NOBODY LEFT BEHIND: GOOD HEALTH AND A STRONG ECONOMY

THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH IN LEEDS 2017/18

Leeds CITY COUNCIL

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We welcome feedback about our annual report or any of our other documents. If you have any comments please speak to Kathryn Jeffreys, Business Partner Manager on 0113 3789221 or on Kathryn.jeffreys@leeds.gov.uk

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Ian Cameron
Director of Public Health

FOREWORD

Welcome to my latest Public Health Annual Report for Leeds.

I am very aware how privileged I am to have the opportunity to produce an Annual Report. Last year, in celebration of 150 years of Medical Officers of Health (now Director of Public Health), I told the story of Public Health in Leeds through the Annual Reports of my predecessors, going all the way back to 1866. I'm grateful for the level of interest that resulted. I hope the filmed lecture and resources will help future generations and my thanks go to the Thackray Medical Museum for their Public Health Trail.

However, I am also privileged in that I am able to decide the content of my report. To be frank, this year's report is not the one that I started out writing. I decided to change direction because the most recent life expectancy figures for women showed a decline while those for men have stayed the same, rather than improving as we would have hoped. This followed on from a worsening picture for deprivation in Leeds. I have become concerned.

Some of my colleagues believe that I should wait till there is a clearer picture of the trends in our city. Perhaps they are right. Perhaps I am over-concerned and the next set of health information will show that all this has been a temporary blip.

On the other hand, there is the national context. Nationally, there has been a slowing down in the improvement of life expectancy. There have been only slight improvements in recent years both for males and females. Also, in 2009, the Prime Minister declared we are in an "age of austerity". We still are. I see Leeds City Council working hard to minimise the negative impacts on Leeds residents of huge nationally determined budget cuts, including regrettably to public health. I see partner organisations in Leeds faced with similar difficult challenges.

Taking this into account, my report this year focuses on what lies beneath these disappointing life expectancy figures – and asks the question, should we be concerned? Perhaps surprisingly, the big killers – cardiovascular disease, cancer, respiratory disease – don't play a significant part. We will therefore be continuing with the huge amount of work going on across the city to reduce the impact these conditions have on health and health inequalities.

So what has emerged? Firstly, an increase in infant mortality accounts for about half of the worsening position. After 10 years of significant progress we have gone from being a city of concern to a city with an infant mortality rate below that of England as a whole. A remarkable achievement. However, the recent rise highlights the need, despite these difficult times, for a continued city-wide focus on giving children the best possible start in life. A small change here has had a disproportionate effect.

Of even more concern is that we are seeing increasing number of deaths as a consequence of changing health trends – and this is having a significant impact on life expectancy. More women are dying through alcohol harm, more men are dying from suicide, more men are dying through drug overdoses.

We are also seeing more women, especially young women, self-harming. So my report will focus on these four areas, recognising the need to better understand the importance of gender. However, before that, my report will also consider the worsening deprivation statistics and how Leeds City Council's new Inclusive Growth Strategy must contribute to reversing this position.

As always there are specific recommendations for action, but I wish also to ensure a continuing close eye on our life expectancy figures, for men and for women.

For those who wish to see a broader range of health statistics, whether for the whole city or just their local area, please go to *http://observatory.leeds.gov.uk*

I am indebted to many people who have supported and contributed to my report. They are listed at the end of the report. I would particularly like to thank Kathryn Jeffreys, project manager, and Barbara MacDonald, editor.

I also want to thank all my Public Health staff for their hard work and support. Many thanks go to Catriona Slade, my personal assistant.

I hope you find my report of interest. As always, I would welcome your feedback, comments and suggestions.

Ian Cameron
Director of Public Health

STEERING IN THE RIGHT DIRECTION

Leeds has a strong economy that has enabled the city to recover well from the recession. We have a diverse talent pool, world class assets, innovative businesses and beautiful countryside. The Council, universities, schools, innovators and entrepreneurs have all played their part in creating growth. There is much to be proud of in Leeds and we have a great story to tell.

(Leeds City Council's new Inclusive Growth Strategy)[1]

Trinity Leeds opening 2013

Leeds is doing well. The evidence is there for all to see – the opening of Trinity Leeds in 2013 and Victoria Gate in 2016, the £4bn of major developments over the last ten years, the largest increase in average earnings anywhere in the UK. We are proud that Leeds has been named the best city in Britain for quality of life. All of this positive progress is testament to the hard work and co-operation of organisations, sectors and individuals over many years.

However, as is well known, Leeds is also a city marked by inequalities, including health inequalities. Is the economic growth in Leeds benefiting the many or just the few? Are inequalities narrowing or getting wider?

We know that improving the socio-economic position of individuals, communities and neighbourhoods is central to reducing the health inequalities in our city. This has been a consistent theme in my previous Annual Reports. So how are we doing now?

Since the 1970s the government has calculated local measures of deprivation across England. They do this by using the Index of Multiple Deprivation (IMD). The IMD is measured across the country by neighbourhood. Each of these neighbourhoods typically represents around 1,500 people.[2] This is not an easy task but it is a very important one. Measuring deprivation enables us to see what is happening – good or bad – across different areas of Leeds over periods of time.

Just as important as identifying areas of deprivation is assessing change over time. In 2009, Leeds City Council and the NHS produced its first Joint Strategic Needs Assessment (JSNA). This looked at unmet needs and the future health, social care and wellbeing needs of the city. At the time, based on the information we had, I believed we would continue to see a gradual decrease in the number of neighbourhoods in Leeds falling into the worst 10% of deprived neighbourhoods nationally. Alongside this, we expected to see a drop from the 150,000 people living in such neighbourhoods. In the intervening years we have seen that gradual progress and I had hoped that this would lay the foundations for faster progress to reduce the health inequalities in our city.

However, the latest release of the IMD paints a worrying picture for Leeds. Put simply, we now have 100 neighbourhoods that fall in the worst 10% nationally. This is compared to 88 in 2010 – in other words, a worse position. This new figure represents around 164,000 people in Leeds.

1 Leeds City Council (2017) *Leeds inclusive growth strategy 2017–2023: consultation draft* http://www.leedsgrowthstrategy.com
2 Department of Communities and Local Government (2015) *The English indices of deprivation 2015* https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

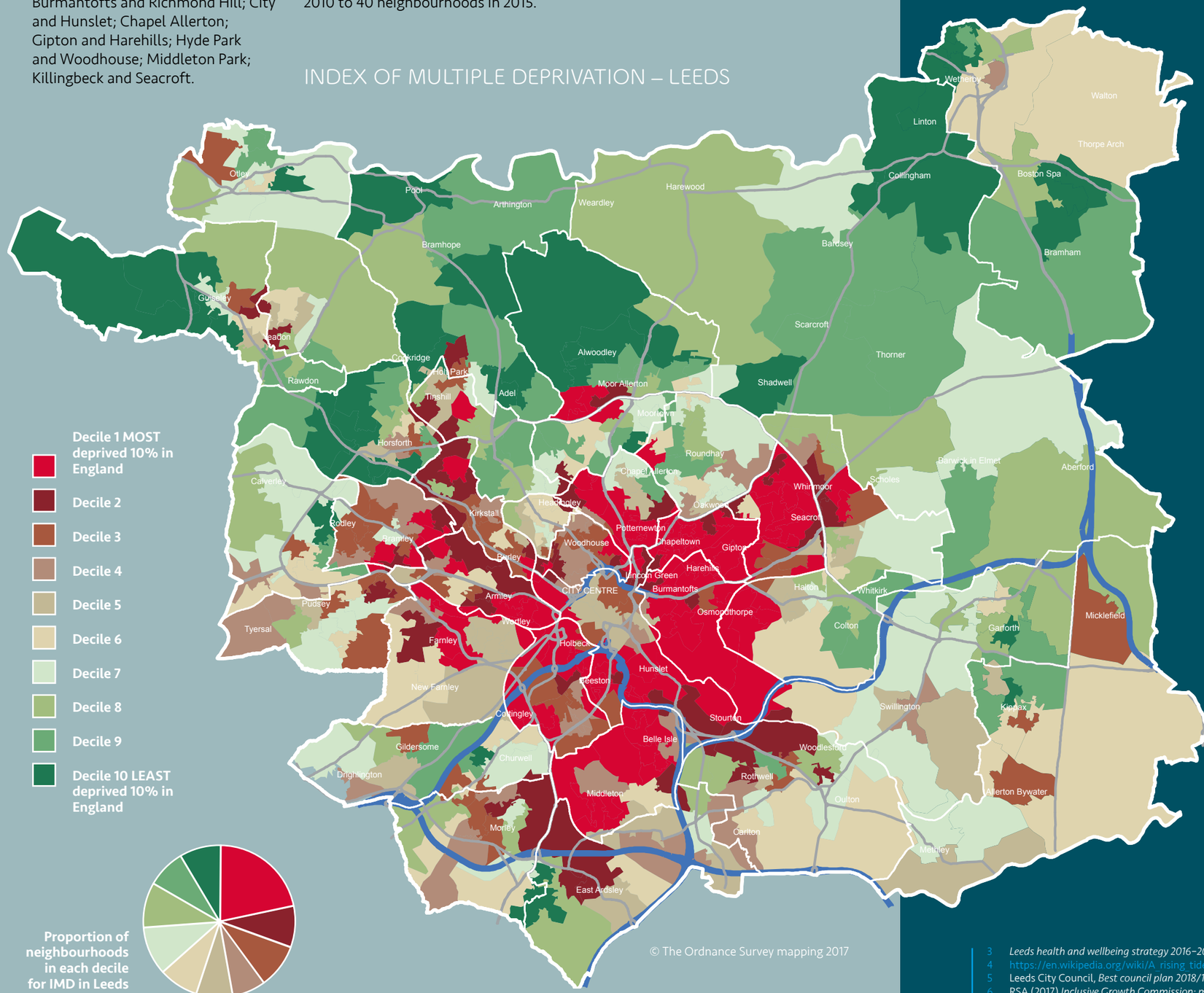
Indeed, 16 of these neighbourhoods are in the most deprived 1% nationally and fall within nine of our wards: Armley; Beeston and Holbeck; Burmantofts and Richmond Hill; City and Hunslet; Chapel Allerton; Gipton and Harehills; Hyde Park and Woodhouse; Middleton Park; Killingbeck and Seacroft.

On the other hand, we have the good news that we have increased the number of neighbourhoods in the 10% *least* deprived nationally from 27 in 2010 to 40 neighbourhoods in 2015.

Taking these figures together, we now have a city with a greater concentration of most deprived and least deprived neighbourhoods.

In other words, the inequality gap in Leeds is getting wider – we are going in the wrong direction.

INDEX OF MULTIPLE DEPRIVATION – LEEDS



Decile 1 MOST deprived 10% in England
Decile 2
Decile 3
Decile 4
Decile 5
Decile 6
Decile 7
Decile 8
Decile 9
Decile 10 LEAST deprived 10% in England

Proportion of neighbourhoods in each decile for IMD in Leeds

The aim of the Leeds Health and Wellbeing Strategy 2016–2021[3] is to improve the health of the poorest fastest. This latest information about our neighbourhoods shows the foundations to do this getting weaker rather than stronger. Leeds may well be experiencing strong economic growth, but our increasing number of deprived neighbourhoods shows that we are not seeing a trickle-down effect from our recovery from recession. A rising tide has not lifted all boats.[4]

Leeds City Council will continue to take the lead in determining the future of our city. As part of that role, Leeds City Council is now focusing on how it can work with partners to tackle deep-rooted and long-standing problems in six of the most deprived neighbourhoods in the city. These include Holdforths and Clydes; Stratfords and Beverleys; Recreations, Crosby St and Bartons; Boggart Hill and Clifton; Nowells; Lincoln Green. This will require a new transformational approach.

