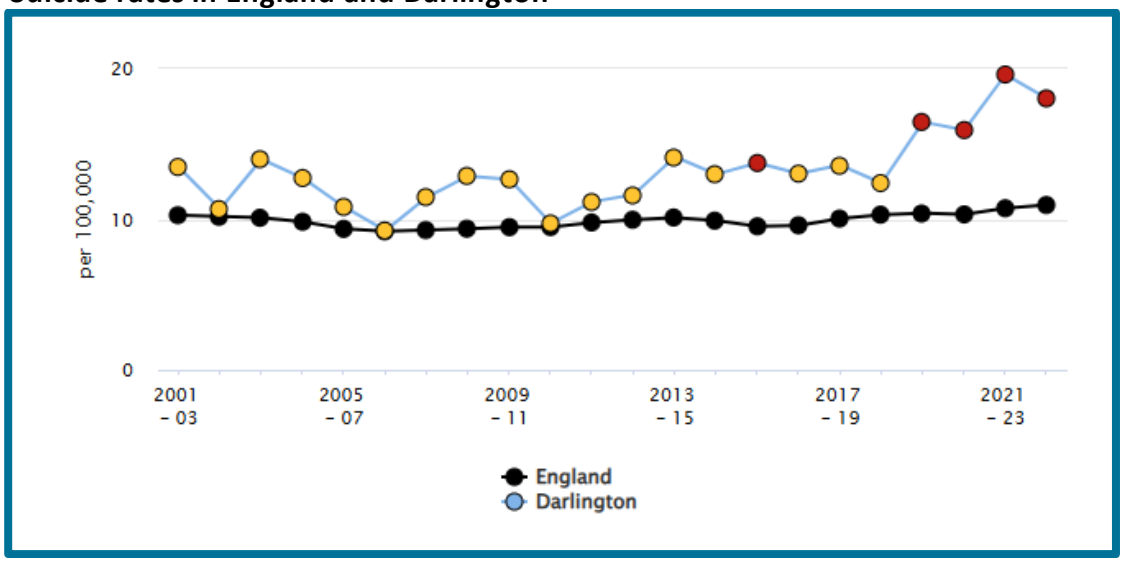


Fig 9: Graph showing rates of suicide per 100,000 people in England and in Darlington. Source: www.fingertips.phe.org.uk

Inequalities by sex

103. The inequality rates of suicide according to sex are getting wider, with the rate for males increasing to 29.1 per 100,000 population and females decreasing to 7.5 per 100,000 population (see Fig 10, below).

104. While the rate of the increase in males has slowed, there is still a slightly upward trend for men, while rates in females have decreased.

