Redcar and Cleveland

Adults Joint Strategic Needs Assessment

Self-Harm & Suicide

Aug 2021

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OUR APPROACH TO THE JSNA

The needs assessment process aims to provide a comprehensive analysis of the current and future needs of the local population to inform service commissioning and help improve health outcomes and reduce inequalities. The Redcar and Cleveland Adults Joint Strategic Needs assessment (JSNA) uses data, intelligence, and evidence to identify the current and future health and social care needs of the adult population in Redcar and Cleveland. It provides a compendium of evidence of the health needs of our local population for use by anyone working with delivering or planning services for our local population.

The local authority and CCG have a joint statutory duty to produce and maintain the JSNA, and health and social care commissioners are obliged to have “due regard” to the JSNA in exercising their functions. Having an effective Adults JSNA underpins the effectiveness of local strategies, services, and programmes for addressing poor health and care outcomes.

The Adults JSNA will help to improve the health and wellbeing of the local population by:

- Providing an up-to-date evidence-based resource to support health and wellbeing planning and commissioning.
- Highlighting areas where there is a need to improve health and wellbeing outcomes for the local community.
- Identifying groups with a greater or unmet need (vulnerable groups)
- Supporting decision makers to allocate resources.

To ensure that our local Adults JSNA is comprehensive and adequately describes the current and future needs of our local population it has been broken down into a number of individual needs assessments for specific topic areas or population groups. This document assesses the needs of adults living in Redcar and Cleveland in relation to their ‘Self-Harm & Suicide’. This JSNA topic will have links to many other JSNA topic areas and should be read in conjunction with these to give a more detailed assessment of local needs.

WHY IS SELF-HARM & SUICIDE IMPORTANT?

Suicide

Suicide is defined by the Office for National Statistics (ONS) as "a death with an underlying cause of intentional self-harm or an injury or poisoning of undetermined intent". In 2019, there were 5,691 suicides registered in England and Wales.

There is no simple explanation for why someone chooses to die by suicide, and it is rarely due to one particular factor. Factors that lead to suicide are complex but nonetheless preventable. Mental health problems are important influences, as well as alcohol and substance misuse, the current economic climate and welfare reforms, feeling desperate, helpless or without hope.

Suicides are not inevitable; indeed most are preventable (WHO, 2004)

Following a suicide there is an impact across the community and that for each suicide, it can directly affect at least 10 people. Other estimates by Public Health England (PHE) suggest that around 50 people are affected by a suicide.

For each person who dies by suicide it costs the economy an estimated £1.67 million (2009 figures). Which further shows the need for Public Health to address suicide prevention as a key priority.

Self-harm

Self-harm is defined as 'self-poisoning or self-injury, irrespective of the apparent purpose of the act'. Self-harming can take many forms such as cutting/scratching, burning, scalding, hair pulling and ingesting toxic substances or objects. Self-harm isn't always obvious, and can include things that might not think of as self-harm such as over-exercising, misusing drugs or alcohol, not eating, getting into fights or having unsafe sex.

The Children's society annual Good Childhood Report (October 2019), which examines the state of children's well-being in the UK, found that out of the 11,000 children surveyed one in six reported self-harming at 14.

There are many reasons why a person may self-harm including feeling isolated, academic pressures, and suicide or self-harm by someone close to them, low self-esteem, or poor body image, bullying and difficult personal relationships including family issues, trauma, depression or anxiety. In addition, there are a range of risk factors that can impact generally on mental health including deprivation, parental factors, domestic abuse, and school factors.

People who have self-harmed or made a serious attempt at suicide in the past are more likely to do so again and are therefore at much greater risk of dying by suicide in the future.

Other JSNA topics this topic is closely linked to:	
Mental health	Armed forces communities
Employment	Alcohol misuse
Domestic abuse victims	Illicit drug use

WHAT IS THE LEVEL OF NEED?

Suicide

In England and Wales, all suicides are certified by a HM Coroner following an inquest. The death cannot be registered until the inquest is completed, which can take months and sometimes years, therefore providing a delay on the release of information.

Suicide figures are representative of the year in which the death was registered, not necessarily the year in which the death took place.

Where there is insufficient evidence to suggest that an individual did die by suicide an open or narrative verdict is given by HM Coroner. This therefore means that often there is an under reporting of the actual number of suicides that happen within the UK each year.

In 2018 there was a ruling that the standard of proof for recording a suicide would change from the Criminal Standard to the Civil Standard, which aims to address the under reporting of suicide nationally. The Office for National Statistics are conducting a study to review if this change of recording has had an impact on 2019 rates.

In Redcar and Cleveland, the suicide rate was similar to the national average for a number of years, until 2017 – 2019 when there was an increase (Fig 1). See above re change of recording which may have influenced increase in our rates for 2019.

Fig 2 and Fig 3 show that males remain at a significant increase of risk of suicide compared to females.

Self-Harm

In Redcar and Cleveland the admissions rates for intentional self-harm are higher than the national average (Fig 4, Fig 5 and Fig 6)

It is worth noting that the recording of self-harm over the years has apparently been misleading and Pubic Health England reports that the large rise they suggest probably reflects improved data collection. In contrast to the trends in completed suicide, the incidence of self-harm has continued to rise in the UK over the past 20 years. It is worth noting that self-harm rates across the whole of Teesside and the North East in general are higher than the national average.

Hospital admissions for self-harm in children have increased in recent years, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.

Teesside Audit

The Tees Suicide Prevention Coordinator who is part of Tees Public Health Local Authorities is responsible for producing an annual suicide audit based on coroner inquest data.

In 2021, an audit was undertaken using Coroners records to gather information regarding local suicide data for year August 2019 – July 2020. Please note, owing to the COVID-19 pandemic there was a timescale when the Coroners offices were not conducting inquests, which impacted on the number of cases included in the local audit.

The local audit found the following themes identified and recorded as contributory factors. In 70% of cases, two or more of these themes recorded:

- Poor mental health
- Bereavement
- Financial issues
- Relationship issues/breakdown
- Recent involvement with the criminal justice system

From the coroner data, it found:

- 80% of deaths were within the home
- 20% of the deaths were in a public space
- Rates for men is quadruple the suicide rate for females (chart 1)

The audit highlights the need for agencies to work together on this key issue to provide points of potential intervention at an earlier stage to identify suicidal ideation as still most deaths occur in a place where there is minimal opportunity for intervention.

Tees early alert data contributes to the regional and national real time data surveillance programme for suspected suicides to enable collective response to emerging national trends.

Chart 1: To show that in Redcar & Cleveland the suicide rate for males is quadruple the suicide rate for females.