In taking forward its vision for Leeds to be the 'best city in the UK', Leeds City Council will shortly publish its Best Council Plan 2018/19-20/21.[5] The Plan states an intention to address poverty and inequalities by maintaining a long-term strategic focus on strengthening the economy whilst supporting the most vulnerable. There are seven priority areas in the Plan. One of these is Health & Wellbeing and this is to be welcomed. Another priority is Inclusive Growth. I hope to show why we need to give equal attention to both.

The Inclusive Growth Priority

What does 'Inclusive Growth' actually mean? There are a number of similar phrases in circulation. Inclusive Growth has been defined as 'enabling as many people as possible to contribute and benefit from growth'. This was the definition used by the Inclusive Growth Commission led by the RSA (Royal Society for the Encouragement of the Arts, Manufactures and Commerce) in 2017.[6]

The Inclusive Growth Commission called for a new look at economic growth because, it said, too many families, communities and places are being left behind in our economy. In the past unemployment was the key problem, but a staggering 55% of households living in poverty nationally now are in work.[7] To get a job, any job, is no longer a route out of poverty. Low-paid, low-status jobs with poor job security, coupled with low productivity and a proliferation of low-skilled jobs, make a potent and toxic mixture.

Cuts to council budgets as a result of the government's policy of austerity have heightened the challenge by producing a focus on the short term and crisis management at the expense of prevention, early action and a focus on the long term.

3 *Leeds health and wellbeing strategy 2016–2021* http://www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf
4 https://en.wikipedia.org/wiki/A_rising_tide_lifts_all_boats
5 Leeds City Council, *Best council plan 2018/19-20/21*
6 RSA (2017) *Inclusive Growth Commission: making our economy work for everyone* https://www.thersa.org/discover/publications-and-articles/reports/final-report-of-the-inclusive-growth-commission
7 Joseph Rowntree Foundation/New Policy Institute (2016) *Monitoring poverty and social exclusion 2016* https://www.jrf.org.uk/report/monitoring-poverty-and-social-exclusion-2016

HOLDFORTHS AND CLYDES

Holdforths and Clydes is the pathfinder for the new approach. This is a neighbourhood facing many challenges. It is ranked ninth most challenged neighbourhood in Leeds. Over 43% of its residents experience income deprivation and 36% are unemployed. Unemployment amongst younger people is double the city average. Out-of-work benefits payments are three times higher than across the city as a whole. Men are more likely to be unemployed than women.

The loss of heavy industry and manufacturing means that men are now taking on work within the service industry as opportunities for full-time, permanent physical work disappear. Women often balance several part-time, insecure jobs, as well as providing the main caring role at home. In Holdforths and Clydes, 41% of residents have no qualifications and 82% of low-income families earn less than £15,000 per year. One in four residents lives in a flat, and a high proportion of residents rent.

This is a diverse population, with 14% of residents born outside the UK. There is significant anti-social behaviour linked to community tensions and the growth of new communities. Under-reporting of crime remains an issue. There are significant health challenges too, particularly around drugs and alcohol. The male suicide rate is the highest for the city, linked to high levels of mental ill health. There are gaps in community infrastructure and community engagement, and social isolation is a problem.

However, there is positive change emerging. A new community centre has been built alongside the existing one. New Wortley Community Centre was announced as Leeds City Council Partner of the Year at an awards ceremony in November 2017. The four tower blocks have received major investment to improve the physical environment and safety, as well as providing social support to the most vulnerable tenants (see later case study, p.46). There is potential to harness surrounding council land and assets to drive economic investment in the area. There is also scope for significant infrastructure changes at Armley gyratory to improve connectivity to the city centre. It is hoped that these changes will help to drive forward an improvement in health and wellbeing.

36%
of residents are unemployed

41%
of residents have no qualifications

14%
of residents born outside the UK

CASE STUDY

The figures below highlight the scale of the challenge for Leeds. While this might be familiar, the importance lies in the direction of travel. To repeat, in terms of improving the levels of deprivation being experienced by some of our communities, we are now going in the wrong direction.

Furthermore, what these figures don't show is the disproportionate impact for particular groups who face exclusion from the labour market, for example disabled people, women and ethnic minorities.

POVERTY AND DEPRIVATION IN LEEDS – THE FACTS

(Leeds City Council Executive Board Report 2016)

175,000
are classified as being in 'absolute poverty'
(around a quarter of our population)

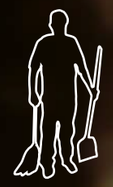
28,000
Leeds children are in poverty
(around 20%) -

of those...

...64%
are estimated to be from working families

15,000
households affected by in-work poverty

24,000
full-time workers earn less than the Living Wage



80,000
in jobs paid less than Real Living Wage

8,000
workers are on zero hour contracts

38,000
households are in fuel poverty

121,000
payday loans accessed by Leeds residents (2013)

The Inclusive Growth Commission argues that a 'grow now, re-distribute later' approach is failing to support adequately those who are out of work or in low-paid jobs. Economic growth has become de-coupled from poverty. In other words, the nation is getting richer but many individuals are finding themselves worse off than ever. To tackle this, we need a new approach that combines social and economic policy.

So yes, there needs to be investment in business development and, yes, there must be investment in high-class transport, housing and digital infrastructure such as faster broadband to connect labour markets to economic opportunity. But what is the value of this investment if particular places or neighbourhoods are not able to connect to its benefits? This might be because the skills base is too low, or because health and complex social issues act as barriers to participation. Economic investment alone is not enough. We need to develop the capacity and capabilities of individuals, families and communities to participate more fully in economic growth and in society.

Getting back to Leeds, we need to ensure that the Inclusive Growth Priority in the Best Council Plan not only powers the whole city forward but also reverses the worsening socio-economic position in many of our neighbourhoods. We must adopt a perspective that includes *quality* of growth as well as dry numbers. We need to find out what people are experiencing in terms of opportunities, barriers, skills, employment and living standards – and make sure that our actions reflect this.

RECOMMENDATION

Leeds City Council to identify a broad range of indicators to assess progress on Inclusive Growth through the new Inclusive Growth Strategy, reflecting different geographies and populations within the city.

The council's leadership role will be of critical importance. In February 2017, Cllr Judith Blake, leader of Leeds City Council, said this to the Inclusive Growth Commission:

Leeds has been working in a new way as a city, asking local government to become more enterprising, business to be more civic and citizens to become more engaged. This – as Ofsted has recognised – has transformed our Children's Services. We've established our open 'Leaders for Leeds' network to address major challenges across our city. The next step is to see this approach from the basis of even more productive city partnerships that have the power to work together, without creating new bureaucracies and management boards.

The call for business to be more civic is to be welcomed. Businesses should be concerned not just with profit, but with promoting and contributing to the quality of life of the communities around them.

There is growing public concern about the values of big business. For example, Starbucks only reported a taxable profit once in the 15 years up to 2013 in the UK. Despite annual UK sales of £400m, Starbucks didn't pay any corporation tax at all to the government for four years prior to 2013. The Public Accounts Committee of MPs 'found it hard to believe Starbucks was trading with apparent losses for nearly every year of its operation in the UK'. Perhaps we should be grateful that the 13 Starbucks outlets in Leeds survive!

Alongside the need for greater partnership working to help foster social responsibility on the part of businesses, we need to seek out opportunities for enterprise, innovation and support to local communities – and find ways of connecting the commercial economy, the public sector economy and the social economy.

This is what we need to see happening in our most deprived neighbourhoods:

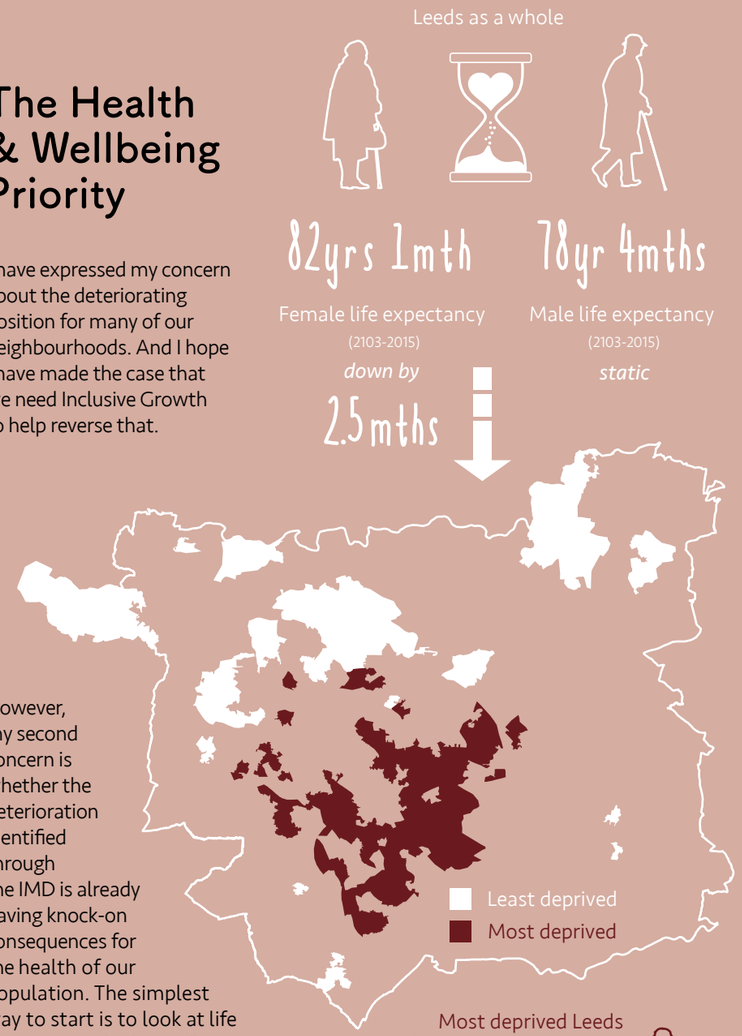
- Inclusive Growth that consciously focuses commitment and resources on deprived neighbourhoods around the priority growth sectors in the city e.g. digital, culture.
- Development of the physical infrastructure to ensure that transport, housing and digital services connect to job growth.
- Development of the social infrastructure to ensure that early years support, education, skills, life-long learning, careers advice and community development enable individual families and communities to participate more fully both in society and in economic growth.
- Provision of family-friendly, quality jobs that offer fair pay, security, job progression and a health-promoting workplace.

RECOMMENDATION

Leeds City Council to ensure that its new Leeds Inclusive Growth Strategy improves the socio-economic position of the most deprived 10% communities in the city.

The Health & Wellbeing Priority

I have expressed my concern about the deteriorating position for many of our neighbourhoods. And I hope I have made the case that we need Inclusive Growth to help reverse that.



However, my second concern is whether the deterioration identified through the IMD is already having knock-on consequences for the health of our population. The simplest way to start is to look at life expectancy. The latest figures (2013–2015) tell us that female life expectancy has dropped to 82 years 1 month – a drop of around 2.5 months. This is not where we want to be as a city. Now, it must be said that this drop is not statistically significant. It may be that this drop is a blip and the figures will improve next time around. I will then have been proved to be alarmist. However, I am very concerned at what lies beneath this apparent step backwards in the health of females in our city. I am also concerned that the gap for women living in the deprived parts of Leeds and the rest of Leeds has worsened by about six months, to 4 years 8 months.

Male life expectancy has levelled off at 78 years 4 months. However, here also the gap between those living in deprived Leeds and the rest of Leeds has worsened by about three months, to 5 years 5 months.

The result of this is that life expectancy for both males and females in our city is falling further behind England a whole. The challenge now is to understand what lies behind this gloomy picture.

