HEALTH AND HOUSING SCRUTINY COMMITTEE
7 JANUARY 2026

DEEP DIVE: SUICIDE PREVENTION

SUMMARY REPORT

Purpose of the Report

1. This report is intended to provide an update to the Health and Housing Scrutiny Committee in relation to the priority of reducing suicide rates in Darlington.
2. The report will provide an update on the current data, work currently underway and planned next steps and challenges.
3. The report will also provide an overview of the different services available locally to support good mental health, including specific suicide prevention services.

Content warning

4. **This report contains information relating to 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.

Summary

5. Rates of suicide in Darlington are higher than the England average, and third highest in the North East.

6. In line with national trends, Darlington sees high rates of suicide in men, and in particular in men age 45-64.

7. Local authorities have a lead responsibility for coordinating local action to support suicide prevention, working alongside other statutory partners and local community organisations in order to be effective and reduce duplication.

8. Suicidal thoughts and actions rarely occur in isolation, but rather are the result of a complex interaction of people's individual factors, social and economic circumstances and cultural expectations. Therefore, a system-wide approach is needed to address the wider challenges facing those in suicidal crisis.

9. Key actions and opportunities may include:

   (a) Seeking out opportunities for improving clarity and collaboration between organisations.

Members can encourage organisations they work with to consider ways that they can work collaboratively to adopt a person-centred approach, such as raising awareness of services, utilising funding opportunities and taking up training opportunities.

(b) Challenging stigma

Stigma and assumptions should be challenged at every opportunity to encourage open dialogue about the role of mental health support, so that people in Darlington know how to access help, and feel safe to do so. Local, regional and national campaigns that align with Darlington's approach should be promoted and supported in order to raise awareness, open conversations and reduce stigma.

(c) Supporting work to identify and address inequalities in Darlington communities

Local organisations offering support to those at greater risk of suicide should be promoted and supported to work together as a system to take an evidence-based, person-centred approach to improve outcomes. Nationally, higher risk groups and communities include (but are not limited to) men, people with mental health problems, financial challenges, people who have self-harmed, relationship breakdown, people who are neurodiverse, people who use harmful substances and veterans.

(d) Prioritising early intervention

Prevention and early intervention opportunities should be promoted and invested in, so that Darlington people of all ages can access the right support 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) Championing the role of lived experience and stories of hope

Encourage organisations who support mental health to ensure that people with lived experience play a role in the development of interventions and in improving services, including experiences of accessing and moving between different support services, and outcomes of interventions on mental health and suicidality.

(f) **Recognising that we can all play a role in reducing suicide**

Suicide awareness and prevention training procurement is underway and will include targeted training to address inequalities and community-wide opportunities, to improve confidence and knowledge in supporting someone who makes a disclosure or shows signs of considering suicide. Elected members will be encouraged to take up dedicated training in suicide awareness and prevention to enable them to better understand and support those in their communities who may need further help, and to raise awareness of the options available.

When making and scrutinising decisions around local priority-setting and resource allocation, members are encouraged to consider the protective or negative impact they can have on mental health, including decisions that impact access to mental health

services, addressing risk factors (above), housing, green spaces, employment, work places, social isolation, accessibility and inclusivity.

Recommendations

10. The report recommends that members of Health and Housing Scrutiny Committee:

    a) Accept the content of the report
    b) Consider the recommendations and key actions set out in the report, and the role of elected members and scrutiny in supporting them.
    c) Identify any further opportunities to address the important issue of suicide prevention.

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

Deep Dive: Mental Health and Wellbeing, Health and Wellbeing Board report, 4 Dec 2025

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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 recommendations are directly intended to improve mental wellbeing, support early intervention, and better long-term outcomes for mental health
S17 Crime and Disorder	There are no direct implications arising from this report.
Wards Affected	All
Groups Affected	All, some groups are identified as greater risk but prevention approach applies to all.

Budget and Policy Framework	There are no direct implications arising from this report.
Key Decision	n/a
Urgent Decision	n/a
Impact on Looked After Children and Care Leavers	There is evidence of inequalities relating to Looked After Children in terms of self-harm data

MAIN REPORT

Information and Analysis

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

12. 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 1, below).