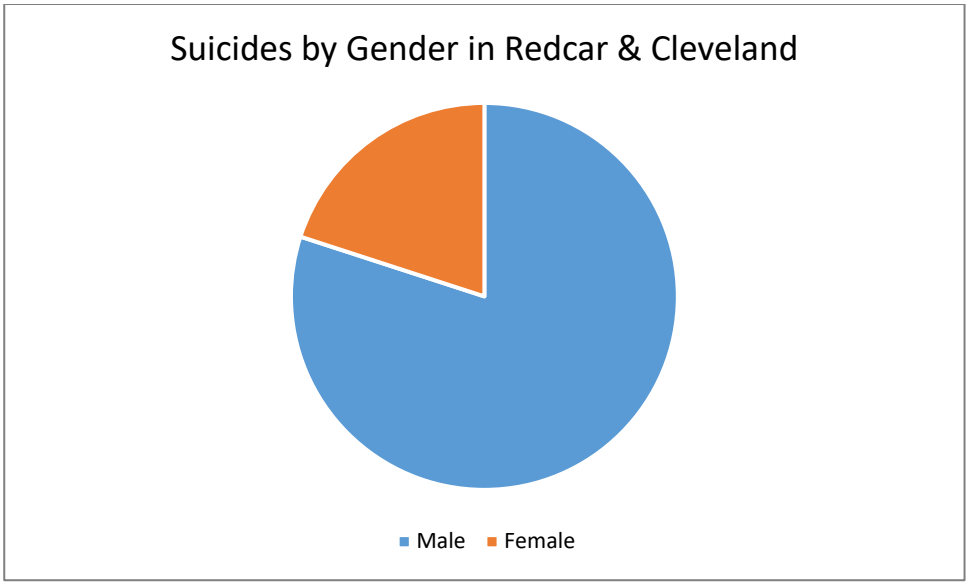
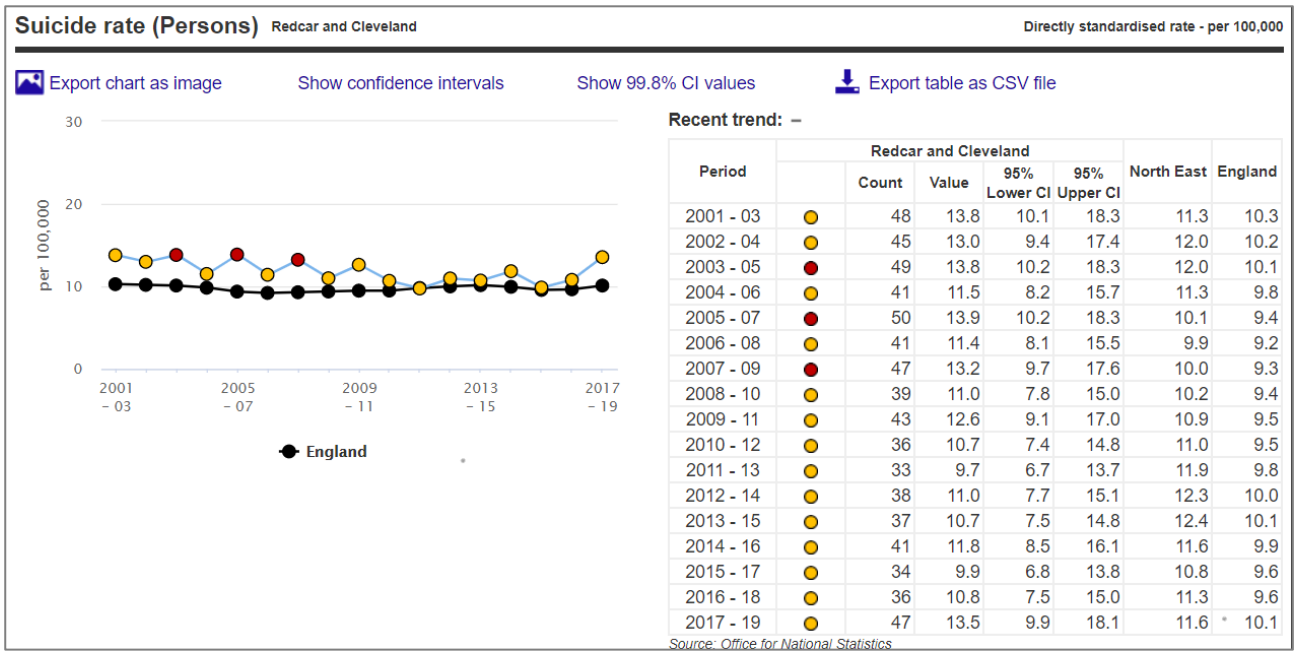


Figure 1: To show the suicide rate is similar to the national average for a number of years until 2017 – 2019 then there is an increase.



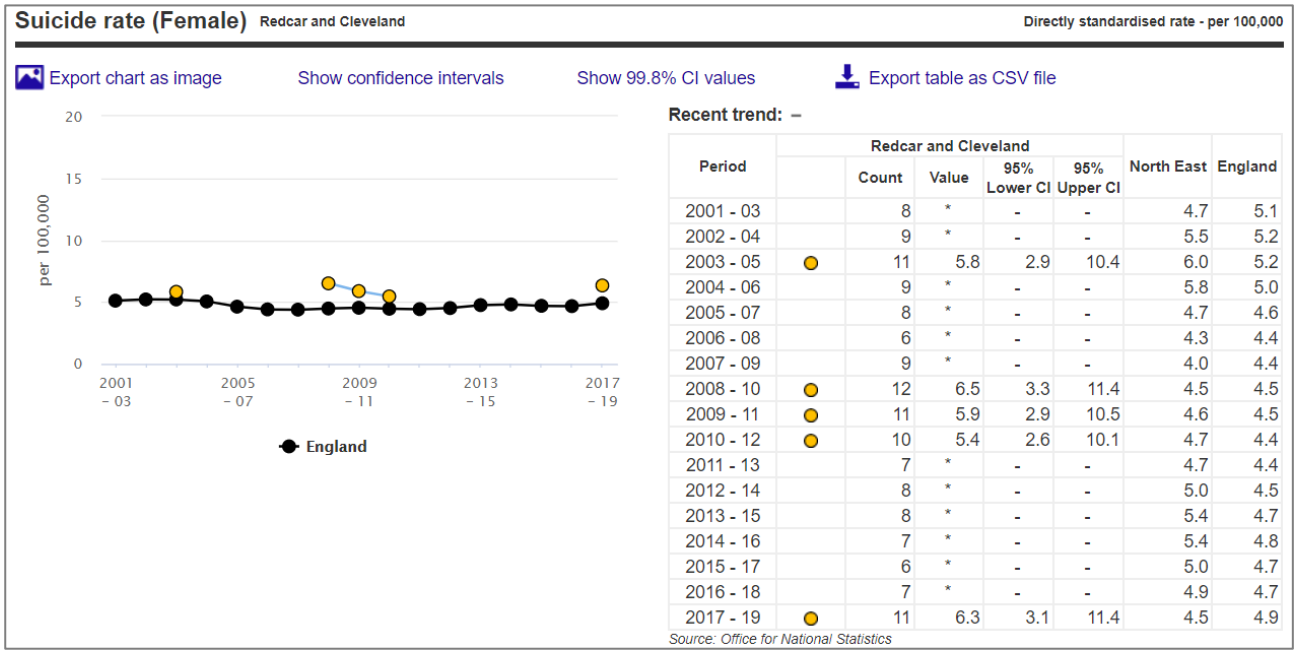
Recent trend: –

Period		Redcar and Cleveland				North East	England
		Count	Value	95% Lower CI	95% Upper CI		
2001 - 03	●	48	13.8	10.1	18.3	11.3	10.3
2002 - 04	●	45	13.0	9.4	17.4	12.0	10.2
2003 - 05	●	49	13.8	10.2	18.3	12.0	10.1
2004 - 06	●	41	11.5	8.2	15.7	11.3	9.8
2005 - 07	●	50	13.9	10.2	18.3	10.1	9.4
2006 - 08	●	41	11.4	8.1	15.5	9.9	9.2
2007 - 09	●	47	13.2	9.7	17.6	10.0	9.3
2008 - 10	●	39	11.0	7.8	15.0	10.2	9.4
2009 - 11	●	43	12.6	9.1	17.0	10.9	9.5
2010 - 12	●	36	10.7	7.4	14.8	11.0	9.5
2011 - 13	●	33	9.7	6.7	13.7	11.9	9.8
2012 - 14	●	38	11.0	7.7	15.1	12.3	10.0
2013 - 15	●	37	10.7	7.5	14.8	12.4	10.1
2014 - 16	●	41	11.8	8.5	16.1	11.6	9.9
2015 - 17	●	34	9.9	6.8	13.8	10.8	9.6
2016 - 18	●	36	10.8	7.5	15.0	11.3	9.6
2017 - 19	●	47	13.5	9.9	18.1	11.6	10.1

Source: Office for National Statistics

In 2017 – 2019, the suicide rate saw an increase to 13.5 per 100,000 population, 13.5% that was higher than the North East and England average.