The figures tell us that the decline in female life expectancy and the stagnation of male life expectancy is not down to our major killers of cardio-vascular disease, respiratory disease and cancer. We must look elsewhere. The first stop is infant mortality.

Infant mortality and life expectancy

Infant mortality is the death of a live-born baby before their first birthday. There has been a dramatic reduction in infant mortality in Leeds over the last 150 years. Indeed, the decline in infant mortality is the clearest evidence of the progress we have made in improving the health of our population. We went from more than one in five babies dying before the age of one year in the 1870s to one in 250 babies. We had a record low infant mortality, even below the England rate. We were also able to narrow the gap between the most deprived and least deprived communities.

However, the latest figures show an increase in infant mortality. There were 48 infant deaths in 2015 – our highest number since 2009.

Infant mortality has a relatively big impact on life expectancy. This is because that child, tragically, has lost so many years of potential life. Although the actual number of Leeds babies who die in their first year may seem small at 48, this recent increase accounts for about half the decline in life expectancy for females and is a significant contributor to the stagnation of the male life expectancy. Although it is important to understand the contribution of infant death to life expectancy, given the small numbers I have not selected infant mortality as a major theme of this report. However, I would like to say something about the work that Leeds has been doing in this key area before moving on to the themes I have chosen to explore in more detail.

Leeds has a very active programme of work around infant mortality. This work began nearly 10 years ago, when the number of babies dying each year was approaching 60. The decline in infant mortality in Leeds reflects the national trend. However, over the course of the last 10 years, the Leeds rate has been falling faster than the national rate until the most recent period (2013–15), when it has risen for the first time in many years – to those 48 deaths in 2015.

Why has Leeds been so successful in addressing infant mortality to date? In 2002, the government set a national target to reduce inequalities in infant mortality:

> Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.

Sadly, despite this target, a national review in 2007 showed that big differences still existed across the country, and Leeds was identified among 43 local authorities with a higher number of infant deaths. Leeds rose to the challenge, bringing together partners from across sectors, under Public Health leadership, to launch the Leeds Infant Mortality Plan in 2008. Drawing on published evidence about identifiable actions to reduce the gap, Leeds collectively focused its efforts on initiatives such as: reducing smoking during pregnancy and in households; increasing breastfeeding; addressing child poverty; reducing teenage pregnancy and supporting teenage parents; improving maternal nutrition; actions to reduce sudden infant death – and many more. This preventative agenda was widely embraced across the city by the public sector, the third sector and by communities at local level in two highly successful 'demonstration sites' in Chapeltown and Beeston Hill. The narrowing of the gap in Leeds, at a time when the population of women giving birth in the city was becoming increasingly mobile, complex and vulnerable, is a testament to the energy and commitment of all the partners. The recent upturn in Leeds figures is very disappointing. The figures show a similar trend in some of the other core cities, although not nationally. We can only speculate on the reasons for the overall rise and the widening of the gap, despite our ongoing efforts. Very likely it is the effect of recession. Economic recession makes families more vulnerable and also impacts on the quantity and depth of public and third-sector services. This is despite continued attempts to focus services on those in greatest need.

In recent years, Leeds has broadened its approach to infant mortality. We have adopted a Best Start priority which spans the period from conception to the child's second birthday, also known as the first thousand days. Best Start is a priority in the Leeds Health & Wellbeing Strategy. The Leeds Best Start Plan 2015–19[8] builds on the previous evidence-based actions, but extends this to consider key aspects of early life that will promote social and emotional capacity and cognitive development, such as parenting, attachment and bonding, and communication. Once again, strong city-wide partnerships lie at the heart of Best Start, including at local level in our Best Start Zones. These will determine whether we can successfully deliver the huge return in potential outcomes for future generations of children in our city.

RECOMMENDATION

The Leeds Best Start Strategy Group to help ensure that parents are well prepared for pregnancy and that families with complex lives are identified early and supported.

8 Leeds City Council, *Leeds best start plan 2015 –2019* http://democracy.leeds.gov.uk/documents/s126845/10%202%20Best%20Start%20Plan%20long%20version%20FINAL%20VERSION%20for%20HWB%20Board%204%202%202015.pdf

What other trends should concern us?

If infant mortality accounts for half the poorer position around life expectancy, and if cardiovascular disease, cancer and respiratory disease are not responsible for the other half, then what is?

The evidence suggests that we need to focus our concern on:

- a rise in deaths in men from drug overdose
- a rise in deaths in women from alcoholic liver disease.

There are two additional trends that should concern us. Although they are not statistically significant in terms of mortality, we also need to look at:

- a rise in deaths in men from suicide
- a rise in the number of women who self-harm.

These are the four areas that I shall cover in the following sections of this report.

Readers will have noted that all four of the public health trends mentioned above show a gender difference. Yet how often do we properly acknowledge gender when we consider unmet needs, access to services, interventions or follow-up support? The answer is, not often enough.

Here in Leeds, we have identified a nationwide failure to acknowledge gender differences in health.

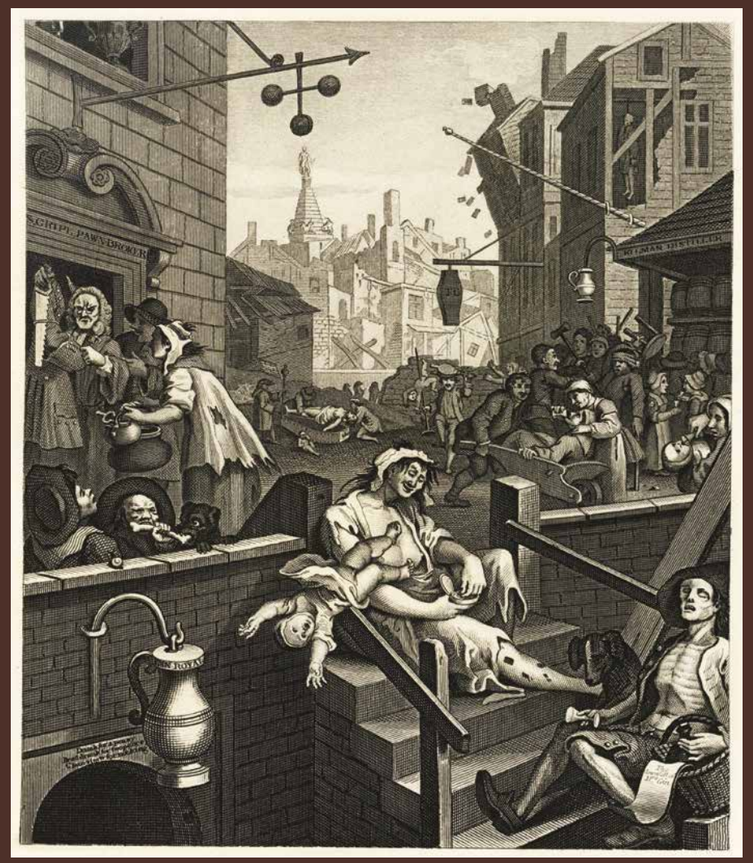
NHS England has established 44 Sustainable Transformation Partnerships across England to meet the enormous challenges faced by the NHS. Leeds falls within the West Yorkshire and Harrogate Sustainable Transformation Partnership. Each Partnership has developed plans to improve health and wellbeing, improve care and address the financial problems in the NHS.

Now, we already know that men have a poorer life expectancy than women as well as higher rates of the 'big killers'. Accordingly, Professor Alan White and Amanda Seims from Leeds Beckett University, along with Tim Taylor (Leeds City Council) and myself, have reviewed all 44 plans to check whether men's health is specifically highlighted. We made the shocking discovery that only 15 of these 44 major plans even mention that men have higher death rates. Fortunately, the *British Medical Journal* has recognised the importance of the gender gap in public health by publishing our work to a wider audience.[9]

We will now look in more detail at the four areas of concern, beginning with what is happening around the rise in alcohol-related deaths in women.

9 Cameron, I, White, A, Seims, A and Taylor, T (2017) Missing men when transforming health care, *British Medical Journal* 357: j1676

ALCOHOL-RELATED MORTALITY IN WOMEN



More years of life are lost in England as a result of alcohol-related deaths than from cancers of the lung, bronchus, trachea, colon, rectum, brain, pancreas, skin, ovary, kidney, stomach, bladder and prostate combined.[10] It therefore comes as no surprise that the World Health Organization (WHO) places alcohol as the third biggest global risk for burden of disease.[11] Alcohol has been identified as a causal factor in more than 60 medical conditions.[12] Let's pause and think about that for a minute. It seems mad to think that a substance that can cause so much harm is still widely available – but it is, and this is unlikely to change.

The UK has a long history with alcohol. As far back as 1751, the artist William Hogarth was making a visual connection between alcohol and poverty, crime and urban squalor, and the harmful effects of commerce and taxation on the poor, in his satirical images *Gin Lane* and *Beer Street*. All of this still rings true today. Public health has made huge progress since the eighteenth century, but alcohol harm is still with us. Unlike 200 years ago, though, we now know a lot more about what causes these harms.

10 Public Health England (2016) *The public health burden of alcohol: an evidence review* https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

11 Mathers, C *et al* (2009) *Global health risks: mortality and burden of disease attributable to selected major risks*, Geneva: WHO http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

12 Alcohol Concern (2016) *Statistics on Alcohol* https://www.alcoholconcern.org.uk/alcohol-statistics

What is the story?

Evidence demonstrates a clear relationship between the volume of alcohol consumed and the risk of a given harm. As the alcohol dose increases, so does the risk. The frequency of drinking also influences the risk of harm. Repeated heavy drinking is associated with alcohol dependence,[13] whereas a single bout of heavy drinking – so-called binge drinking – is associated with alcohol-related crime, physical injury and increased risk of cardiovascular disease.[14]

The Office for National Statistics (ONS) reports that of those who drank alcohol in 2016, 27% of adults (around 7.8 million people) 'binged' on their heaviest drinking day prior to interview. Young drinkers are more likely than any other age group to binge-drink.[15] This not only has health implications but social and economic consequences too. However, frequent and most harmful drinking tends to be among middle-aged people, with this age group of both men and women more likely to drink every day.[16]

THE UK CHIEF MEDICAL OFFICER'S GUIDELINES ON ALCOHOL CONSUMPTION (2016)

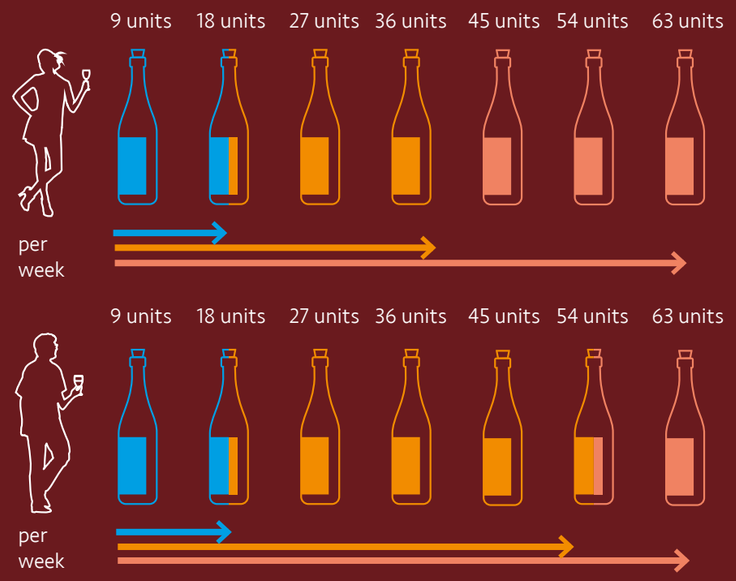
categorise consumption as follows:

'low risk' – men or women who do not regularly drink more than 14 units of alcohol per week

'increased risk' – for men, 14–50 units per week; for women 14–35 units per week

'higher risk' – for men, over 50 units per week; for women, over 35 units per week

One 750ml 12.5% bottle of wine = 9 units



The number of adults consuming alcohol at a level putting them at increased risk or above rises with age, peaking at 55–64 for both men and women.