Fig 10: Suicide rates in Darlington by sex

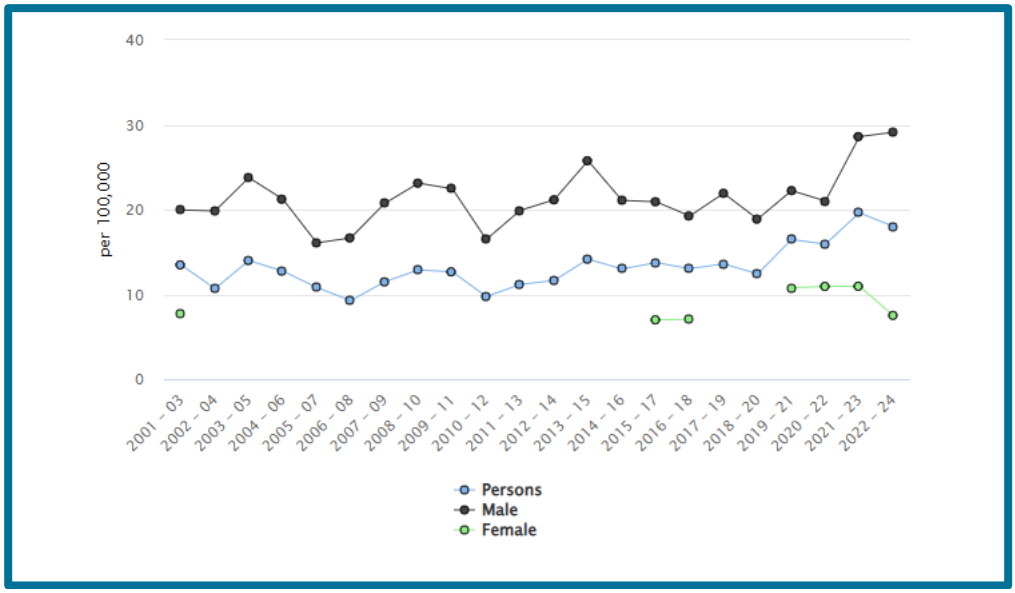


Fig 10: Graph showing rates of suicide according to sex in Darlington. Source: www.fingertips.phe.org.uk

105. In England, in 2024, the age-standardised male suicide rate was 17.1 per 100,000 population. This means that Darlington is significantly above the average rate for males for England.

106. While the national picture reflects that the rate for males is approximately three times greater than the rate for females, in Darlington this disparity is wider, with almost four times the rates for men compared to women.

Inequalities by age

107. The age profiles described below are national reporting categories, published by ONS, over a five-year pooled period. The most recent data for 2020-24 has not yet been broken down by age.

108. In Darlington, we have seen a steady decline of rates of suicide in people aged 25 – 44 years, and a steady increase in rates of people 45 – 64 years to 24.8 per 100,000 population in 2021-23 (see Fig 11, below).

109. Whilst there are indications of a rise in the under 24 years age group, the data is not yet available for 2020-24. In the absence of this updated data, we have reviewed local real time surveillance data (described below). This data set, which is not publicly available until verified, suggests that most cases in this cohort are over 18 years old, and it is anticipated that this rate will show a decline in the pending update from ONS.

110. We will continue to monitor the published and real time surveillance data for any emerging trends.

Fig 11: Suicide rates in Darlington by age

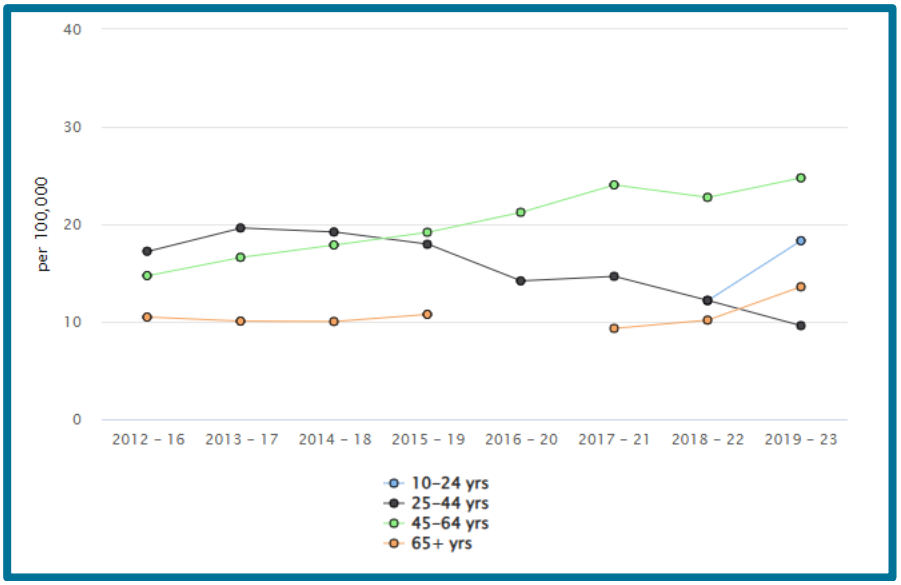


Fig 11: A graph showing rates of suicide in Darlington according to broad age-groups. Source: www.fingertips.phe.org.uk

Interaction of sex and age

111. As rates in males are significantly higher than females in Darlington, further analysis to review the interaction of age and sex has indicated that the group with the highest rate of loss of life to suicide in Darlington is males age 45 – 64 years at 32.6 per 100,000 in 2021-23 (see Fig 12, below).