Figure 2: To show suicide rate for females (6.3/100,000)

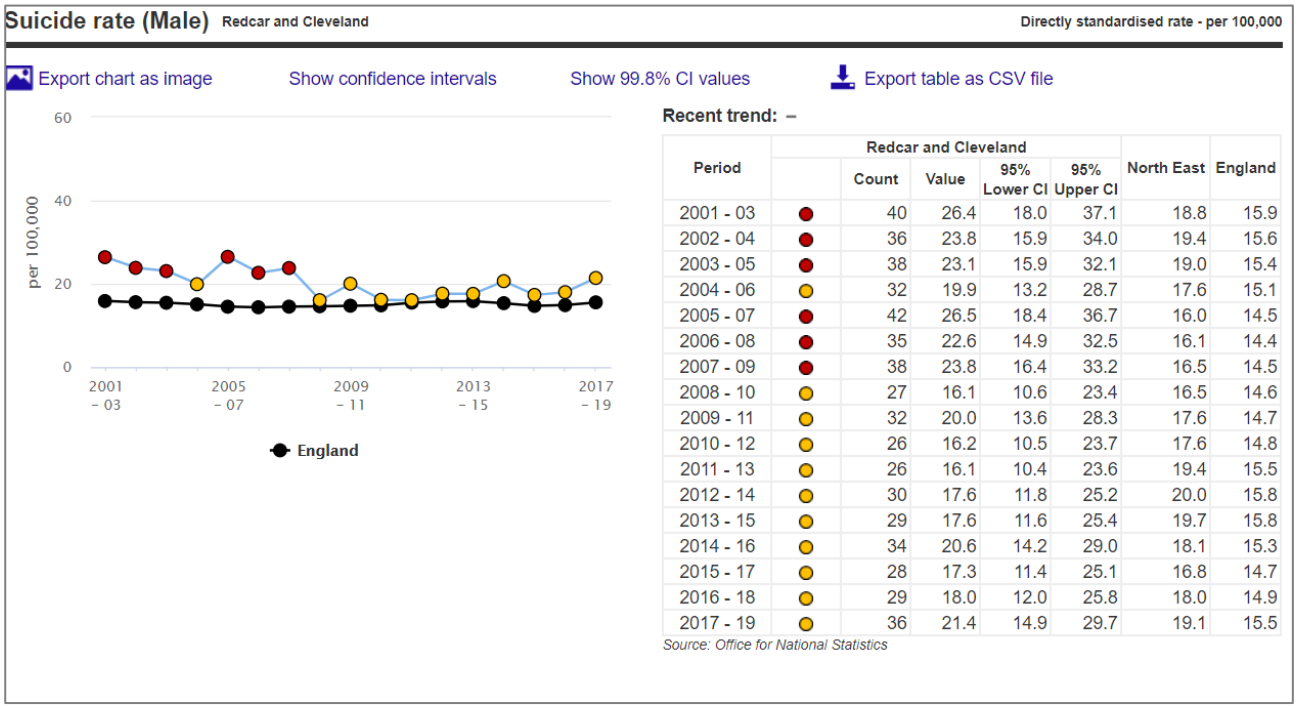


Recent trend: –

Period		Redcar and Cleveland				North East	England
		Count	Value	95% Lower CI	95% Upper CI		
2001 - 03		8	*	-	-	4.7	5.1
2002 - 04		9	*	-	-	5.5	5.2
2003 - 05	●	11	5.8	2.9	10.4	6.0	5.2
2004 - 06		9	*	-	-	5.8	5.0
2005 - 07		8	*	-	-	4.7	4.6
2006 - 08		6	*	-	-	4.3	4.4
2007 - 09		9	*	-	-	4.0	4.4
2008 - 10	●	12	6.5	3.3	11.4	4.5	4.5
2009 - 11	●	11	5.9	2.9	10.5	4.6	4.5
2010 - 12	●	10	5.4	2.6	10.1	4.7	4.4
2011 - 13		7	*	-	-	4.7	4.4
2012 - 14		8	*	-	-	5.0	4.5
2013 - 15		8	*	-	-	5.4	4.7
2014 - 16		7	*	-	-	5.4	4.8
2015 - 17		6	*	-	-	5.0	4.7
2016 - 18		7	*	-	-	4.9	4.7
2017 - 19	●	11	6.3	3.1	11.4	4.5	4.9

Source: Office for National Statistics

Figure 3: To show the suicide rate of males (21.4/100,000)