Socio-economic status is a key factor in drinking behaviour, with important differences between increased-risk drinking and higher-risk drinking. Let's look at increased-risk drinking first. The NHS Digital Health Survey 2015 reported that adults in higher-income households are more likely to drink weekly at levels that put them at increased risk than those in lower-income households. Women in the highest-income households are over twice as likely to be drinking at levels presenting an increased risk of harm than women in the lowest-income households.

However, higher-risk drinking is greatest in the lowest-income households, with the most severe alcohol-related harm being experienced by those in the lowest socio-economic groups. This is called the 'alcohol harm paradox'.[17] It has been estimated that females (and males) in the most socio-economically deprived neighbourhoods are two to three times more likely to die from an alcohol-related condition than those living in the least deprived areas.[18]

Gender is an important factor. Research consistently demonstrates gender differences in rates of alcohol use. The latest statistics highlight that men are both more likely than women to be drinkers and twice as likely to drink at levels that present an increased risk or higher risk, irrespective of age. However, recent decades have seen a narrowing of the gap between men and women.[19]

13 NICE (2011) *Alcohol-use disorders: NICE guidelines on the diagnosis, assessment and management of harmful drinking and alcohol dependence* https://www.nice.org.uk/guidance/cg115
14 Roerecke, M & Rehm, J (2010) Irregular heavy drinking occasions and risk of ischemic heart disease: a systematic review and meta-analysis, *American Journal of Epidemiology* 171(6), pp.633–44
15 Office for National Statistics (2017) *Adult drinking habits in Great Britain: 2005 to 2016* https://www.ons.gov.uk/releases/adultdrinkinghabitsingreatbritain2015
16 NHS Digital (2016) *Health survey for England, 2015: adult alcohol consumption* www.content.digital.nhs.uk/catalogue/PUB22610/HSE2015-Adult-alc.pdf
17 Alcohol Research UK (2015) *Understanding the alcohol harm paradox*, Alcohol Insight 122 http://alcoholresearchuk.org/alcohol-insights/understanding-the-alcohol-harm-paradox-2/
18 Deacon, L *et al* (2011) *Alcohol consumption: segmentation series report 2*, North West Public Health Observatory, Liverpool: Liverpool John Moores University
19 Greenfield, S F *et al* (2010) Substance abuse in women, *Psychiatric Clinics of North America* 33(2), pp.339–55

Less is known about problematic alcohol use in women than in men[20] but we do know that women accelerate from starting to drink to problematic use of alcohol much faster than men. This is known as 'telescoping'. Women also develop liver disease more rapidly than their male counterparts[21] and generally present for treatment with a more severe clinical profile.

What is happening in Leeds?

A worrying picture has started to emerge in Leeds in recent years. Significantly more women are dying because of their alcohol use.

Alcohol-specific/ alcohol-related

Alcohol-specific conditions are conditions caused solely by alcohol use, for example cirrhosis of the liver, some physical injuries.

Alcohol-related conditions are those in which alcohol use is a factor, for example some cases of cardiovascular disease, cancer and falls.

Admissions to hospital for alcohol-specific conditions are high. In 2013–15, 93 women died from these conditions and, for the first time, the number of years of life lost by women due to alcohol-related conditions has significantly worsened. The primary driver behind this increase is female deaths from alcoholic liver disease.

Of the 93 deaths in 2013–15, 71 were from alcoholic liver disease. We are seeing women dying from alcoholic liver disease as young as 35–39 years, with a peak at 50–54. This is younger than found nationally.

The rate of alcoholic liver disease, as with levels of drinking, is higher for men than women across all age groups in Leeds. However, whilst deaths in men have been reducing, deaths in women have been increasing since 2012, as noted above. This means that there has been a narrowing of the gap between men and women to the point where numbers of deaths from alcoholic liver disease in men and women are very similar.

In Leeds, the most deprived parts of the city are experiencing the highest rates of alcohol harm and mortality. When we look at the numbers of deaths from alcohol-related liver disease over the last five years, we see that the most deprived areas are experiencing the highest numbers across all age groups. People living in deprived Leeds, both men and women, also account for the majority of alcohol-specific hospital admissions. Twice as many women in deprived Leeds are admitted for reasons attributable to alcohol use than women in non-deprived Leeds.

In 2016, 52% of registered patients in Leeds received alcohol identification and brief advice, or IBA (alcohol screening – Audit C), in an attempt to assess people's drinking levels locally. This local data reflects the national picture. The majority of people who drink in Leeds drink at low-risk levels. Of those who are drinking at risky levels, 88% are drinking at increased risk and 12% at higher-risk or dependency levels. More men are drinking above the low thresholds than women. However, through this alcohol screening data, the Audit C scores have revealed two previously unseen patterns of alcohol use.

First, a significantly larger proportion of 18–29 year old women are drinking at increased-risk and higher-risk levels compared to other age groups. This may in part be due to the large number of students in the city who register with a GP on arrival and therefore undertake an alcohol screen. Nevertheless, we shouldn't ignore this finding as we know that this age group is more likely to binge-drink. As well as its health implications, binge-drinking has both social and economic impacts, through alcohol-related crime and antisocial behaviour. For all these reasons we need to consider targeted interventions with this younger population.

The second finding of concern from Audit C is that similar numbers of men and women in the 40–49 age group are now higher-risk drinking.

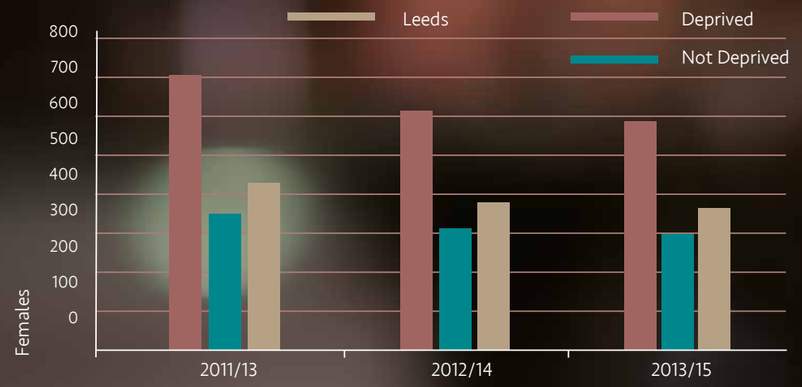
These new trends – increased and higher-risk drinking at a younger age, and increased higher-risk drinking in middle age – are potentially starting to show in our female mortality figures.

What are we doing to tackle alcohol harm in Leeds?

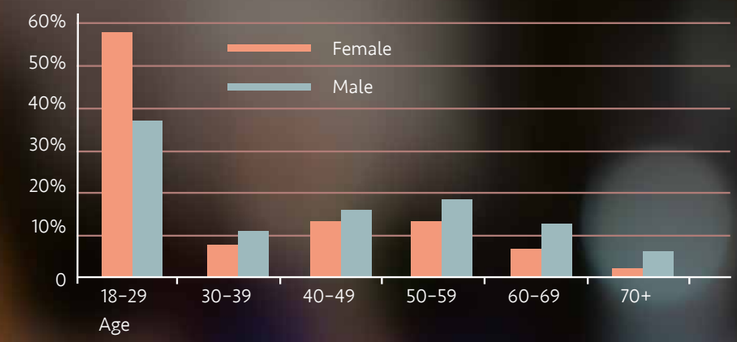
The Leeds Drug and Alcohol Strategy (2016–2018) embeds the 2011 NICE guidelines on the management of alcohol harm. In Leeds, we are adopting a holistic approach to ensure that we not only support alcohol recovery through Forward Leeds, the local alcohol and drug service, but also adopt measures to prevent alcohol harm, identify problems earlier and address the impact alcohol has on the family and the economy. We have made much progress but there is still much work to do if we are going to achieve our vision for Leeds.

20 Lancet Psychiatry (2016) Sex and gender in psychiatry (editorial), *Lancet Psychiatry* 3(11), p.999
21 Hamilton, I (2017) Why women who misuse drugs have different needs, *The Pharmaceutical Journal*, August 2017 https://www.researchgate.net/publication/318883925_Breaking_the_silence_on_women_and_drug_use

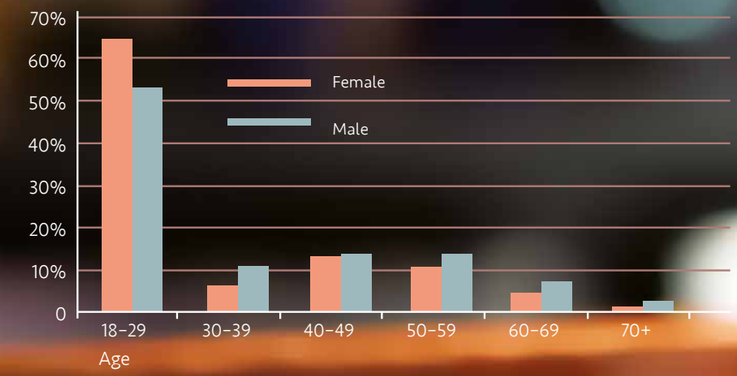
ADMISSIONS TO HOSPITAL DIRECTLY ATTRIBUTABLE TO ALCOHOL (FRACTION OF 1) CRUDE RATE: 100,000