Fig 1: Rates of suicide in Darlington per 100,000 population

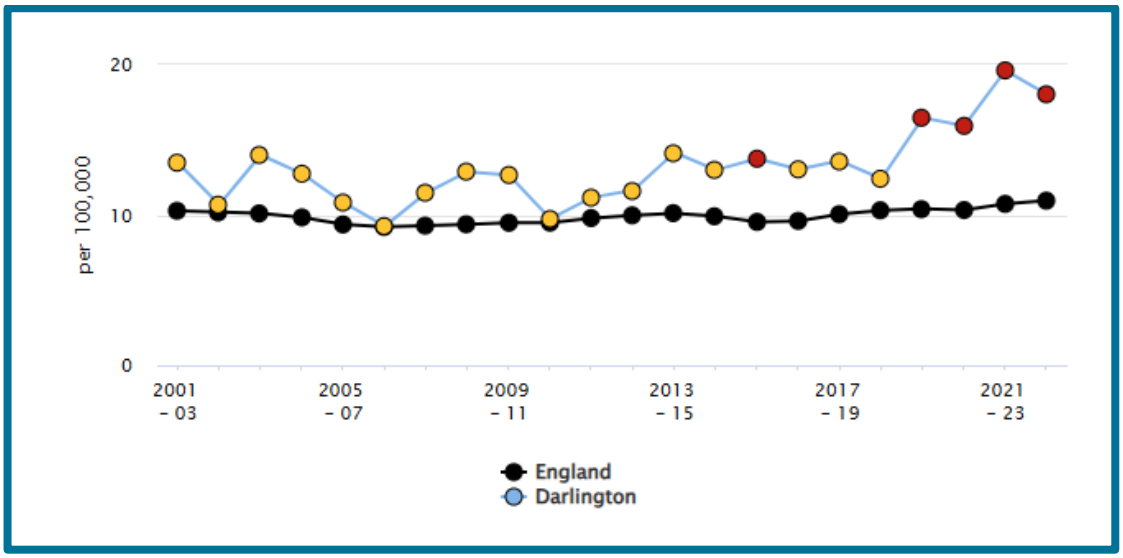

Fig 1: Graph showing rates of suicide per 100,000 people in England and in Darlington. Source: www.fingertips.phe.org.uk

13. 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).

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

15. 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.

16. A recent publication by ONS (Understanding suicide registrations following a change to the standard of proof in England and Wales - Office for National Statistics) has highlighted the impact of changes in standard of proof used by coroners on suicide rates. The change in the standard came into effect in July 2018, and changed the standard of proof from the criminal standard of "beyond all reasonable doubt", to the civil standard of "on the balance of probabilities".

17. The review states that these changes were likely to have increased the number of deaths registered as suicide, but that this is unlikely to be the sole cause, and lag times in recording, the pandemic and an actual increase may also have contributed to the increased figures.

18. While it is important to recognise the change in standard and the impact it may have had, Darlington's figures reflect an increased rate of suicides per 100,000 population that was significantly greater than the England average over recent years, and must therefore be addressed as a priority.

Inequalities by sex

19. 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 Samaritans Latest suicide data | Suicide facts and figures | Samaritans).

20. The inequality in rates of suicide according to sex in Darlington is 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 2, below).