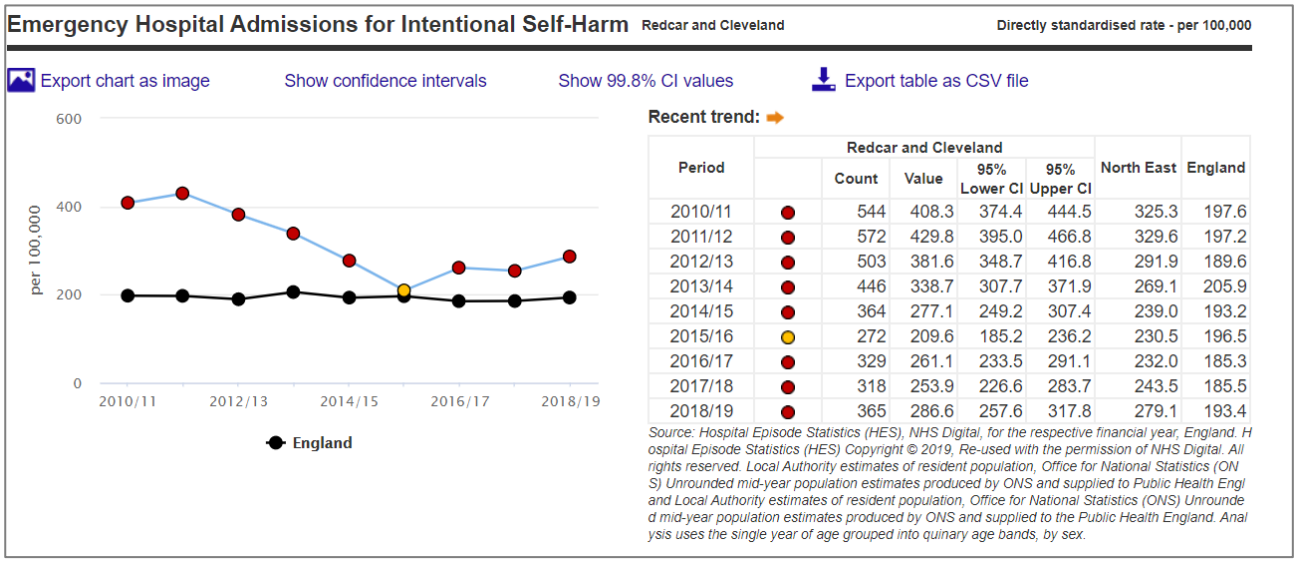
Recent trend: –

Period		Redcar and Cleveland Count	Value	95% Lower CI	95% Upper CI	North East	England
2001 - 03		40	26.4	18.0	37.1	18.8	15.9
2002 - 04		36	23.8	15.9	34.0	19.4	15.6
2003 - 05		38	23.1	15.9	32.1	19.0	15.4
2004 - 06		32	19.9	13.2	28.7	17.6	15.1
2005 - 07		42	26.5	18.4	36.7	16.0	14.5
2006 - 08		35	22.6	14.9	32.5	16.1	14.4
2007 - 09		38	23.8	16.4	33.2	16.5	14.5
2008 - 10		27	16.1	10.6	23.4	16.5	14.6
2009 - 11		32	20.0	13.6	28.3	17.6	14.7
2010 - 12		26	16.2	10.5	23.7	17.6	14.8
2011 - 13		26	16.1	10.4	23.6	19.4	15.5
2012 - 14		30	17.6	11.8	25.2	20.0	15.8
2013 - 15		29	17.6	11.6	25.4	19.7	15.8
2014 - 16		34	20.6	14.2	29.0	18.1	15.3
2015 - 17		28	17.3	11.4	25.1	16.8	14.7
2016 - 18		29	18.0	12.0	25.8	18.0	14.9
2017 - 19		36	21.4	14.9	29.7	19.1	15.5

Source: Office for National Statistics

The above data shows the breakdown between males and females, and follows the national trends of male suicides being significantly higher than female suicide. In the period 2017/19, the percentage rates were 76% Male and 24% female.

Figure 4: To show the emergency admissions rates for intentional self-harm.



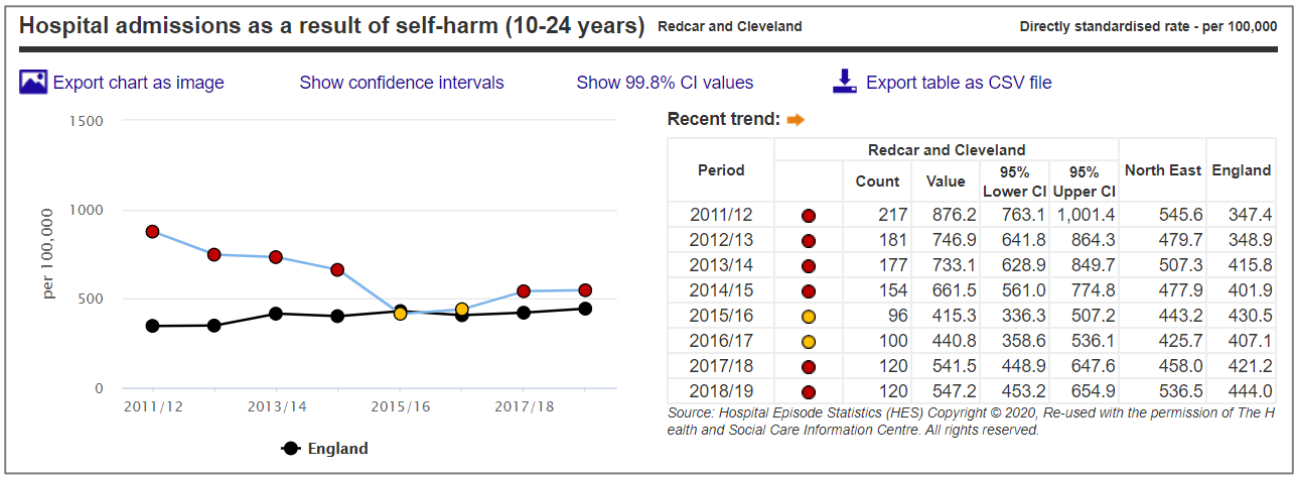
Recent trend: ➡

Period		Redcar and Cleveland Count	Value	95% Lower CI	95% Upper CI	North East	England
2010/11		544	408.3	374.4	444.5	325.3	197.6
2011/12		572	429.8	395.0	466.8	329.6	197.2
2012/13		503	381.6	348.7	416.8	291.9	189.6
2013/14		446	338.7	307.7	371.9	269.1	205.9
2014/15		364	277.1	249.2	307.4	239.0	193.2
2015/16		272	209.6	185.2	236.2	230.5	196.5
2016/17		329	261.1	233.5	291.1	232.0	185.3
2017/18		318	253.9	226.6	283.7	243.5	185.5
2018/19		365	286.6	257.6	317.8	279.1	193.4

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2019, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to Public Health England and Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

The rate of emergency hospital admissions for intentional self-harm in Redcar and Cleveland is statistically significantly higher than the national average. This has been the case for a number of years.

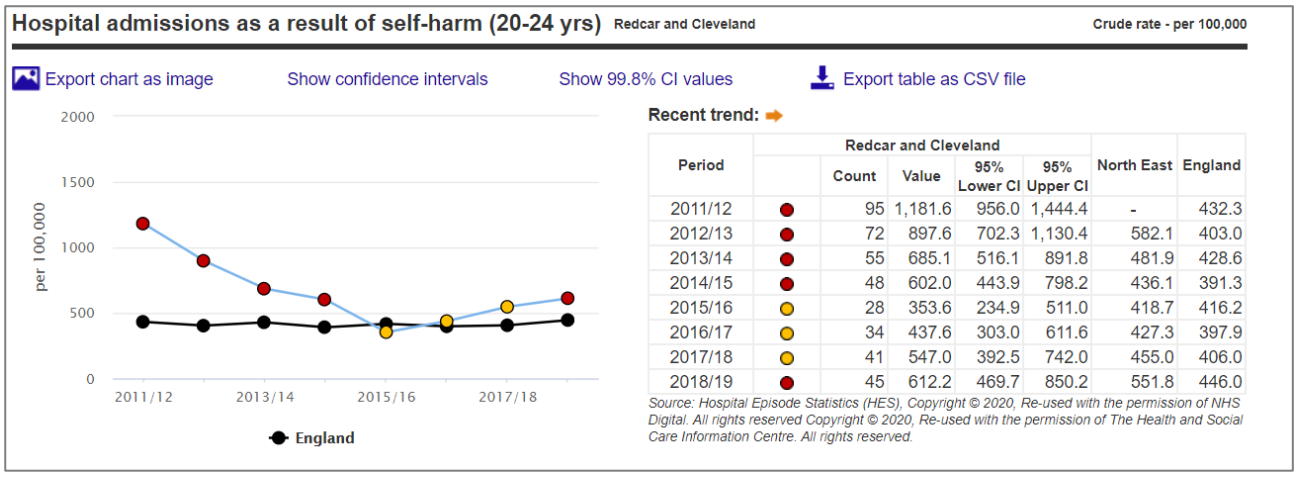
Figure 5: To show the hospital admissions rates for intentional self-harm for 10-24 year olds.



Period		Redcar and Cleveland				North East	England
		Count	Value	95% Lower CI	95% Upper CI		
2011/12		217	876.2	763.1	1,001.4	545.6	347.4
2012/13		181	746.9	641.8	864.3	479.7	348.9
2013/14		177	733.1	628.9	849.7	507.3	415.8
2014/15		154	661.5	561.0	774.8	477.9	401.9
2015/16		96	415.3	336.3	507.2	443.2	430.5
2016/17		100	440.8	358.6	536.1	425.7	407.1
2017/18		120	541.5	448.9	647.6	458.0	421.2
2018/19		120	547.2	453.2	654.9	536.5	444.0

The rate of hospital admissions as a result of self-harm (10-24 years) in Redcar and Cleveland is statistically significantly higher than the national average. This has been the case for a number of years.