Fig 12: Suicide rates in males in Darlington

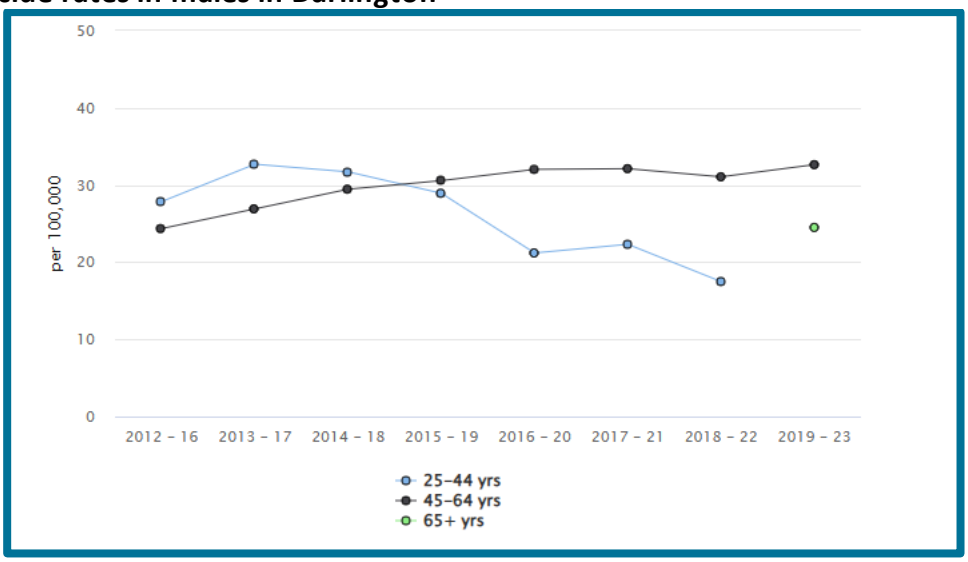


Fig 12: A graph showing suicide rates in males in Darlington according to broad age-groups. Source: www.fingertips.phe.org.uk

Suicide Prevention Approach

112. In 2020, Public Health England published *Local Suicide Prevention Planning: A practical resource* (PHE_LA_Guidance_25_Nov.pdf)

113. In the paper, key responsibilities for Local Authorities in suicide prevention were set out, including:
    - develop a multi-agency suicide prevention partnership
    - make sense of local and national data
    - develop a suicide prevention strategy and action plan

114. The **Suicide Prevention Partnership** was established in July 25, chaired by Public Health Darlington, with Terms of Reference setting out the roles and objectives of members.

115. The Suicide Prevention Partnership has representatives from a range of partners who are directly involved in reducing risk of suicide and serious self-harm, including emergency services, TEWV (adults and CAMHS), ICB, HDFT, education partners, coroner's office and VCSE organisations such as Darlington Mind, James Place (see below), Darlington Samaritans, Papyrus, and organisations working with those identified as being at greater risk, such as those supporting people with drug/ alcohol use, domestic abuse victims, neurodiverse people, refugees and asylum seekers.

116. Healthwatch Darlington creates a formal link between the Suicide Prevention Partnership and the Mental Health Network (update below). This supports the need to work collaboratively to promote good mental health, early intervention and primary prevention.