Fig 2: Rates of suicide in Darlington according to sex

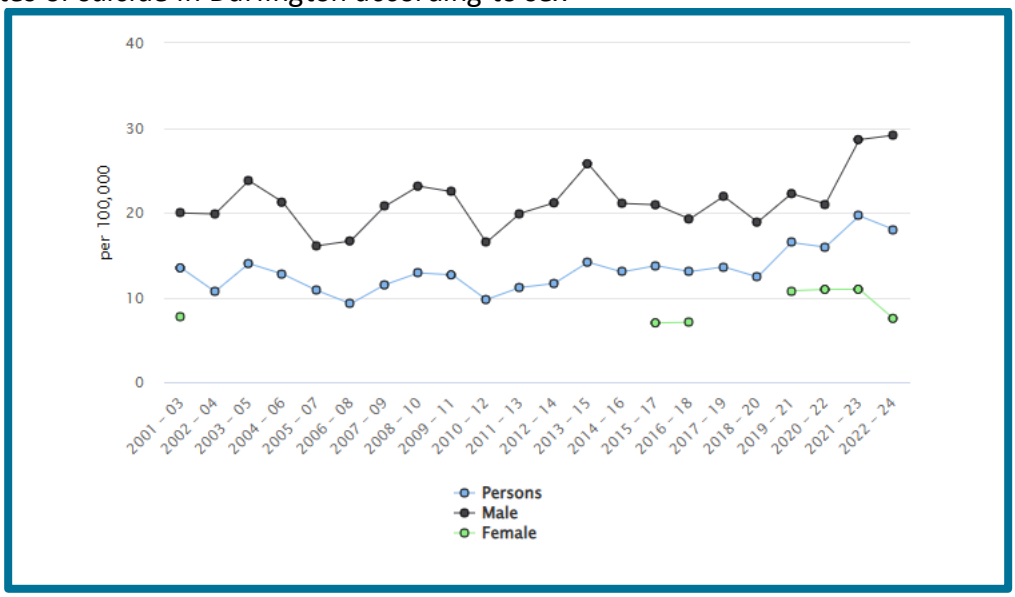

Fig 2: Graph showing rates of suicide according to sex in Darlington, per 100,000 population. Source: www.fingertips.phe.org.uk

21. 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.

22. 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.

23. 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

24. 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.

25. 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 3, below).

Fig 3: Suicide rates in Darlington by age

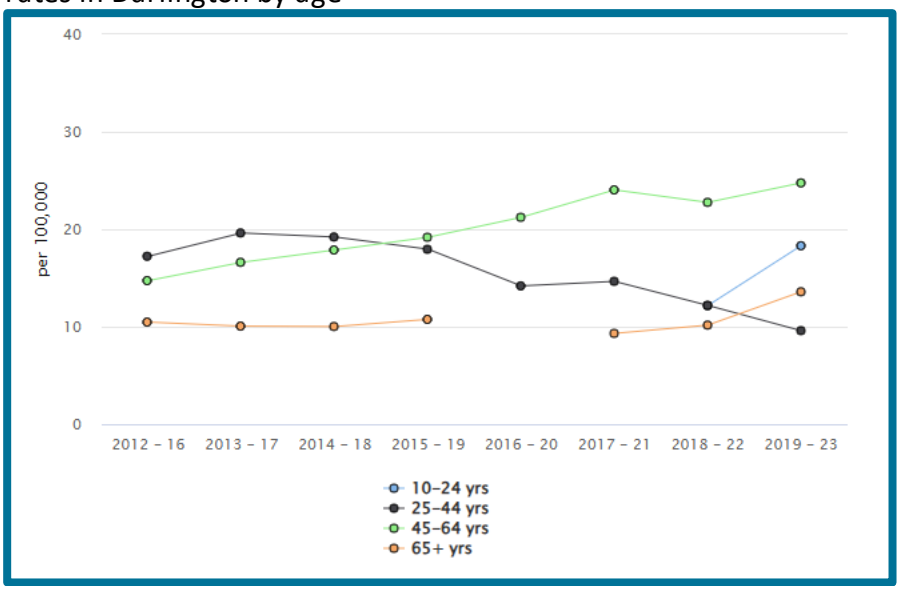

Fig 3: A graph showing rates of suicide in Darlington according to broad age-groups. Source: www.fingertips.phe.org.uk

26. 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.

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

Interaction of sex and age

28. 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 4, below).