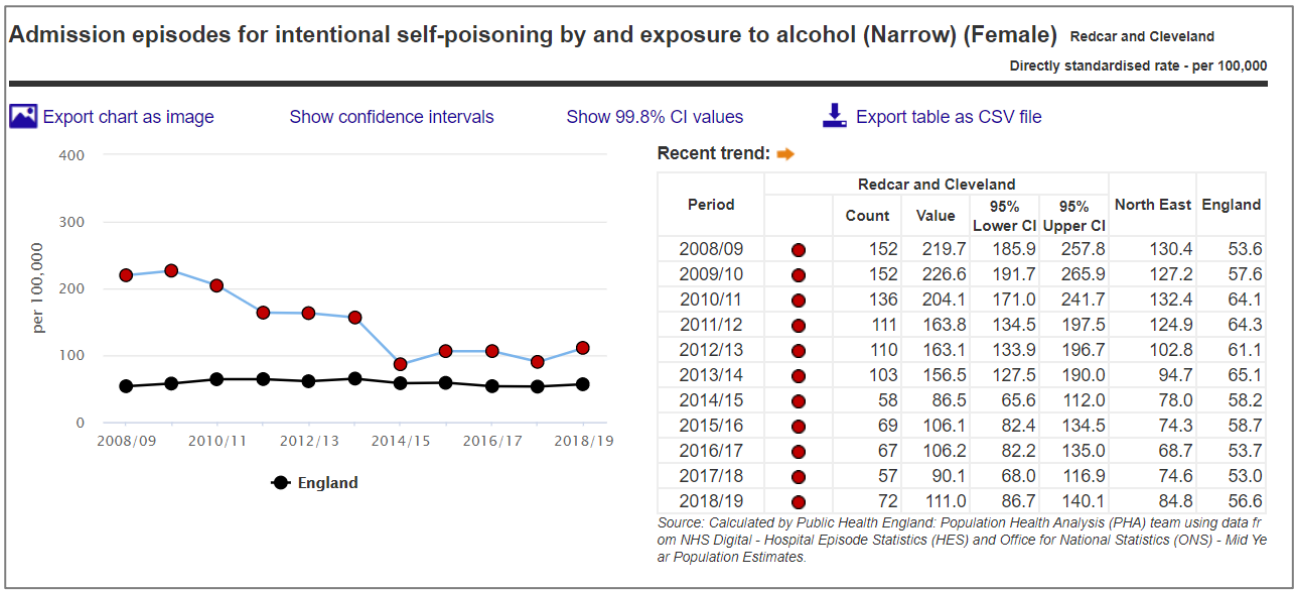
Figure 6: To show the hospital admissions rates for intentional self-harm for 20-24 year olds.



Period		Redcar and Cleveland				North East	England
		Count	Value	95% Lower CI	95% Upper CI		
2011/12		95	1,181.6	956.0	1,444.4	-	432.3
2012/13		72	897.6	702.3	1,130.4	582.1	403.0
2013/14		55	685.1	516.1	891.8	481.9	428.6
2014/15		48	602.0	443.9	798.2	436.1	391.3
2015/16		28	353.6	234.9	511.0	418.7	416.2
2016/17		34	437.6	303.0	611.6	427.3	397.9
2017/18		41	547.0	392.5	742.0	455.0	406.0
2018/19		45	612.2	469.7	850.2	551.8	446.0

In period 2011/15, Redcar and Cleveland followed national trends on hospital admissions as a result of self-harm (20-24year olds). Period 2018/19 saw an increase with Redcar and Cleveland higher than national average.

Figure 7: To show the admissions episodes for self poisoning by and exposure to alcohol for females.

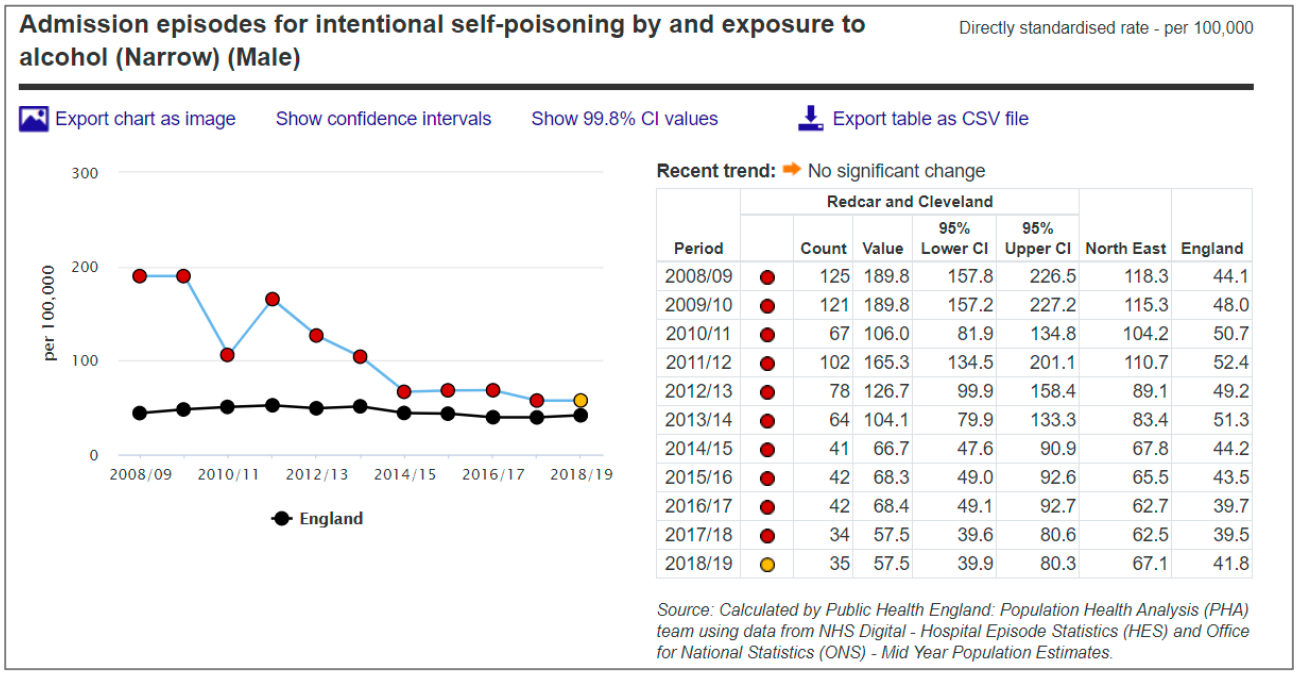


Recent trend:

Period		Redcar and Cleveland				North East	England
		Count	Value	95% Lower CI	95% Upper CI		
2008/09		152	219.7	185.9	257.8	130.4	53.6
2009/10		152	226.6	191.7	265.9	127.2	57.6
2010/11		136	204.1	171.0	241.7	132.4	64.1
2011/12		111	163.8	134.5	197.5	124.9	64.3
2012/13		110	163.1	133.9	196.7	102.8	61.1
2013/14		103	156.5	127.5	190.0	94.7	65.1
2014/15		58	86.5	65.6	112.0	78.0	58.2
2015/16		69	106.1	82.4	134.5	74.3	58.7
2016/17		67	106.2	82.2	135.0	68.7	53.7
2017/18		57	90.1	68.0	116.9	74.6	53.0
2018/19		72	111.0	86.7	140.1	84.8	56.6

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Figure 8: To show the admissions episodes for self poisoning by and exposure to alcohol for males.