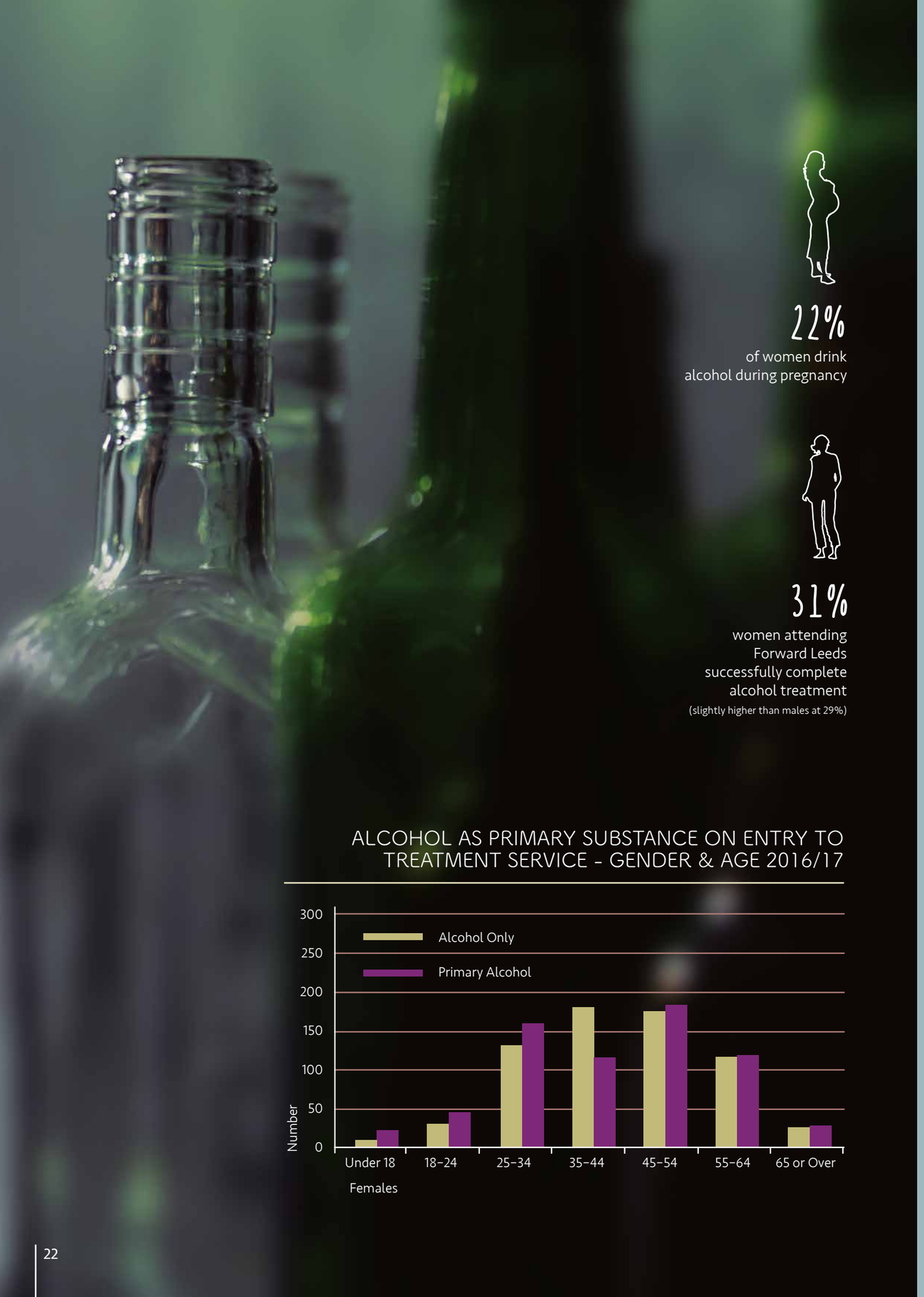


PROPORTIONS FROM AUDIT C SCORE CLASSIFIED AS INCREASING RISK (SCORE 1-15) – SEX AND AGE



PROPORTIONS FROM AUDIT C SCORE CLASSIFIED AS HIGH RISK (SCORE 16-19) – SEX AND AGE





22%
of women drink
alcohol during pregnancy

31%
women attending
Forward Leeds
successfully complete
alcohol treatment
(slightly higher than males at 29%)

ALCOHOL AS PRIMARY SUBSTANCE ON ENTRY TO TREATMENT SERVICE - GENDER & AGE 2016/17

Prevention

'Making every contact count' is about changing behaviour. Health workers and organisations have millions of day-to-day interactions with people and are being encouraged to use every one of these to promote changes in behaviour that will have a positive effect on the health and wellbeing of individuals, communities and populations.

We are also working to support the national initiative on alcohol identification and brief advice (IBA). This typically involves using a screening tool to identify risky drinking, for example alcohol screening of newly-registered patients at GP practices (Audit C). Once a potential problem has been identified, frontline staff deliver short, structured 'brief advice' with the aim of encouraging a risky drinker to lower their level of risk by reducing their alcohol consumption.

For example, the Under 18's Pocket Guide to Alcohol was developed locally as a tool for frontline practitioners to deliver brief advice for young people around alcohol use. Over the last four years, 30,000 pocket guides have been distributed and 300 members of the children's workforce have been trained in its use. It has also been adopted in other areas of the UK.

As well as equipping frontline staff in both the children and adult workforce with the skills to identify alcohol harm earlier through the delivery of IBA, we have also implemented social marketing campaigns to improve people's knowledge of responsible alcohol consumption and alcohol harm, to enable people to make more informed choices and to signpost to Forward Leeds, the local alcohol support service.

Launched in 2014, 'Like My Limit' is a local equivalent to the successful national 'Know your Limits' campaign. It is predominantly a social media campaign to challenge the social norm of female drinking at home and raise awareness of the effects of regularly drinking over the recommended guidelines.

Pregnant women are more than three times as likely not to drink alcohol at all compared to other women, but still 22% of pregnant women in the UK report drinking alcohol during pregnancy.[22] High prenatal exposure to alcohol is linked to a high risk of developing foetal alcohol syndrome – a spectrum of preventable disabilities including birth defects, behavioural problems, growth deficiencies and learning disabilities. We don't yet know whether there is a 'safe' level of alcohol consumption that carries no risk of foetal alcohol spectrum disorder or other health problems, so the message has to be that there is no safe level. Unfortunately, as in many other areas in the country, there has been a lack of consistent messages regarding alcohol consumption during pregnancy in Leeds. The Leeds 'No Thanks I'm Pregnant' social media campaign was launched in April 2016 to advise women that the safest choice is not to drink any alcohol during pregnancy. Posters, leaflets and fact sheets were made available to health professionals to support this ongoing social media campaign.

22 Office for National Statistics (2013) *Adult drinking habits in Great Britain, 2013* https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/compendium/opinionsandlifestylesurvey/2015-03-19/adultdrinkinghabitsingreatbritain2013

'P'

P is a 42-year-old full-time mum. She had been a drinker throughout her adult life but had considered herself a 'social drinker'. With hindsight she realises that she was drinking more than other people and that her alcohol consumption had steadily crept up over the years. She was 'drinking on anxiety, thinking it would calm my nerves'.

After a number of events in her personal life, including the loss of family members, P's alcohol consumption increased to the point where she had become physically addicted to alcohol and was finding it a problem in her day-to-day life. Her GP recommended Forward Leeds. P had a successful community detox and combined this with cognitive behaviour therapy and other psychosocial therapies to become sober. She has now been sober for almost a year.

CASE STUDY

FORWARD LEEDS INSPIRING CHANGE

Alcohol treatment – Forward Leeds

In 2015, the newly recommissioned integrated Drug and Alcohol Prevention and Treatment Service – Forward Leeds – began its work in the city. We are now starting to see the hard work and dedication of the staff in this service come to fruition.

The number of clients entering the service in 2016–17 with alcohol as the primary substance of use was just below 40% of the total. The percentage of clients who have successfully completed alcohol treatment and who have not re-presented to the service within six months – a national indicator – has steadily increased over 2017.

The percentage of women who successfully complete their alcohol treatment is about 31%, slightly higher than the percentage of males at 29%.

This indicates that women who do access the service for their alcohol use engage with treatment and are able to progress towards recovery.

However, the age when women start to enter the service in greater numbers is from 25 years. There were two cohorts of concern from Audit C scores. These were women aged 18–29 and women aged 40–49. The figures show that younger women are not accessing the service. We therefore need to review female services and points of access to explore how we can intervene earlier and ensure that we are doing all we can to provide a service that women feel they can access for the support they need. In particular, we need to find ways of engaging and supporting younger women to reverse the higher level of harm and mortality that we are currently seeing in the city.

Public Health cannot achieve alcohol harm prevention work alone. Only by influencing and supporting the wider alcohol agenda and working with our partners in the city will we be able to achieve our vision set out in the Leeds Drug and Alcohol Strategy (2016–2018). For example, we have for a number of years supported primary care in the delivery of the IBA. Through partnership with the three Leeds Clinical Commissioning Groups (CCGs), we have supported the delivery of alcohol treatment in community primary care settings. And, through the Leeds health and social care plan, we are supporting the delivery of brief interventions around alcohol harm within our hospitals.

I would like to end this section on alcohol harm with two further brief examples of our partnership working within the council.

Recently, Leeds was one of eight local authorities to participate in the health as a licensing objective (HALO) national pilot. Public Health has a strong relationship with the Leeds City Council licensing team and is an active member in the Licensing Enforcement Group. We have supported the development and implementation of local licensing policies in Inner West, Inner East and South Leeds. These policies seek to minimise the negative impact that new premises may have on the health of the local area. South Leeds local licensing policy has been showcased nationally as an example of best practice and was recently used as a case study by Public Health England in their Alcohol Licensing and Public Health Guidance.[23]

23 Public Health England (2017) *Reducing alcohol related health harms in Leeds (case study)* https://www.gov.uk/government/case-studies/reducing-alcohol-related-health-harms-in-leeds

PURPLE FLAG STATUS
FOR THE EVENING & NIGHT TIME ECONOMY

Purple Flag is an award which recognises the efforts of partners in the city working together to ensure the city is clean, safe and well after 5pm. As a key member of this partnership, Public Health is working to promote health and wellbeing within the night-time economy, particularly in relation to responsible drinking. The partnership has developed alcohol and drug awareness training for all staff working in the night-time economy. This is delivered by Forwards Leeds, with the aim of reducing the impact of alcohol-related harm associated with evening entertainment in the city.

RECOMMENDATIONS

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Forward Leeds to use local insight to develop a social marketing campaign targeting young women and aimed at reducing alcohol consumption and promoting access to services.

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Leeds NHS Trusts to increase identification and brief advice (IBA) in primary and secondary care with a particular focus on areas of deprivation with highest alcohol harm.

Leeds City Council and Forward Leeds to review alcohol treatment services for females and ensure services are appropriate to the needs of women.

16,000

women in Leeds have experienced extensive physical and sexual violence and abuse

1 in 20

women in Leeds have experienced extensive physical and sexual violence and abuse

80,000

women in Leeds with common mental health disorders

16-24

age group women in Leeds have the highest rates of common mental health disorders, self-harm and PTSD

WOMEN'S MENTAL HEALTH

In Leeds, as in the rest of England, more women than men have mental health problems such as anxiety and depression. These types of problems are called common mental health disorders. A recent national study[24] found that rates of these disorders have risen significantly in the last 10 years, and this is mainly due to the increasing number of women with these mental health problems. In Leeds, there are twice as many women as men with common mental health disorders: that's over 80,000 women. Women's mental health is getting worse.

The percentage of women and men with more serious mental illness, for example psychosis, is similar overall, although men tend to develop psychosis at a younger age and women later on in life. However, there are particular groups of women who have high rates of other serious conditions such as post-traumatic stress disorder (PTSD). Self-harming – often a way of coping with mental distress – is thought to be worsening in young women.

The reasons why women have poor mental health include financial worries such as debt and low-paid work and stress associated with caring responsibilities. Women are more likely than men to be in lower paid and less secure jobs – on temporary or zero-hour contracts, for example – and the negative impact of welfare reform has been shown to affect women disproportionately.

Experience of violence, trauma and abuse is another significant risk factor for common mental health disorders. Women are twice as likely as men to experience violence and abuse in the home; the more extensive the violence, the more likely that it is experienced by women. Women's Lives Leeds report that about one in every 20 women in England has experienced extensive physical and sexual violence and abuse across their life course – that's over 16,000 females of 15 years and older in Leeds.[25] These women have been sexually abused in childhood or severely beaten by a parent or carer; many have been raped and suffered severe abuse from a partner, including being choked, strangled or threatened with a weapon. It is thought that such abuse may explain, in part, the higher rates of common mental health disorders seen in women. Abuse also increases the risk of more serious conditions like PTSD and personality disorder. Abuse may mean that women experience other circumstances that impact on their mental health, such as drug use, insecure work or poor housing.

Certain groups have poorer mental health than others. Risk factors for poor mental health, some of which have been discussed above, cluster in areas where people have a low level of income. This means that women living in poorer neighbourhoods are likely to have worse mental health. Black/Black British women show higher rates of common mental health disorders, whilst asylum seekers and vulnerable immigrants and refugees often have poor mental health associated with trauma. Lesbian and transgender women are also at higher risk of poor mental wellbeing.

Finally, the mental health of young women is worsening. In England, women aged 16– 24 years have the highest rates of common mental health disorders, self-harm and PTSD of all groups. It is suggested that this may in part be due to social media exposure, excessive use of computers and mobile phones, and poor sleep, although this research is at an early stage.