Fig 4: Suicide rates in males in Darlington

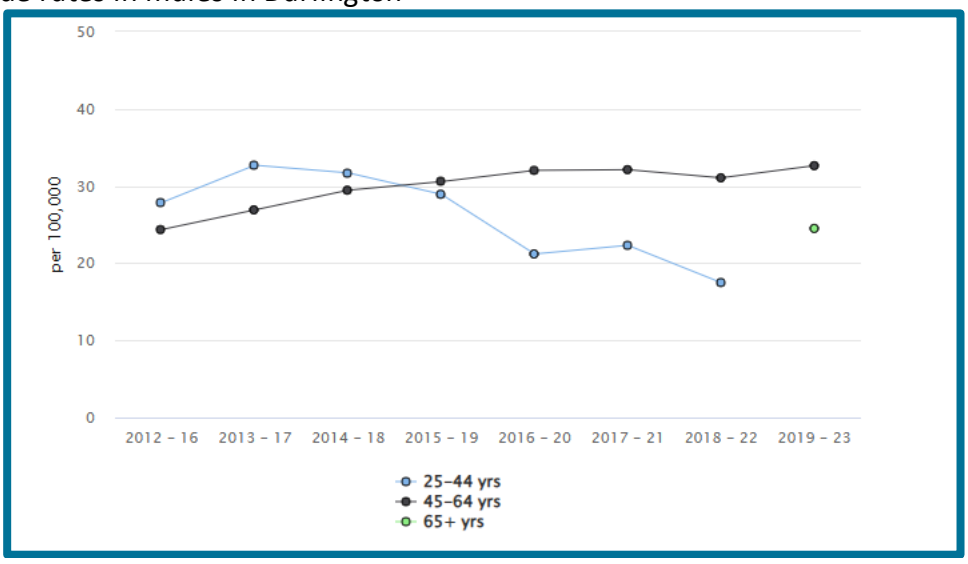

Fig 4: A graph showing suicide rates in males in Darlington according to broad age-groups, per 100,000 population. Source: www.fingertips.phe.org.uk

Self-harm admissions data

29. While the focus of this report is suicide prevention, it is important to also recognise that self-harm in children and young people in Darlington is a priority, and self-harm admissions are associated with increased risk of further self-harm and suicide attempts across the life course.

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).

31. The rate of self-harm admissions for 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 than 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).

Fig 5 Self harm in children and young people in Darlington

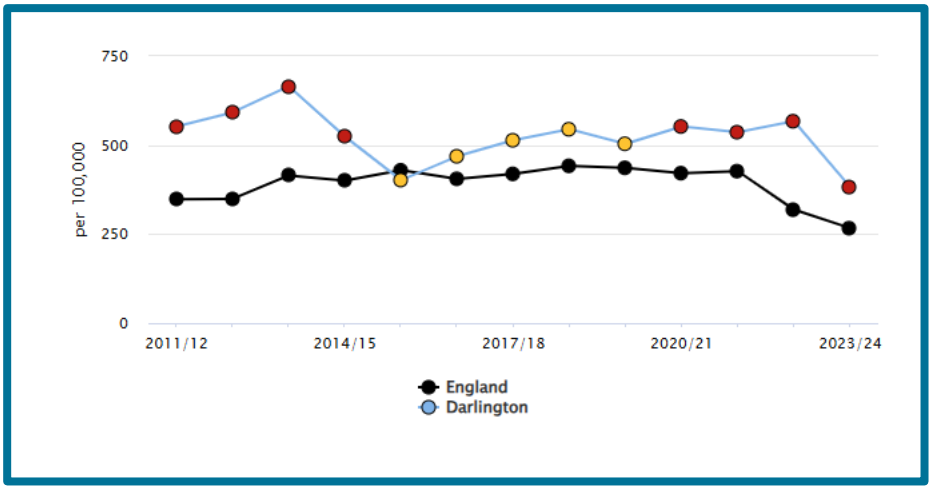

Fig 5: Graph showing total Emergency Hospital Admissions for Intentional Self-Harm in children and young people (10-24) Darlington and in England. Source: www.fingertips.phe.org.uk

32. Rates of admissions from self-harm in males in Darlington 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, but remain high.