Recent trend: No significant change

Period		Redcar and Cleveland				North East	England
		Count	Value	95% Lower CI	95% Upper CI		
2008/09		125	189.8	157.8	226.5	118.3	44.1
2009/10		121	189.8	157.2	227.2	115.3	48.0
2010/11		67	106.0	81.9	134.8	104.2	50.7
2011/12		102	165.3	134.5	201.1	110.7	52.4
2012/13		78	126.7	99.9	158.4	89.1	49.2
2013/14		64	104.1	79.9	133.3	83.4	51.3
2014/15		41	66.7	47.6	90.9	67.8	44.2
2015/16		42	68.3	49.0	92.6	65.5	43.5
2016/17		42	68.4	49.1	92.7	62.7	39.7
2017/18		34	57.5	39.6	80.6	62.5	39.5
2018/19		35	57.5	39.9	80.3	67.1	41.8

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

The rates for self-poisoning and exposure to alcohol follows the national trend of being higher in females. In 2018/19, 71% were females and 29% male.

WHAT ARE WE CURRENTLY DOING?

Service Pathways

Community

- Teesside Samaritans – providing 24/7 support to those in distress, working with schools and business to provide training and support for both suicide prevention and postvention.
- A wide range of voluntary and community sector (VCS) organisations that support individuals to improve emotional wellbeing and mental health.
- Job Centre Plus – each site has a 'Complex Needs plan' which is accessible to all work coaches. The plans vary by site depending on what local resources are available. The plan has information to signpost and support our most vulnerable adults including Mental Health, Homelessness, Disability, Forces Community, Addictions, Debt, feeling Suicidal/Self-harm, ex offender etc. Each JCP work coach working with customers in front facing roles have attended a two-day Mental Health awareness training.
- Adult Social Care – Social Workers/ Social Care Officers offer Strength based assessment, and develop support plans in partnership with Adults. The plans may vary by complexity and may include information to signpost and support adults including community support, Mental Health / Suicidal/Self-harm ideation, Autism, Learning Disabilities, Homelessness, ex Forces, Addictions, Debt management /Poverty, etc.
- Citizens Advice- 'Help Through Crisis' scheme supporting those going through financial crisis to support their emotional wellbeing.
- CRUSE – Bereavement service, including specialist suicide bereavement postvention support.
- Redcar and Cleveland Mind – promote good mental health for all and provide wellbeing, prevention, and recovery. They are part of the Mind Network.
- Tees Mental Health Training hub – This offers the community and professionals a variety of accredited and non-accredited mental health training courses and promotion of evidence-based programmes.
- A wide range of Community Mental Health and Wellbeing Support Services. Recognizing that mental health and wellbeing are often interrelated with organisations that provide specialist and non-specialist support e.g., domestic abuse, substance misuse, befriending, carer support etc.
- Cross sector of agencies promoting national and regional mental health and suicide prevention campaigns at a local level (Suicide Prevention Awareness Week; World Mental Health Day; Mental Health Awareness Week)

Primary care:

- GP practice assessment, support and treatment.
- Social Prescribing support within Primary Care Networks

Secondary care & specialist services:

- Tees Esk & Wear Valley Mental Health Foundation Trust
- Community Mental Health Services

- Adult and Older People's Mental Health Social Work Services
- Criminal Justice Services
- NHS Acute Hospitals
- Child & Adolescent Mental Health Services (CAMHS)
- Crisis Service (TEWV) – Single point of access (24 hr phone line); Crisis Assessment Suite & Crisis Intervention
- Liaison Psychiatry
- Substance Misuse Services
- Tees Psychological Wellbeing and Therapy (16+) Service Model - IMPACT

Workplaces

The Better Health at Work Award Programme promotes good emotional wellbeing and mental health within the standards of the award.

Partnerships

Tees Suicide Prevention Taskforce

As part of the ***cross-government report,*** it was recommended that all local authorities had a suicide prevention plan in place. This led to the formation of the Tees Suicide Prevention Taskforce and development of an annual action plan within this are key priority areas:

- Sustain current funding for the Tees Suicide Prevention Taskforce (TSPT) Group and activities.
- Reduce the risk of suicide in key high – risk groups.
- Tailor Approaches to improve mental health in specific groups.
- Reduce access to the means of suicide.
- Provide better information and support to those bereaved or affected by suicide.
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
- Support research, data collection and monitoring.
- The Action Plan is adopted and delivered by a Tees Suicide Prevention Taskforce – multiagency working group to collectively work together to reduce suicides.

Local and regional partnership that support suicide prevention agenda

- Tees Mental Health and Wellbeing Alliance (prevention to crisis)
- North East and North Cumbria (NENC) Suicide Prevention Integrated Care System (ICS).
- Redcar & Cleveland Trio of Risk C19 Group (mental health/substance misuse/domestic abuse)

Programmes

Standard Operating procedure/pathway

In 2020 a Standard Operating Procedure across Tees was developed. This facilitates the sharing of suspected suicide information with relevant parties. This procedure includes the process for managing a local response to multiple suicides or cluster suicides.

In 2020 a Postvention Pathway was developed, resulting in a targeted marketing campaign with Cleveland Police who would attend suspected suicides to ensure that they had all the information available for the local suicide postvention provider.

WHAT WOULD WE LIKE TO ACHIEVE?

The Cross-Government National Suicide Prevention Strategy for England was published in 2012. The National Strategy committed to tackling suicide in six key areas for action, with the scope of the strategy now expanded to include addressing self-harm as a new key area:

- Reducing the risk of suicide in high-risk groups.
- Tailoring approaches to improve mental health in specific groups.
- Reducing access to means of suicide.
- Providing better information and support to those bereaved or affected by suicide.
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviours.
- Supporting research, data collection and monitoring.
- Reducing rates of self-harm as a key indicator of suicide risk.

The National Strategy identified the following high-risk groups:

- Young and middle-aged men.
- People in care of mental health services, including inpatients.
- People in contact with criminal justice system.
- Specific occupational groups, such as health care, farmers, veterinary workers.
- People with a history of self-harm.

The survey by the All Party Parliamentary Group on Suicide Prevention published in January 2015 and Five Year Forward View for Mental Health recommended that all local authorities have multi-agency suicide prevention plans in place to provide the co-operation and focus necessary to deliver effective suicide prevention interventions that are tailored to local needs (Ref: Preventing suicide in England: Third progress report of the cross government outcomes strategy to save lives.)

A Tees Suicide Prevention Multi-agency taskforce seeks to drive local implementation of the National Strategy and coordinate partnership working in Teesside, ensuring that prevention is everyone's business. The Taskforce brings together key partners, local knowledge about groups at higher risk of suicide, applying the evidence of most effective interventions and most importantly highlighting the resources needed to implement these plans in a way that reflects local population needs.

The North East and North Cumbria ICS Suicide Prevention priority work streams are:

- System wide competency
- Real time alerts and postvention support
- Learning from incidents
- Targeting high risk groups and locations
- Developing safer services
- Developing suicide safer communities

This has led to the Every Life Matters 3 key messages: Look after yourself, Look out for others and Get help early.

WHAT DO LOCAL PEOPLE SAY?

In October 2019 an Annual Suicide Prevention Event – 'Solutions to Suicide Prevention' was attended by a wide range of organisations across Teesside to contribute to views about local challenges and gain an understanding of local support services, including community grassroots projects.