Suicide Prevention Strategy

117. The Government policy paper *Suicide prevention strategy for England: 2023 to 2028* (Suicide prevention in England: 5-year cross-sector strategy - GOV.UK) sets out 8 key areas for the focus for local suicide prevention efforts. These are:
    - Improving data and evidence
    - Tailored, targeted support to priority groups, including those at higher risk
    - Addressing common risk factors linked to suicide at a population level
    - Promoting online safety and responsible media content
    - Providing effective crisis support across sectors
    - Reducing access to means and methods of suicide
    - Providing effective bereavement support (Post-Vention)
    - Making suicide everybody's business

Action Plan

118. A Strategic Action Plan is awaiting final feedback from the Suicide Prevention Partnership members, based on these National Strategy priority areas for action (above).

119. The Action Plan will take a five-year approach, recognising that change takes time and allowing time to demonstrate impact, to review and evaluate efforts so far, and to reflect changes to national and local priorities.

120. Initial areas identified for focused work include ongoing improvements to data, mental health support for men (specifically 45 – 64 age group), children and young people, and those bereaved or affected by suicide, as well as the role of crisis services across sectors. These are discussed below, with the exception of children and young people (discussed above).

Area for action: Data

121. Data is a key component in the development of the action plan, to ensure that those most at risk are identified and resources are allocated to offer the most effective support.

122. As well as the publicly available data shared above, the ICB has developed a regional near to Real Time Suspected Suicide Surveillance (nRTSSS) and Clinical Audit model.

123. The purpose of the nRTSSS is to increase speed of response so that support can be offered quickly and interventions can be mobilised as themes or issues are identified. The nRTSSS uses information from deaths identified by the coroner as "suspected suicide". This means that information is available quickly and local/ regional themes may be identified and acted upon quickly.

124. The ICB's Clinical Audit provides further indication of regional themes and supports the development of shared regional and place-based working priorities.

125. The ICB are leading the development of a project to improve both data and interventions for those making attempts of suicide. This will help to improve identification of those in need of support and establish a consistent model to improve community-based services and care for people who self-harm.

126. Other data sources which will begin to feed into the Partnership includes data from identified at-risk groups, such as those who are neurodiverse, those using drugs and alcohol, those accessing other services and data from partner organisations such as education partnerships and mental health services.

127. The Partnership has used the data described above to identify groups at greater risk, and to begin to plan interventions and approaches to reduce these risks.

Area for action: Men's mental health support

128. A small task and finish group from the Suicide Prevention Partnership has been established to develop a marketing campaign to highlight the specific support that is available in Darlington for men experiencing suicidal crisis.

129. The campaign will draw on the World Suicide Prevention Day 2024 – 2026 theme of "Changing the Narrative on Suicide", which reflects the need to challenge stigma and harmful myths, while fostering open and compassionate conversations (World Suicide Prevention Day 2025).

130. Feedback from the group included the need for the campaign to be "real" and "connected". Several Darlington men who have experienced suicidal crisis have shared their personal stories of reaching and attending groups, and we are grateful for their openness in helping to create a local environment where people feel able to speak up and seek help.

131. The campaign will launch over the winter and run for a year, linking in to key events and activity over the course of the year, to raise awareness of the different types of support available in the borough, and to support men to find the route that works for them.

132. As well as a number of charities, such as Andy's Man Club, Man Health and Darlington Mind providing support for men's mental health, James's Place have recently been commissioned by the ICB to pilot a service in Darlington for men in suicidal crisis (see detail below).

Area for action: Post-Vention Support after Suicide

133. While figures vary between studies, it is estimated that between six and 135 people are impacted by a single loss of life to suicide, and the loss impacts family and friends, communities, employers, health and care providers and beyond (The economic cost of suicide in the UK).

134. Those bereaved or affected by suicide are at greater risk of taking their own life, and other adverse mental and physical health outcomes, so post-vention support is an essential component to help those affected, and to prevent further loss of life to suicide.

135. **If U Care Share Foundation** have been commissioned by the ICB to provide post-vention support in the North East region, and began working in Darlington in April 2025.