Fig 6 Self harm admissions in children and young people

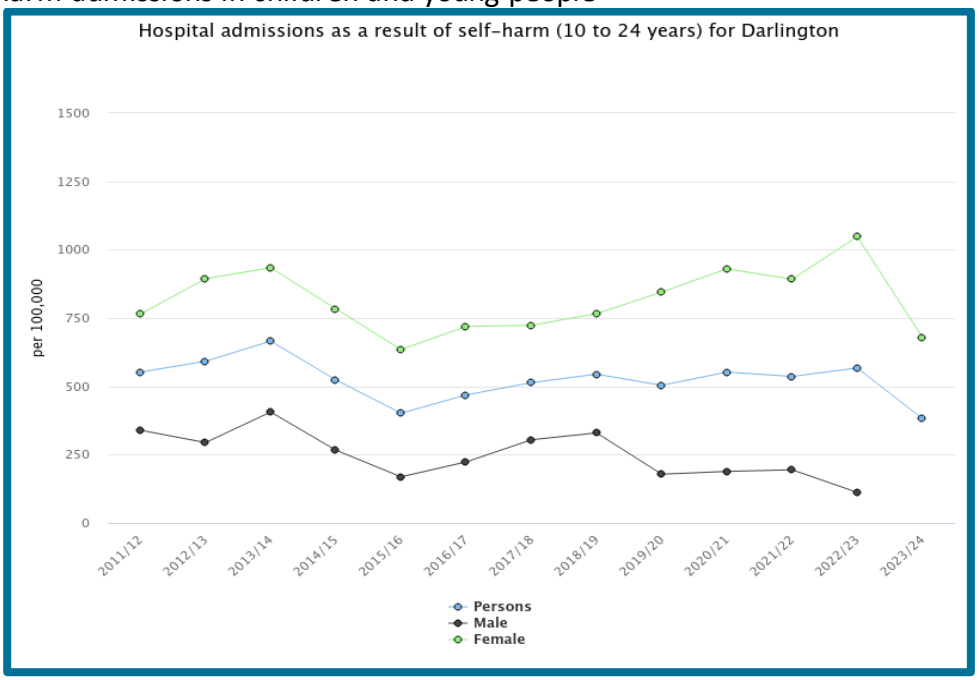

Fig 6: Graph showing total Emergency Hospital Admissions for Intentional Self-Harm in children and young people (10-24), split by sex, in Darlington. Source: www.fingertips.phe.org.uk

33. A recent audit was undertaken by CDDFT of self-harm admissions across the trust. 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:
    - 83% of those admitted were female and 17% were male.

- Some children had more than one admission to CDDFT for self-harm in 2023/24 (approx. 17% of admissions were repeat admissions).
- Just over 40% of children admitted lived in the most deprived quintile (CORE 20) as measured by the Index of Multiple Deprivation.

34. 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).

35. 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:

    - The majority of admissions for self-harm were a result of an overdose.
    - 64% had previous episode of self-harm recorded
    - 80% had previous contact with CAMHS prior to their self-harm admission.
    - 43% had previous contact with Children's Social Care recorded.
    - 100% were referred to CAMHS as a result of the self-harm episode.
    - 63% had a full HEEADSSS assessment undertaken and recorded (This includes detail around: Home, Education, Eating, Activities, Drugs, Sexuality, Suicide, Safety).
    - 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.
    - 11% of the children in the deep-dive audit were living in children's residential homes
    - 22% of the children in the deep-dive audit self-reported drug use
    - 24% of the children in the deep-dive audit had SEND/ Neurodivergence recorded

36. 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.

37. 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.

38. 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.

Suicide Prevention Approach

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

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

41. 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.

42. 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.

43. 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

44. 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

45. A Strategic Action Plan is awaiting final feedback from the Suicide Prevention Partnership members, based on the National Strategy priority areas for action set out above.

46. The Darlington Action Plan will take a five-year approach, in recognition that it will take time to effect change and demonstrate impact.
47. Initial issues and target groups identified for focused action 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, a cohort which has been explored above.

Area for action: Data

48. 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.

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

50. 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.

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

52. 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.

53. Other data sources which will begin to feed into the Partnership include local qualitative and quantitative data from nationally 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.

54. The Suicide Prevention Partnership has used the data available 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

55. 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.

56. 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).

57. 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 out 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.

58. 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.

59. 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).

60. The Men's Health Strategy was published in November. Mental health was identified as a key area for focus and investment. We will continue to monitor updates to the implementation of the strategy and actively seek opportunities to reflect this work in Darlington.

Area for action: Post-Vention Support after Suicide

61. 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).