Personal wellbeing

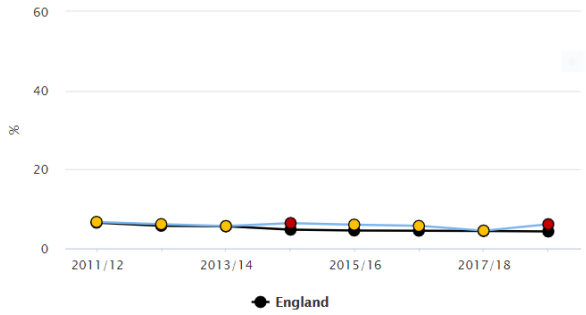
We can see in the charts below taken from PHE fingertips – suicide profile for Redcar & Cleveland that residents are reporting higher than England and North East average for low satisfaction, are similar in terms of scoring for low worthwhile and low happiness but are marginally better for high anxiety scoring. Trends for our locality over the years have not significantly changed.

Figure 9: To show self reported low satisfaction scores

Self-reported wellbeing - people with a low satisfaction score

Proportion - %

Export chart as image | Show confidence intervals | Show 99.8% CI values | Export table as CSV file



Recent trend: Could not be calculated

Period		Redcar and Cleveland Count	Value	95% Lower CI	95% Upper CI	North East	England
2011/12	●	-	6.7%	5.0%	8.4%	6.5%	6.5%
2012/13	●	-	6.1%	4.5%	7.7%	6.7%	5.7%
2013/14	●	-	5.7%	4.2%	7.2%	6.3%	5.6%
2014/15	●	-	6.4%	4.8%	8.1%	6.0%	4.7%
2015/16	●	-	6.0%	4.4%	7.6%	5.3%	4.6%
2016/17	●	-	5.7%	3.8%	7.6%	5.1%	4.5%
2017/18	●	-	4.5%	2.9%	6.1%	5.0%	4.4%
2018/19	●	-	6.1%	4.4%	7.8%	5.4%	4.3%

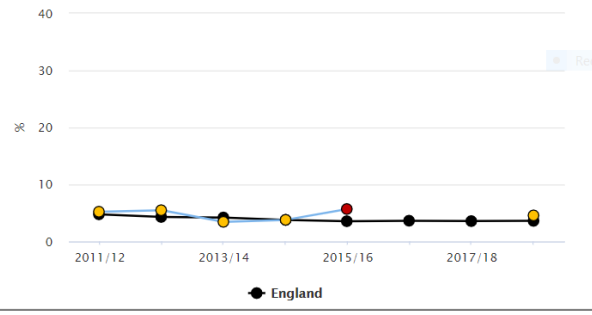
Source: Annual Population Survey (APS); Office for National Statistics (ONS).

Figure 10: To show self reported low worthwhile scores

Self-reported wellbeing - people with a low worthwhile score

Proportion - %

Export chart as image | Show confidence intervals | Show 99.8% CI values | Export table as CSV file



Recent trend: Could not be calculated

Period		Redcar and Cleveland Count	Value	95% Lower CI	95% Upper CI	North East	England
2011/12	●	-	5.2%	3.8%	6.6%	5.2%	4.8%
2012/13	●	-	5.5%	3.9%	7.1%	5.4%	4.3%
2013/14	●	-	3.4%	2.2%	4.7%	4.9%	4.2%
2014/15	●	-	3.8%	2.6%	5.0%	4.7%	3.8%
2015/16	●	-	5.7%	4.1%	7.3%	4.3%	3.6%
2016/17		-	*	-	-	4.2%	3.6%
2017/18		-	*	-	-	4.0%	3.6%
2018/19	●	-	4.6%	3.1%	6.1%	4.5%	3.6%

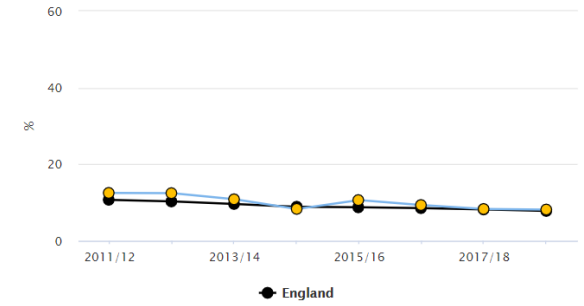
Source: Annual Population Survey (APS); Office for National Statistics (ONS).

Figure 11: To show self reported low happiness scores

Self-reported wellbeing - people with a low happiness score

Proportion - %

Export chart as image | Show confidence intervals | Show 99.8% CI values | Export table as CSV file



Recent trend: Could not be calculated

Period		Redcar and Cleveland Count	Value	95% Lower CI	95% Upper CI	North East	England
2011/12		-	12.5%	10.3%	14.8%	11.9%	10.7%
2012/13		-	12.5%	10.1%	14.8%	12.3%	10.3%
2013/14		-	10.9%	8.6%	13.1%	11.6%	9.6%
2014/15		-	8.3%	6.5%	10.2%	10.7%	8.9%
2015/16		-	10.6%	8.5%	12.8%	10.2%	8.8%
2016/17		-	9.4%	7.0%	11.7%	8.7%	8.5%
2017/18		-	8.3%	6.2%	10.5%	9.1%	8.2%
2018/19		-	8.2%	6.0%	10.3%	9.7%	7.8%

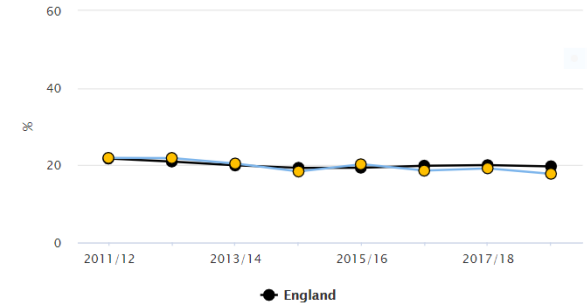
Source: Annual Population Survey (APS); Office for National Statistics (ONS).

Figure 12: To show self reported high anxiety scores

Self-reported wellbeing - people with a high anxiety score

Proportion - %

Export chart as image | Show confidence intervals | Show 99.8% CI values | Export table as CSV file



Recent trend: Could not be calculated

Period		Redcar and Cleveland Count	Value	95% Lower CI	95% Upper CI	North East	England
2011/12		-	21.9%	19.1%	24.7%	23.4%	21.7%
2012/13		-	21.9%	19.1%	24.6%	22.4%	21.0%
2013/14		-	20.4%	17.7%	23.2%	21.4%	20.0%
2014/15		-	18.4%	15.8%	21.0%	22.1%	19.3%
2015/16		-	20.2%	17.3%	23.2%	21.4%	19.4%
2016/17		-	18.6%	15.7%	21.6%	19.8%	19.9%
2017/18		-	19.2%	16.2%	22.2%	20.1%	20.0%
2018/19		-	17.8%	15.0%	20.6%	20.2%	19.7%

Source: Annual Population Survey (APS); Office for National Statistics (ONS).

WHAT ARE THE KEY ISSUES & CHALLENGES?

Strategic issues

Suicide is complex and multi-faceted and there is never one single factor which leads to suicide, often there are many different issues ongoing. Suicide is often the end point of a complex pattern of risk factors and distressing events, and the prevention of suicide has to address this complexity.

A global pandemic in 2020 that has led to dramatic and immediate changes to our way of life, coupled with deep uncertainty about the future has inevitably affected our mental health.