136. If U Care Share Foundation provides practical and emotional support to those affected by suspected suicide, with no restriction of length of time since the bereavement, reflecting the fact that grief is different for each person and support may be needed in different ways at different points.

137. The service is provided by professionals who have personal experience with suicide, and referrals may be made to clinical and community services as appropriate.

138. Support offered takes a number of forms, and is offered by phone or in-person and can be arranged at a location that is best for the person or family.

139. Referrals can be made via the police, coroner, primary care and self-referral, and referrals can be for anyone who has been affected by the loss, not only the next of kin or family.

140. If U Care Share have also developed a bespoke children's programme entitled "SAS Kids" which is available for children aged 6-16 years of age. The programme includes appointments which take place on an individual basis with the child and are usually held in the school environment. This is because it has been identified that children feel more confident and relaxed sharing their emotions outside of their home environment. Various craft based and written activities are used to explore the child's emotions and memories around their loss and this can be tailored to their individual needs. A one-year pilot of this service has been commissioned by the ICB.

141. In addition to SAS Kids, **Darlington Mind** have been commissioned to provide **Thrive after Tackling Trauma.** The service offers compassionate trauma support for children and young people affected by suicide and traumatic death. Darlington Mind is now taking referrals for

this scheme supporting the 6 to 24 age group (plus 24-29 for those leaving care). A pilot of this service has been commissioned by the ICB and will be evaluated in the coming year.

Area for action: Training

142. As part of all above priorities, training and education have been identified as a key component to reducing suicide risk by challenging the stigma of mental health and suicidal crisis, and by raising awareness of how people can respond and offer help and support.

143. The ICB has commissioned a number of training opportunities in both suicide prevention and in the provision of postvention for NHS staff, emergency responders and those commissioned to deliver NHS services.

144. In addition, further community-based training is being commissioned by the local authority, funded through the public health grant. This will be open to people within the borough, including VCSE organisations, as well as targeted training for people working in places where people may present for help, such as public-facing council spaces and community venues.

Area for action: Effective Mental Health Crisis Services

145. Adult Crisis Support Services in Darlington are provided by **Tees, Esk, and Wear Valley Foundation Trust (TEWV).**

146. In April 2024, 111 select mental health (option 2) which is now the single point of access for mental health crisis nationally was introduced in the Trust/region/s.

147. Calls are screened by appropriately trained staff and if appropriate transferred to the respective Crisis Resolution Home Treatment (CRHT) service. The line provides access to all age response within the respective care groups (CRHTs) and their functions have not changed; the CRHTs still provide triage, face to face assessment, and Intensive Home Treatment (IHT) although some CRHTs have distinct teams now to deliver these aspects, along with central hubs where referrals come into.

148. Summary of Call Data and Clinical Response (Durham Tees Valley – October 2025):
- 111 Select Mental Health Option Screening:
    - 5291 calls received
    - 95% call answer rate (97% national KPI, 73% national average)
    - 5% calls abandoned (3% national KPI, 27% national average)
    - 33s average call answer time (20s national KPI, 217s national average)
    - 32% of calls referred for crisis triage by a registered clinician.
- Crisis Triage:
    - 1677 calls were passed through to a clinician for triage (1222 AMH, 456 CAMHS)
    - 90% of these calls received a response (80% within 7 minutes, 90% with successful call-backs, with an average answer time of 3 minutes and 25 minutes for a call back.
    - CAMHS call answer rate is notably high at 95%.
    - All patients who abandon their call receive a call-back and if unsuccessful a clinical risk assessment is undertaken to determine next steps to maintain safety.

- Clinical Response Times:
    - Based on clinical triage and assessed need:
        - Very urgent: response within 4 hours.
        - Urgent: response within 24 hours.
        - Timing is person-centred, depending on individual need.
- Call abandonment—where callers hang up before the call is answered—is a common reason for lower answer rates. This can happen due to:
    - Long wait times or perceived delays.
    - Caller distress or anxiety, especially in crisis situations.
    - Technical issues (e.g., poor signal, dropped calls).
    - Uncertainty about the process or expectations.
    - Choice may have selected wrong option.