Self-harming and mental health

Self-harm

Self-harm is when someone intentionally causes themselves injury or harm. It is often seen as a way of coping with or expressing feelings and emotions that have become overwhelming. Self-harm involves a range of behaviours, including cutting, self-poisoning and burning. Broader definitions of self-harm can also include alcohol and substance misuse, disordered eating and 'risk-taking' behaviours, which increase a person's vulnerability and susceptibility to harm. Self-harm is associated with both severe and enduring mental health problems, for example personality disorders, as well as common mental health disorders. It is also associated with an increased risk of suicide.

24 McManus, S *et al* (eds.) (2016) *Mental health and wellbeing in England: adult psychiatric morbidity survey 2014*, Leeds: NHS Digital http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

25 Scott, S and McManus, M (2016) *Hidden hurt: violence, abuse and disadvantage in the lives of women* https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf

Self-harm is not restricted to a particular group. Much self-harming behaviour goes undetected, so it is difficult to know with certainty how often it happens and to whom. However, we know it is more common in younger people than older people and more common in women than in men. Over twice as many young women aged between 16 and 24 years report self-harming compared to men in the same age group.

A range of reasons may cause a person to start self-harming – family or relationship problems, school or work pressures, low self-esteem and body image, misusing alcohol or drugs, trauma or abuse. Many people who self-harm say they do so to relieve feelings of anger, tension, anxiety or depression. There are likely to be several other reasons that lead someone to self-harm, and these will differ from person to person.

What is the picture for Leeds?

Within Leeds it is estimated that there are 16,000 young women aged 16–24 years suffering from common mental health problems at any one time. Nationally, around 1 in 4 young women have reported having 'ever self-harmed during their lives'. In Leeds, this would be an estimated 16,000 young women.

In Leeds, levels of self-harm are measured by collecting data on hospital admissions. However, because self-harm can take many forms, it is likely to be under-reported. The local data reflects national trends. In Leeds young women aged 15 to 19 have the highest incidence of self-harm admissions: 297 young women were admitted in 2016–17 compared to 78 young men, i.e. around four times the male rate. These figures represent episodes and so include individuals with more than one admission, but we do know that admissions are increasing year on year and that there has been a general increase in admissions over the last two years for both females and males.

Admissions for the youngest age group of girls for which self-harm data is collected (up to 14 years old) are nine times higher than those of boys in the same age group.

Levels of admissions for self-harm are closely linked to living in deprived areas of the city. This is a general trend across all local authority areas in the Yorkshire and Humber region but is more pronounced for Leeds than for any other city in the region. Someone who lives in one of the most deprived areas of Leeds is twice as likely to be admitted to hospital for self-harm than someone living in one of the least deprived areas. This indicates greater health inequality associated with self-harm in Leeds.

The stigma associated with self-harm often prevents people from seeking help. This stigma also affects the people around those who self-harm: families, friends, acquaintances and work colleagues. Self-harm is a complex behaviour that is widely misunderstood, and the stigma surrounding it has serious consequences for those seeking help, both within and outside of health services.

What are we doing in Leeds?

In Leeds, the focus of Public Health initiatives is on prevention by starting work early in the life course. We are working to improve the emotional health of children and young people as part of Future in Mind, the Leeds Local Transformation Plan 2016–2020.[26] We are supporting schools in Leeds to become part of the MindMate Champion programme in order to develop whole-school approaches to promoting positive social, emotional and mental health (SEMH). This includes subsidised training on topics such as self-harm awareness. Recognising and responding to self-harm is also embedded within the new MindMate curriculum – a SEMH curriculum for all key stages which is available to access online.[27] We offer secondary schools support to develop creative anti-stigma campaigns co-produced by young people within the school setting. This aims to encourage young people to talk openly about mental health and reduce the stigma that is stopping them from accessing help.

Selected year groups of primary and secondary schools in Leeds complete an annual 'My Health My School' survey. In 2015, questions were added about self-harm for Year 7 and above. This provides community-level data for young people aged 11–15 that has previously been unavailable in Leeds. For example, 88% of the 2,182 young people who responded to this question said that they had hurt themselves on purpose. In answer to a separate question, 7% of the 377 responders said they hurt themselves every day; 28% said they had hurt themselves once or twice in the last 12 months; 48% said they used to hurt themselves but no longer did so.

The 'Pink Booklet'[28] is a leaflet produced by Public Health along with the three Clinical Commissioning Groups (CCGs) and the Leeds Safeguarding Children Board. The leaflet offers guidance for staff working with children and young people in Leeds who self-harm or feel suicidal. It is used in a wide range of settings such as schools, youth work or community groups. The Pink Booklet sets out key principles and ways of working and has been written in accordance with NICE clinical guidelines.[29]

26 *Future in mind: Leeds 2016–2020* https://www.leedssouthandeastccg.nhs.uk/content/uploads/2017/01/MindMate-Future-In-Mind-Brochure-AW-DIGITAL.pdf
27 MindMate curriculum 2015 responses http://www.myhealthmyschoolsurvey.org.uk/survey-11/webform-results/analysis
28 *Self-harm and suicidal behaviour: a guide for staff working with children and young people in Leeds:* https://www.mindmate.org.uk/wp-content/uploads/2016/05/Self-harm-booklet.pdf
29 NICE (2011) *Self-harm in over 8s: long-term management* https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance

There are also a number of services to support adults who self-harm, including Leeds Survivor-Led Crisis Service (Dial House), The Key and Women's Therapy and Counselling Service. These services are facing challenging times. Cuts to funding, wider reforms across welfare and housing services, and structural barriers to access, all have a disproportionate impact on vulnerable communities.

THE KEY

The Key is a local service run by Womens Health Matters, which supports girls and young women in Leeds to manage the effects of abuse and domestic violence. The Key helps girls and young women identify and acknowledge violence and abuse, develop coping mechanisms and gain confidence and self-esteem.

'When I first started at The Key I felt so down. I was self-harming. I wanted to die. I didn't even want to go outside. Now I am working and going to college every day. I am also convincing myself, slowly but surely, that I am as good as everyone else and I am not left out – I can talk to everyone. And yes, I do still get nervous a lot but I feel normal for the first time in my life. Without the help from The Key I wouldn't be where I am today... thank you.'

B was first referred to The Key in 2013 by the charity Basis Yorkshire. She was 15 years old. B was in an abusive relationship, was experiencing child sexual exploitation and had been physically abused by her step-father. She experienced anxiety and low mood. She had been self-harming since the age of eight but had been unable to engage with talking therapies. She was struggling with bullies at school and in her neighbourhood. This had a negative effect on her self-esteem and increased her anxiety levels. The Key supported B through both one-to-one and group support.

During her first two years at The Key, B found it hard to maintain friendships. She ended one abusive relationship and began another that proved equally abusive. Her self-harming increased during this second relationship. She attempted to take her own life on at least one occasion.

After many intensive sessions around her emotional wellbeing, B felt able to attend therapy. The Key referred her to IAPT (Improving Access to Psychological Therapies). She has not self-harmed for over a year and has come off antidepressants, though she still has mood fluctuations.

In all, B received support from The Key for three years. By her final year, her confidence had improved. She was part of the young people's interview panel during recruitment of a new project worker, and she also joined the steering group.

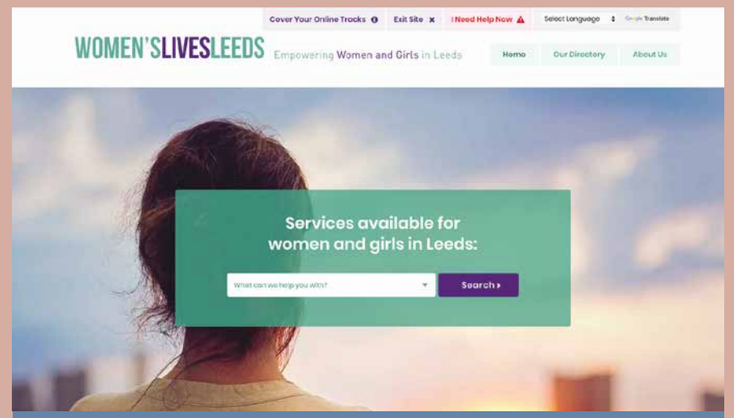
B is now 18 and her time at The Key is coming to an end. The Key has now secured three years of Big Lottery funding. B is really interested in the idea of leading sessions with younger girls, one of the new strands of the project, as she feels this will continue to improve her confidence and self-worth.

CASE STUDY

The Leeds websites Mindwell[30] and MindMate[31] provide information about mental health, including self-harm, along with self-help tips and information about local support services.

We are trying to find out more about this complex problem. The Leeds Suicide Audit has enabled a greater local understanding of self-harm and risk in relation to suicide in the city. Work such as the REACH project[32] with young women has provided valuable insight on high-risk groups.

REACH stands for Respect Encourage Active Confidential Help. The REACH self-harm insight project was commissioned by NHS Leeds to address high rates of A&E attendance by young people in Leeds and to respond to national guidance on self-harm. The work was led by Womens Health Matters and The Market Place. The project was aimed at young women aged 13–19 and was designed to gain insight into their self-harming behaviour. The report found that the young women were engaging in a huge range of activities and risks to their wellbeing. The young women were helped to recognise that situations which they initially thought were fun, such as getting into cars with unknown men, were actually risk-taking behaviours in which they had very little control and could become vulnerable very quickly.



Women's Lives Leeds

Women's Lives Leeds is a unique partnership formed by 12 women's and girls' organisations from across Leeds which specialise in dealing with domestic violence, mental health, sexual health, sex work, trafficking, child sexual exploitation and education. The aim is to improve the support given to the most vulnerable women and girls. Some members work specifically with women and girls from black and minority ethnic groups.

Experience of physical and sexual violence and abuse is linked to mental health problems and physical health conditions including alcohol and drug dependency. It is also linked to poverty and job insecurity. The greatest disadvantage is suffered by those who experience violence over their life course, of whom 80% are women.

Women's Lives Leeds use their combined knowledge, experience and networks to reach more women, especially those who are most vulnerable, and to provide holistic, joined-up support, no matter where in the city the women live. They do this by:

- developing a co-production model to ensure they reach the most vulnerable women
- providing specialist support for women with multiple and complex needs
- supporting the development of peer support across the city
- developing a Virtual Women's Centre – a single point of information.

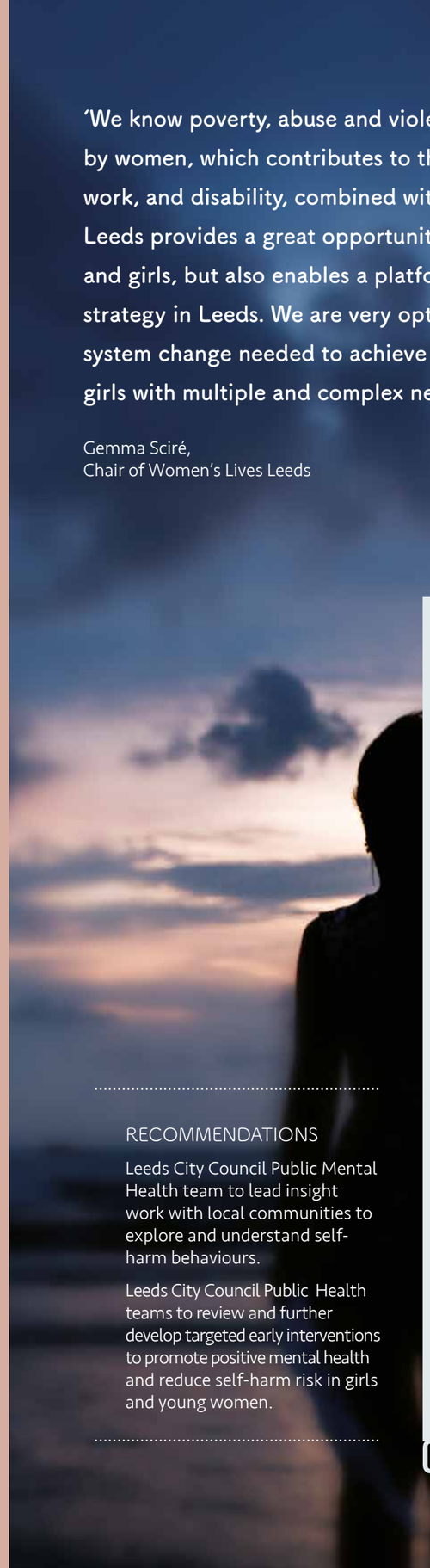
Through this work, Women's Lives Leeds seeks to:

- improve and extend access for vulnerable women and girls to the services and support they want, when and where they choose
- provide holistic responses to meeting complex and multiple needs
- empower women and girls to support their peers and influence service development, delivery and design across the city.