Almost half of the population of Great Britain (49.6%) reported high levels of anxiety at the start of lockdown, compared with 21% in the last quarter of 2019 (Ref: ONS people, population and community wellbeing article named “coronavirus and anxiety, GB).

A survey of psychiatrists found a 43% increase in urgent and emergency mental health cases.

Around half a million more people in the UK will experience a mental health difficulty over the next year as a result of the pandemic, according to an estimate from the Centre for Mental Health. This has led to Psychiatrists and the World Health Organisation warning of an unprecedented increase in mental health referrals following the Covid-19 pandemic.

Not everyone is at equal risk however, and in recent months, anxiety levels in the UK have fallen as many people adjust to this ‘new normal’. The Tees area has been in Tier 3 and has seen significant restrictions placed on its population. Previous research indicated that large-scale pandemics are almost always accompanied by short, medium and long-term impact on mental health.

Suicide disproportionately affects residents of the most deprived areas compared with the least deprived areas.

Suicide affects those in the care of mental health services at a higher rate. It was found that nationally almost 90% of people who died by suicide had a diagnosed mental health condition, most notably a depressive disorder.

Certain factors are known to be associated with increased risk of suicide, which may fall into one of three categories – individual, socio-cultural and situational. These include:

- Autistic adults
- Drug and alcohol misuse
- Family breakdown
- Gambling
- History of trauma or abuse
- Imprisonment

- People living with a long-term condition or persistent physical symptoms
- Poor social conditions
- Poverty
- Social isolation
- Those from the LGBT community
- Those with a history of self-harm
- Unemployment
- Veterans
- Violence
- Bereaved by suicide

Self-Harm

Anyone can self-harm, but it is more common in:

- Women and girls
- Young people
- People with a mental health problem such as depression, anxiety, borderline personality disorder or an eating disorder
- LGBTQI+ people, possibly because of the stress of stigma and discrimination
- Prisoners, asylum seekers and veterans of the armed forces
- People who experienced abuse as a child
- People who have been bereaved by suicide

While there are no studies that show the correlation between socioeconomic status and self-harm, it is known that mental health disorders and emotional disorders are more prevalent within those from the most deprived areas, and self-harm is more common in those who have mental health and emotional disorders. Therefore, self-harm could be more prevalent within those from the more deprived communities

The impact of harmful suicide and self-harm content online - Social media platforms are difficult to monitor and can contain harmful or incorrect content.

We only have data for hospital admissions for self-harm. Not all cases of self-harm present to health services.

Unmet Needs

There is ongoing collaboration work about sharing Information in relation to self-harm and attempted suicides with Cleveland Police Negotiating Team and the North East Ambulance Service.

Those who have the potential to take their own life access a wide range of services (not just mental health services), therefore, we must ensure that all relevant services recognise and target high-risk groups.

Concern regarding sustainability of some community VCS providers to deliver suicide prevention interventions and support.

A local workforce equipped with the skills, knowledge to recognise, and signpost to support

Unclear if local workforce for Children and Young have knowledge, understanding of self-harm, and pathways.

Although the Tees Suicide Prevention Taskforce is widely represented by key stakeholders, there is not full engagement with key areas for action in the Suicide Prevention Implementation Plan.

Currently we do not have enough data to fully understand the issues and true picture around self-harm and there is no information sharing agreement in place to consult with relevant partners.

The Information Sharing Agreement for Suicides is not widely adopted across services, which would ensure that we gain information from a wider range of partners in addition to the traditional reporting mechanisms.

Time limited funding to provide information and support to those bereaved or affected by suicide.

WHAT ARE THE OPPORTUNITIES AND RECOMMENDATIONS?

What needs to be done and why?

What	Why
1.A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play to prevent suicide and self-harm	Suicide is multi-faceted there is never one single factor which leads to suicide, often there are many different issues ongoing. Only 1 in 6 people were accessing mental health services at their time of death – further work needs to be undertaken to review if these people were accessing other services, e.g., social care, probation, DWP etc. to understand other points of intervention.

	All services across the Tees area should be able to support or signpost individuals who present at risk of suicide. A range of different agencies should be signed up to the work of the Tees Suicide Prevention Taskforce. Suicide prevention should be classed as everybody's business. To address the wider determinants of health and wellbeing. Those who have the potential to take their own life access a wide range of services (not just mental health services), therefore, we must ensure that all relevant services recognise and target high-risk groups. Correct policies and practices should be in place to support any individuals at risk of suicide, and relevant services should engage with the Tees Suicide Prevention Taskforce.
2. Explore the implementation of a data sharing agreement (which all relevant parties sign) to support the gathering of information from a wide range of sources to understand the true impact of suicide and self-harm across Redcar and Cleveland.	To investigate the true prevalence of self-harm within Redcar & Cleveland by developing an information sharing agreement to gather information and data regarding self-harm which does not lead to a presentation at A&E. Work to review the pathways and support that follows on following self-harm to ensure that those who report that they have self-harmed are engaged with support. Link in with the National Suicide Prevention alliance 'Lived Experience Influencer programme'. That aim to train and support people with lived experience to assist in influencing policy and practice both regionally and nationally. To ensure that we consult with the relevant stakeholders to further understand the true impact of suicide and self-harm.
3. To increase mental health knowledge and skills across a range of settings and target training to organisations most likely to meet those most at risk of poor mental health.	Services across the area should be able to support or signpost individuals who present at risk of suicide. Building the capacity and capability across our workforce to prevent mental health problems and promote good mental health within their everyday practice. Do we have a local workforce with the capacity and capability to respond to emerging mental health and wellbeing needs? The COVID-19 response has impacted on the way that society naturally signposts and identifies

	mental health need in those around us, due to changes to work places, GP services, schools, family and friends and support groups. This may be compounded by changes to services delivery methods, accessibility, and availability.
4. To provide information and support to those bereaved or affected by suicide.	Ensure there is sufficient postvention support to reduce future suicides and that those in need have easy access to the information when they are ready to seek support. Strengthen links between key services to ensure dissemination of timely information and support to those bereaved or affected by suicide.

REFERENCES

Public Health England (PHE)

National Institute for Health and Care Excellence (NICE)

Government Office for Health & Social Care

Mental Health Foundation (MHF)

Samaritans

All Party Parliamentary Group (APPG)

Office for National Statistics (ONS)

Local Suicide Prevention Planning: a practice resource

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf

Preventing suicide in community and custodial settings

https://www.nice.org.uk/guidance/ng105

Preventing suicide in England: Third progress report of the cross government outcomes strategy to save lives

https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

Socioeconomic disadvantage and suicidal behaviour

https://www.samaritans.org/sites/default/files/kcfinder/files/Socioeconomic%20disadvantage%20and%20suicidal%20behaviour%20-%20full%20report.pdf

Inquiry into local suicide prevention plans in England

https://www.samaritans.org/sites/default/files/kcfinder/files/APPG%20SUICIDE%20REPORT%2020012015.pdf

Suicides in the United Kingdom

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

https://www.ncbi.nlm.nih.gov/pubmed/21834185

Truth hurts- report of the National Inquiry into self-harm among young people.

https://www.mentalhealth.org.uk/publications/truth-hurts-report1/

Self-harm in over 8s: long-term management

https://www.nice.org.uk/Guidance/CG133

NIHCE: Multi-disciplinary gguidelines to advise on the prevention of self-harm in primary and secondary care.

MHF: An overview of evidence regarding what self-harm is, how to respond to self-harm and plans, which can be put in place to prevent this.

NIHCE: Reviewing the role of a range of different organizations, those who self-harm and their carers to prevent self-harm.

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