149. TEWV CRHTs work with those aged 18 years and over, however most teams deliver crisis intervention to those over 65 years (functional mental health conditions). There are also commissioned Child and Adolescent Mental Health Crisis Teams (see above in Outcomes 1/2/3) and Older Persons crisis teams in some areas. These would see and treat those with both functional and organic presentations. During out of office hours, individuals with diagnosed or suspected learning disability who need crisis support will be supported by the adult mental health crisis team.

150. The primary objective for CRHTs is to minimise distress and harms, including harm to self, harm to others, harm from others and potential unintended harm from our intervention in line with the Safety and Risk Management Policy. They work with patients to prevent relapse and deterioration, and to help support the individual using a bio psychosocial model.

151. Patients who are admitted to an acute mental health inpatient ward following assessment, where appropriate, can access intensive home-based treatment during leave and following discharge from hospital, with an aim to work towards recovery within their home environment.

152. Most patients and carers prefer community-based treatment and research has shown that clinical and social outcomes achieved by community based treatment are at least as good as those achieved in hospital. IHT can be provided in a range of settings and is not restricted to the individual's home. For some, hospital may not be helpful, whereas for others it may be the most appropriate option.

153. Sometimes people may not be well enough to make decisions about their treatment. If their health or safety is at risk, or if other people might be harmed if they are not given treatment, they may be detained under the Mental Health Act and taken to a hospital. This is also called being 'sectioned.' The crisis team should be part of this assessment to ensure that the least restrictive options are explored.

154. Crisis services consider all available options and work collaboratively to ensure the best fit with patients and carers to help aid the individual at a point in time to support their recovery and reduce potential harms. We recognise that complex dynamics occur within relationships and different parties can have different views on needs and care/intervention required.

155. **Staying Safe from Suicide Guidance:** In April 25, new guidance for all mental health practitioners was published by NHS England which promotes a shift towards a more holistic, person-centred approach to managing patient safety in relation to suicidal thoughts rather than relying on risk stratification. (NHS England » Staying safe from suicide).

156. **TEWV** have already begun to build this guidance into their approach:
    - All the speciality development managers are reviewing the implications attached to their areas of work, e.g. documentation, policies etc.
    - Preventing Suicide Programme Managers have implemented preliminary toolbox learning sessions for staff to attend so they were aware at a basic level of the new guidance with links to the full guidance
    - National training is now available and is being shared Trust-wide, and attached to TEWV's person-centred care planning training.

157. **In the event of an emergency call being made to 999,** emergency services response may include triage to mental health services, if this is deemed to be the most appropriate service to meet the needs of the person.

158. **Durham Constabulary** state that "Right Care Right Person (RCRP) is about ensuring that vulnerable people are given the right support by the right agency when they need it. RCRP will not stop the police attending incidents where there is a threat to life. We have a duty to protect our communities, and we will continue to do so. RCRP is about working with our partners in health and social care to make the necessary changes to service provisions to ensure that vulnerable people are given appropriate care by the appropriate agency."

159. Durham Constabulary, North East Ambulance Service and County Durham and Darlington Fire & Rescue Service are members of Darlington's Suicide Prevention Partnership to support the development of these pathways of appropriate care, and to support the focus on prevention and early intervention.

Alternative Crisis Provision

160. From May 2025, the **ICB** have commissioned a 24/7 crisis support text service. The service, reached by texting "CALMER" to 85258, provides urgent support by text for people in the North East and North Cumbria region experiencing urgent mental health challenges, including anxiety, stress, depression, self-harm, suicidal thoughts. This service has been commissioned for two years and will be evaluated in 2026/27.

161. **TEWV** are in the process of developing crisis alternative provision using design-thinking methodology. This provision is currently being shaped and designed by people who have used TEWV services, clinicians and other professionals e.g. VCSE. Further information will be available in the near future.