62. 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.

63. **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.

64. If U Care Share Foundation provides practical and emotional support to those affected by suicide or 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.

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

66. 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.

67. 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.

68. 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.

69. 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 is under evaluation.

Area for action: Training

70. 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.

71. 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.

72. 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: Mental Health Crisis Services

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

74. In April 2024, 111 became the single point of access for mental health crisis nationally and has been introduced in the Trust/region/s.

75. 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.

76. 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.

77. 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.

78. 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.

79. 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.

80. 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.

81. 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.

82. 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.

83. **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).

84. **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.

85. **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.

86. **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."

87. 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

88. 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.

89. **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.

90. **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.

91. **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.

92. 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.

93. 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.

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

95. 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.

Area for action: Crisis services and mental health support for children and young people

96. In Darlington, there is a range of provision to support mental health and wellbeing of children and young people, from VCSE and community organisations to statutory providers, offering prevention to risk management and crisis support.

97. 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, an approach endorsed in the NHS long term plan (www.longtermplan.nhs.uk/).

98. 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/).

99. 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).

Fig 7: The I Thrive model for children and young people's mental health services

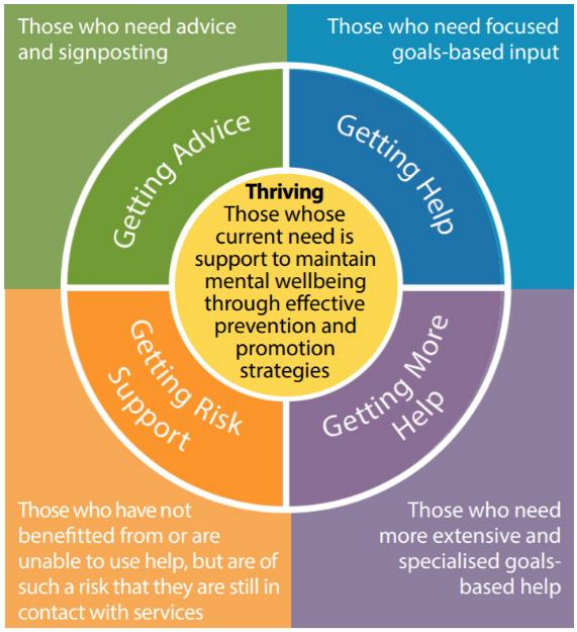

Fig 7: The I-Thrive model. Source: i-THRIVE | Implementing the THRIVE Framework

100. 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.

101. TEWV Children and Adolescent Mental Health Services provide mental health crisis services from children and young people. All young people have immediate access to Crisis Teams via 111, select mental health option. 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.

102. 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:

103. 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
    a) 100% of routine referrals seen within 4 weeks
    b) 100% of urgent referrals seen within 1 week

104. 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.

105. 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.

106. 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

107. 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.

108. This Multi-Disciplinary Team and approach is expected to mobilise before the end of 2025/26. Following the I-Thrive model (see Fig 7 above) 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.

Early Mental Health support and interventions

109. Early intervention is identified as particularly important for children and young people experiencing mental health challenges. While not directly supporting children experiencing crisis, interventions at the earliest opportunity can reduce the risk of reaching crisis, and therefore play an important role in preventing loss of life by suicide in children and young people.

110. 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."

111. 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.

112. 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.

113. The roll out and review of Mental Health Support teams in schools, emotional resilience support from the 0-19 service, support and training by the Education Partnerships Team, Early Help interventions, and VCSE organisations including Darlington Mind, The Listening Post and YMCA all offer opportunities for mental health challenges to be identified early and appropriate support offered.

114. In the coming year, the Suicide Prevention Partnership intends to explore whether there are any further gaps in provision for children and young people in relation to suicide prevention activity, and explore opportunities for further actions as required.

Conclusion

115. Suicide prevention and risk reduction continue to be a focus for system-wide activity in Darlington and in the wider regional structures. Initial work to explore and further develop local action will continue, co-ordinated by the Suicide Prevention Partnership. Local data and intelligence, alongside the evidence base for suicide prevention, will be utilised to inform further local actions.