30 MindWell https://www.mindwell-leeds.org.uk/
31 MindMate https://www.mindmate.org.uk/
32 NHS Leeds (2012) *REACH: A self harm insight project* http://www.womenshealthmatters.org.uk/wp-content/uploads/REACH-Final-Report3.pdf

'We know poverty, abuse and violence are inequalities that are disproportionately suffered by women, which contributes to the picture of poor mental health, insecure housing and work, and disability, combined with high levels of caring responsibilities. Women's Lives Leeds provides a great opportunity not only to directly deliver positive outcomes for women and girls, but also enables a platform for the partner organisations to influence policy and strategy in Leeds. We are very optimistic about our ability as a partnership to generate the system change needed to achieve improvements to the health of disadvantaged women and girls with multiple and complex needs.'

Gemma Sciré,
Chair of Women's Lives Leeds



RECOMMENDATIONS

Leeds City Council Public Mental Health team to lead insight work with local communities to explore and understand self-harm behaviours.

Leeds City Council Public Health teams to review and further develop targeted early interventions to promote positive mental health and reduce self-harm risk in girls and young women.

'M'

M was referred to the Women's Lives Leeds Complex Needs Service in February 2017. She had problems with mental health, domestic abuse, gendered violence, poverty and accommodation in a history dating back over 15 years. She had particular problems in her relationships with her children but was unsure of where to go to get parenting help and support. She had not been able to engage with some of the statutory services in the past.

Through intensive one-to-one support, M has taken positive steps towards her future. She has had safety features installed at the property and now has housing band A.

Her relationship with her children has improved. She engaged with the Children and Families Social Work Services and attended a Parents and Children Together course. Her daughter has been referred to Targeted Mental Health in Schools.

By the end of March M was already feeling stronger and taking back control of her situation. Workers supported her to go back to her GP and a change in medication has helped M to sleep better at night.

M has gained in confidence and will be attending the Leeds Women's Aid Staying Safe Programme. This is a programme where women can support one another to understand domestic abuse, how it happens and how to become safe.

CASE STUDY

DRUG-RELATED DEATHS IN MEN

We have known for many years that people who take illicit drugs face a variety of potential health risks and contribute to the global burden of disease.[33] Whilst the level of drug misuse in England and Wales has remained fairly stable for a number of years, including in the 16–24 year old population, the incidences of all drug poisoning, drug misuse death and opiate-related death are at the highest levels in the UK since records began in 1993 (ONS, 2017).[34]

In 2016, the number of people who died due to opiates (1,989) in England alone overtook the number of people who died in road traffic accidents (1,732) across the whole of the UK. But what do we mean when we talk about drug poisoning and drug misuse death? What is an opiate or opioid? And why are so many people dying?

Opiates/opioids

Traditionally 'opiates' refers to drugs derived from the opium poppy, for example morphine and heroin, whereas 'opioids' refers to drugs man-made for use in medicine – for example, fentanyl, oxycodone and codeine – and prescribed by a doctor. However the two terms are often used interchangeably.

All of these opiate or opioid drugs act on the nervous system to relieve pain, but can also have a euphoric effect. Regular use of opioids – even when prescribed by a doctor – can lead to poisoning, overdose incidents and death.

Drug-related death

The European Monitoring Centre for Drugs & Drug Addiction (EMCDDA) defines a drug-related death as a death happening shortly after consumption of one or more psychoactive drugs, and directly related to that consumption.

In the UK, death from 'drug poisoning' includes legal as well as illegal drugs, accidental poisoning and suicides and deaths due to drug misuse.

A 'drug misuse death' is a death arising from drug abuse or drug dependence and where the underlying cause is drug poisoning from any substance controlled under the Misuse of Drugs Act 1971. This includes all drugs which are illegal in the UK, for example, cocaine, amphetamines and ecstasy.

Preventing deaths from drug misuse has become a national priority. The continued rise in deaths from drug misuse led Public Health England (PHE) and the Local Government Association (LGA) to convene a national inquiry to investigate the rise and prevention of these drug deaths.[35,36] In 2016, the Advisory Committee for the Misuse of Drugs (ACMD) advised ministers on how to reduce opiate-related deaths.[37] And this year has seen the publication of the new UK Drug Strategy[38] which signals the government's commitment to the prevention and treatment of drug misuse.

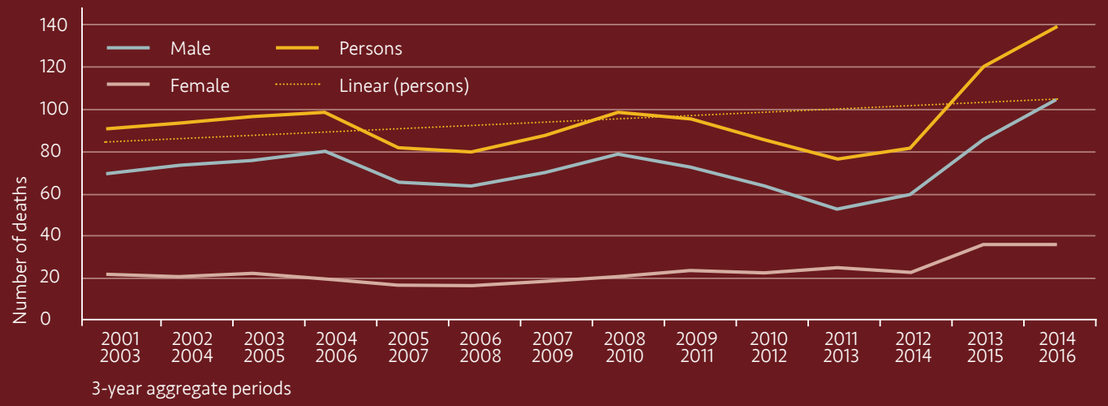
In 2016, 3,744 people died in England and Wales as a result of drug poisoning, an increase of 70 deaths (2%) from the previous year. Of these deaths, 2,593 (69%) were classified as drug misuse deaths, i.e. deaths involving all illegal drugs, not just opiates.

Nationally, despite fluctuations from year to year, drug misuse deaths have shown a 'persistent background rise'[39] since records began in 1993. The majority of these deaths have been from heroin/ opiate misuse.

In 2016, over half of drug poisoning deaths involved opiates. Opiate-related deaths have risen by 60% in England and Wales since 2012.

33 Degenhardt, L *et al* (2013) Global burden of disease attributable to illicit drug use and dependence; findings from the Global Burden of Disease Study 2010, *Lancet* 382(9904), pp.1564–74
34 Office for National Statistics (2017) *Deaths related to drug poisoning in England and Wales: 2016 registrations* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/ deathsrelatedtodrugpoisoninginenglandandwales/2016registrations
35 Public Health England (2016) *Understanding and preventing drug-related deaths* http://www.nta.nhs.uk/uploads/phe-understanding-preventing-drds.pdf
36 Local Government Association (2017) *Preventing drug-related deaths: case studies* https://www.local.gov.uk/preventing-drug-related-deaths
37 Advisory Council on the Misuse of Drugs (2016) *Reducing opioid-related deaths in the UK* https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk
38 HM Government (2017) *Drug strategy 2017* https://www.gov.uk/government/publications/drug-strategy-2017
39 Wright, C (2017) *Health matters: heroin availability and drug misuse deaths* https://publichealthmatters.blog.gov.uk/2017/03/01/health-matters-heroin-availability-and-drug-misuse-deaths/

NUMBER OF DEATHS RELATED TO DRUG MISUSE IN LEEDS. ALL PERSONS, MALES AND FEMALES IN LEEDS – REGISTERED DEATHS BETWEEN 2001 AND 2016



In the last year, for the first time, the 40–49 year age group had the highest rate of drug misuse deaths and the largest increase in opiate-related deaths. These were the people who were in their mid to late teens (the typical age of onset for heroin use) during the heroin 'epidemic' experienced in the UK from the early 1980s to the mid to late 1990s. This is an example of a cohort effect, i.e. a link between a statistical observation and a particular age group.

There is strong evidence that the risk of fatal overdose among heroin/opiate users increases substantially with age. In the short to medium term then, as the ACMD report highlights, we may be observing an increasing rate of opiate-related deaths among a dwindling population of older users. Opiate-related deaths have fallen substantially among people under 30 since the early 2000s. This suggests that, if no new wave of heroin or opiate use occurs, the UK could see a long-term reduction in opiate-related deaths.

Recent evidence suggests that the cohort effect described above is only a partial explanation for the increase in drug misuse deaths since 2012 because drug deaths are also occurring in increasing numbers across other age groups and from different types of drug use.

Drugs implicated in some of these deaths, and of concern, include new psychoactive substances like the synthetic cannabinoids (SCRAs), pregabalin and gabapentin. There are also continued increases in drug misuse deaths where cocaine and benzodiazepines were mentioned on the death certificate. Factors other than the age cohort effect must therefore be in play.

What's happening in Leeds?

Although local records only go back 15 years, all the evidence points to Leeds reflecting the national picture. Leeds too is experiencing a 'persistent background rise' in drug misuse deaths. In all, 139 people died in 2014–16 and more men died than women (75% in 2014–16). We are also seeing a rise in deaths in older, long-term opiate users. There is good news in that, in line with the national picture, we are not seeing a rise in deaths in younger opiate or opioid users. However, we now have a new challenge – rising deaths, particularly in men, from other drugs where different factors may be involved.

Preventing deaths from drug misuse is a priority for Leeds There is an urgent need to understand more about what is going on in Leeds with this changing pattern of deaths. Also, we need to better understand the links to other health issues, including HIV, hepatitis C, sexually transmitted diseases and mental illness. Among young people we've also noted an increase in infectious endocarditis, an infection of the heart valve, often caused by re-use and sharing of contaminated syringes. All of which will have an impact on the need for prevention services and treatment and care services.

As part of the Leeds Drug and Alcohol Strategy (2016–2018),[40] and in line with Public Health England recommendations, Public Health is undertaking an audit of drug misuse deaths in Leeds in partnership with the Coroner. The audit covers 102 deaths occurring during 2014–16. In line with expectations, men account for 80% of these deaths, with a peak in the 30-45 age group. The audit will give us a better understanding of the risk factors and characteristics that have contributed to the story of each person's life and their often premature death. The audit should also help us target interventions to prevent these deaths in ways that better meet the changing circumstances we now face.

Ahead of completion of the audit we have already improved the reporting, monitoring and communication with Forward Leeds, the local drug and alcohol service, about drug deaths amongst people actively engaged with the service. We have also strengthened links and developed better information-sharing with the Leeds Coroner's office.

We are working in partnership with Forward Leeds, NHS Leeds and the health protection team to address factors which increase risk to this population. This includes finding ways of improving the general health and addressing the broader physical and mental health needs of our ageing heroin/opiate user population.