162. **Darlington Mind** provide the Rapid Response Suicide Prevention service. This crisis counselling service has received over 40 referrals in the last six months in Darlington from local people at risk of suicide. The service provides up to 6 counselling sessions starting within 5 days of referral.

163. **James' Place** provides rapid support for men in suicidal crisis. Since opening their first site in 2018 in Liverpool, James' Place have supported over 4000 men, and now have permanent sites in London and Newcastle, with 2 further centres planned to be open by 2027.

164. From November, James Place have been commissioned by the ICB to open a pilot site in Darlington's CAB building to trial the use of a Hub and Spoke model from one of their permanent bases in Newcastle, providing a local, accessible space for men who may not be able to travel to Newcastle for support.

165. Initially, referrals are being taken from local crisis teams and psychiatric liaison teams, in order to manage capacity, with a view to reviewing and opening for wider referrals if capacity allows.

166. On discharge, men will be signposted to other local support services.

167. The pilot was developed to:
- Test the feasibility of delivering the James' Place model in a community-based spoke site;
- Strengthen early intervention and partnership pathways;
- Evaluate outcomes and inform regional and national rollout.

168. Suicide Prevention continues to be a focus for system-wide activity in Darlington and in the wider regional structures. Initial work to explore and continue to improve the systems already in place will continue, while developing further priorities in light of the work of the partnership.

Outcome seven: Support the work of the Darlington Mental Health Network to enable greater collaboration and partnership working, using the learning which emerges to strengthen preventative approaches and inform the future commissioning and delivery of mental health services

169. Since re-establishing the Darlington Mental Health Network in April 2024, Healthwatch Darlington and partners have made significant progress in rebuilding a coordinated approach to mental health collaboration across the borough.

170. Initially a one-year pilot commissioned by Darlington Public Health, the network's success has led to ongoing support from the North East and North Cumbria Integrated Care Board (ICB) and Darlington PCN for the next two years. Healthwatch Darlington continue to lead this work, building on the strong foundation.

171. The Darlington Mental Health Network demonstrates the power of collaboration in strengthening local mental health support and will continue to evolve to meet the community's needs. Members report greater confidence in referrals, improved awareness of available services, and stronger relationships between statutory, voluntary, and community partners.

172. **Key achievements include:**

- Enhanced collaboration: Strengthened partnerships with the Darlington Primary Care Network (PCN) and successful joint funding bids for mental health coordinator roles.
- Improved referral pathways: Increased confidence in signposting and referrals, ensuring individuals access the right support more efficiently.
- Knowledge sharing: Regular updates on services, policies, and best practice have fostered a more connected and informed mental health community.
- Community focus: The network has identified local gaps and co-produced solutions based on lived experience.

173. **Useful Connections & Partnerships:**
    - Darlington PCN and Triage working to support patients who are economically inactive to progress towards meaningful activity in the form of employment, skills development, training or volunteering, transitioning out of prescribed support.
    - A successful partnership bid for mental health coordinators with two other organisations, who are now in place with YMCA and First Stop.
    - Support to establish the Gambling Champions Support Network, which highlights gambling-related harms as a serious mental health risk.
    - The NECA Gambling Service, a short-term treatment service, has benefited from the network by improving its local signposting and referral processes.
    - The network has provided useful contacts and knowledge about other services that can support organisations' work.

174. **Ongoing and future plans:**
    - Events to raise awareness of available services, such as community roadshows expanding the reach of the successful 'Tea-Riffic' events in the market place in summer
    - Mapping the support available to help organisations and individuals navigate services more effectively.
    - Ongoing development of an online database of all services available in Darlington to improve accessibility using MECC Gateway

175. Based on internal and RAIDR data, Darlington PCN identified mental health as a key concern, leading to an agreement from local commissioners (ICB) to form a Darlington **Mental Health Integrated Neighbourhood Team (MH INT),** as a sub-group of the Mental Health Network.

176. In December 2024, primary care GPs and Practice Managers from Darlington Primary Care Network (PCN), the local authority (DBC), the NHS Trust (TEWV), the ICB, and the local voluntary and community sector organisations (VCSE) came together to understand the meaning of Integrated Networks (INTs) and explore how they could work together at a neighbourhood level to improve patient care. Three themes were identified:
    a) signposting and coordination of existing services
    b) advocacy (overcoming the issues in handovers between services)
    c) simplified intensive support for those patients with severe mental illness (those appointments too complex for IAPT services, such as talking therapies and social prescribing).

177. Over the last 12 months the Mental Health INT has:

- **Increased collaboration between stakeholders and key partners**

  - Funding secured to enable Healthwatch Darlington to continue the management/facilitation of Darlington's Mental Health Network
  - Gaps in funding for increased low-level mental health support in the community were identified, leading Darlington PCN to allocate funding to the VCSE for two Community Mental Health Prescribers (above)
  - Triage Pilot co-partnership with Darlington PCN to support getting into employment, volunteering, and training, focusing particularly on those with low-level mental health, disabilities, and long-term health conditions and/or caring responsibilities.
  - Service Development discussions between Primary Care/PHD/TEWV, and changes have been made to ledgers and appointment booking processes to improve wait times for ARRS Mental Health Practitioner appointments.
  - Dementia Working Group established to develop a Darlington Dementia Strategy (DBC/Primary Care/TEWV).
  - Suicide Prevention Partnership membership (above).

- **Improved knowledge and navigation to social prescribing and community support for low-level mental health**
  - Following a review of the Darlington Social Prescribing (SP) Service, key issues identified included internal/external knowledge gaps surrounding the SP role, the delivery and management of proactive/coordinated care for complex patients, and the capturing, sharing, and communication of outcomes. The new SP model was implemented in December 2024 with the main change seeing SPs based in practices to enable them to attend regular MDT meetings/discuss complex cases, increase personalised continuity of care for patients, and improve communication between patients/ healthcare referrers/SPs.
  - Darlington's Mental Health Network, VCSE Steering Group, and DBC identified the sharing/advertisement of community support offers as disconnected. The MECC Gateway is currently being explored as a potential platform to advertise Darlington services in one place.
  - Low-level community mental health support is now included in Darlington's social prescribing offer.
  - Social Prescribing Model, Referral Pathways, and Triaging Processes have been collaboratively reviewed/updated to ensure a smooth service transition.
  - The Community Mental Health Prescribers (CMHP) are in post, have completed training and Primary Care/VCSE/TEWV inductions, and are now taking referrals. CMHPs are based at First Stop Darlington (adults) and YMCA Darlington (children/young people).
  - KPIs have been established to ensure data is captured/shared to evidence the following:
    - To increase access to social prescribing (to reduce wait times and improve population mental health and wellbeing)
    - To reduce non-medical/social appointments in Primary Care (to increase appointment access for medical/more complex issues)
    - To demonstrate VCSE impact (to provide evidence for future commissioning of mental health services)
    - To identify gaps in mental health provision (to provide evidence for future commissioning of mental health services)
- **Improved communication with patients to explain "what happens" between mental health referrals and appointments**

    - Plans to develop a shared patient leaflet (Primary Care/TEWV) explaining "what happens next" (between referral and appointment).
- **Improved mental health triaging between primary care and TEWV to reduce referrals for low-level mental health appointments**
    - New communications sent to Practices have improved appropriate referrals.

178. Over the next 6 months, the outlined INT outcomes will be co-evaluated using qualitative and quantitative data to demonstrate:

- Increased collaboration between stakeholders and key partners.
- Reduced GP appointments for non-medical/social issues.
- Increased social prescribing appointments offered.
- Improved knowledge of community mental health support available.
- Improved understanding of referral pathways.