CASE STUDY

'R'

R is a 44-year-old former heroin user now on opiate substitute treatment. R began using heroin in his late teens when he was prevented by an injury from playing sport. What began as one-off use quickly developed into addiction and R started to engage in low-level criminal activities to support his daily habit. R continued to use heroin for almost 25 years, with breaks when he was in prison. He came to Forward Leeds for help when he realised that life was passing him by in a blur. He is continuing to work his way through a methadone programme until he is ready for a full detox.

40 Leeds City Council (2017) *Leeds drug and alcohol strategy 2016–2018* http://observatory.leeds.gov.uk/resource/view?resourceId=5028

Since 2016, we have been distributing naloxone kits for use in the community through Forward Leeds. This has been shown to be a cost-effective way of reducing deaths from accidental overdose of opiates. Naloxone is a drug that temporarily blocks the effect of opiate and opioid drugs. When it is injected into a muscle it rapidly reverses the harmful effects caused by the these drugs. This effect lasts for about 20 minutes, allowing more time for emergency services to arrive and for ambulance staff to help save a life.

Since Forward Leeds has been distributing these naloxone kits, 11 kits have been used and returned to the service. That's 11 lives saved from accidentally overdosing whilst in the community.

The distribution of naloxone will continue in Leeds. We are also investigating the feasibility of our frontline police officers and Police Community Support Officers carrying naloxone. In addition, we need to ensure that we make this life-saving drug available to people at key points of risk, for example when leaving hospital or on release from prison.

Forward Leeds – the local drug and alcohol service

My report has already mentioned the newly recommissioned integrated Leeds Drug and Alcohol Prevention and Treatment Service – Forward Leeds. As with alcohol treatment, we are starting to see the benefits of the hard work and dedication of the staff in this service.

The figures from Forward Leeds appear to support the gender difference I discussed in the introduction to this report. Males accounted for the majority of clients entering drug treatment in 2016–17. Men also accounted for the majority (75%) of those entering treatment for heroin or opiate addiction. Of those starting treatment for opiate addiction, 72% had received treatment previously. This means that at some point they have left or become disengaged from drug treatment services, putting them at increased risk of harm and of death.

The number of male clients entering the service in 2016–17 with opiates as their primary substance of use was about 20% of the total. The service has highlighted a steady increase in the number of entrants who are choosing to inject their drugs to boost the effect. We know that this type of drug use carries with it the highest risk.

The most common age for entering the service over this period was 35–44 years, closely followed by the 25–34 year age group. Due to the date when Forward Leeds started work in the city we are unable to compare these figures with previous years to get a picture of whether younger people are entering the service. This is something we need to keep an eye on in the future.

The percentage of successful treatment completions for opiates is the lowest across all of the substance groups within the service. However, whilst we want to improve this figure, we need to strike the right balance. It is not just a matter of seeking to improve a particular indicator. We need to make sure that the right people are in drug treatment for the right amount of time to ensure a sustained recovery and that service users do not increase their risk of harm, or even death, through disengaging with the service. Forward Leeds has been supporting long-term opiate users with aspects of their lives such as secure housing, social support networks, employment and resilience to help achieve sustained recovery.

There are positive signs. As with alcohol, the overall percentage who successfully completed their opiate treatment and did not re-present to the service within six months – a national indicator – has steadily increased over 2017. Men accounted for 62% of opiate users who successfully completed treatment and did not re-present. These recent improvements are great news as we know through evidence the protective benefit that drug treatment can have.[41]

Forward Leeds are working on improving their outreach services. This will introduce clients to the service who will then be more likely to engage with their treatment and recovery. However, we do still need to review treatment pathways and explore how we can improve them to ensure that we intervene at points of greatest risk to reverse the high level of harm and mortality that we are currently seeing amongst men in the city.

RECOMMENDATIONS

Leeds City Council to use the drug misuse death audit findings to better target interventions to prevent drug deaths in Leeds.

Leeds City Council and Forward Leeds to review routes of opiate drug treatment for males and ensure that interventions occur at times of greatest risk and that treatment services are appropriate to need.

Leeds City Council and Leeds Drug and Alcohol Board members to ensure that partners work collaboratively to address the physical and mental health needs of heroin/opiate users, enhancing access and support with employment, housing and other services that promote sustained recovery.

62%

of opiate users who successfully completed treatment and did not re-present were men

'J'

J is a 40-year-old woman who is a former opiate user with complex mental health needs. As she had friends who were also heroin users, Forward Leeds were concerned about the risk of relapse and so ensured that she took a naloxone kit home with her when they were first made available. She had received the relevant training and the accompanying instructional leaflet.

On Friday she had phoned in to Forward Leeds in distress and reporting thoughts that alternated between relapse and suicide. Her key worker was able to talk her around but had concerns because this was happening over a weekend.

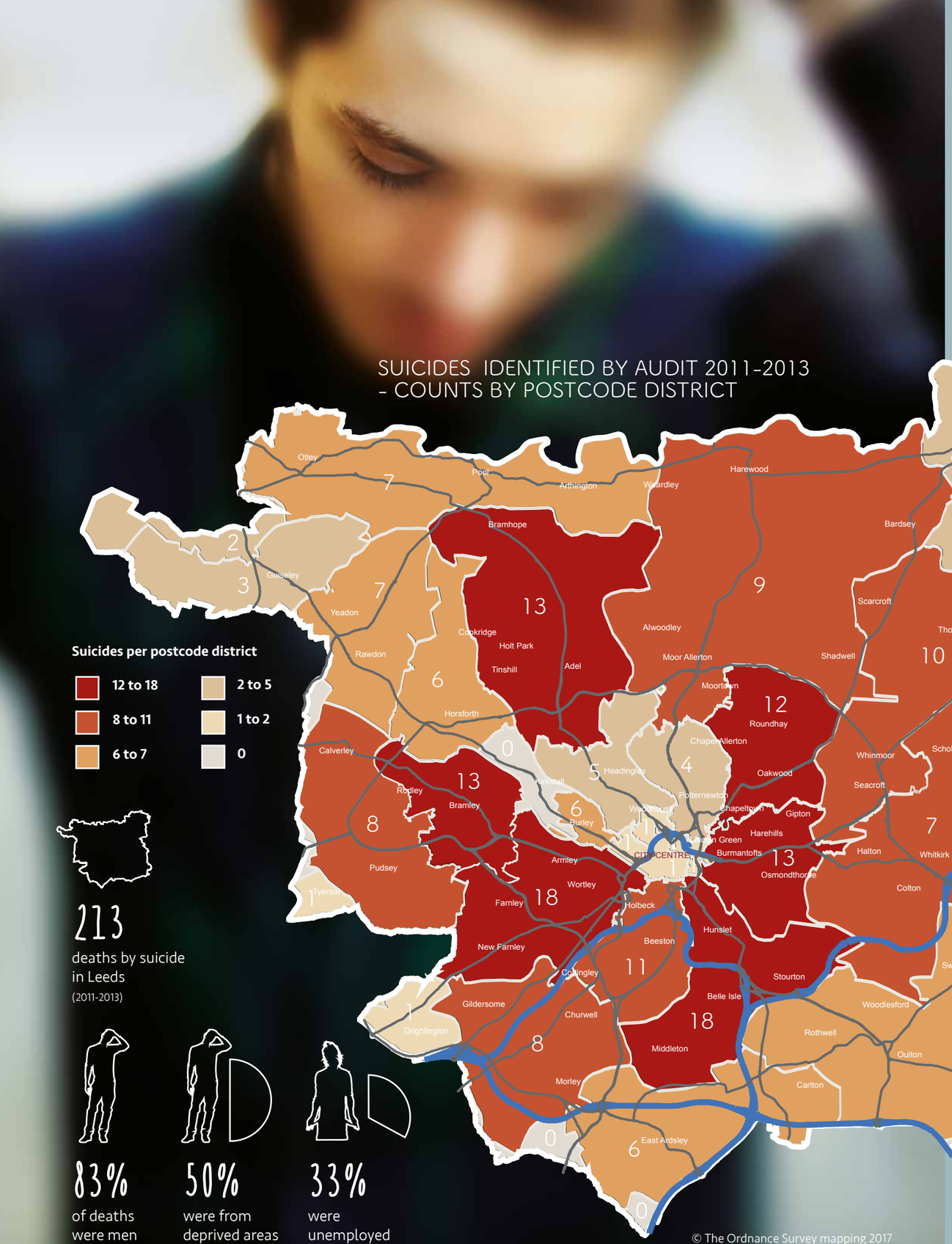
On Monday J's key worker called her to see how she was feeling. J explained that she was still distressed. The reason she was upset was that over the weekend a friend had called round and started using heroin in front of her.

J was able to resist the temptation to use. Moreover, when her friend overdosed in front of her, she had the presence of mind to use the naloxone kit she had been provided with. She recalled the training, followed the instructions, revived her friend and called an ambulance.

CASE STUDY

41 White, M *et al* (2015) Fatal opioid poisoning: A counterfactual model to estimate the preventive effect of treatment for opioid use disorder in England, *Addiction* 110(8), pp.1321–9

SUICIDES IN MEN



Suicide prevention is both a national priority and a long-standing priority in Leeds. The national suicide prevention strategy, *Preventing Suicide in England: a cross-government outcomes strategy to save lives* (2012, refreshed 2017),[42] gives councils a local leadership role in preventing suicides.

A key recommendation of the national suicide prevention strategy is to undertake a local suicide audit in order to determine the characteristics, events and risk factors that contribute to a person taking their own life. The idea of this is to ensure that interventions to prevent suicide are targeted at high-risk groups where there is most need. In Leeds, the Audit of Suicides and Undetermined Deaths in Leeds (or Leeds Suicide Audit) has for some time provided 'gold standard' intelligence about high-risk groups for suicide in the city. Indeed, the Leeds Suicide Audit 2008–2010 (published in 2012) has received national recognition from Public Health England as an example of best practice.[43]

Work in Leeds is steered by the multi-agency Leeds Strategic Suicide Prevention Group. The city-wide Suicide Prevention Action Plan for Leeds 2017–2020[44] identifies three key high-risk groups in Leeds:

- men aged between 30 and 50 years with risk factors outlined in the most recent Leeds Suicide Audit (2011–13)[45]
- people at risk of or with a history of self-harm
- people in the care of mental health services.

What is the picture for Leeds?

There were 213 deaths by suicide in Leeds between 2011 and 2013. The rate of death from suicide was 9.5 deaths per 100,000 people in Leeds. The vast majority of the people who took their own life were men (83%). In Leeds, men are almost five times more likely to end their own life than women (5:1). This is higher than the national average of 3:1. The rate of suicide in men has increased slightly since the previous audit (2008–10), whereas the rate in women has remained stable.

The majority of people who took their own life were white British. In Leeds, white British men are over twice as likely to end their own life than men from black or minority ethnic (BME) backgrounds.

Over half of the people who took their own life lived in the poorest or most deprived areas of the city. The map shows that the two areas with the highest number of suicides lie slightly west and south of the city centre.

The majority of the people who took their own life were single, divorced or separated. Nearly half of the people lived alone, and over half experienced problems with a personal relationship. This suggests that social isolation is a risk factor.

42 Department of Health (2012, refreshed 2017) *Preventing suicide in England: a cross-government outcomes strategy to save lives* https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
43 Public Health England (2014) *Suicide prevention: developing a local action plan* https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan
44 *Suicide prevention action plan for Leeds 2017–2020* http://www.leeds.gov.uk/docs/Working%20action%20plan%20draft%202017.pdf
45 Leeds City Council (2016) *Audit of suicides and undetermined deaths in Leeds 2011–2013* http://www.leeds.gov.uk/docs/Leeds%20Suicide%20Audit%202011-2013.pdf

Around a third of the people were unemployed at the time of their death. This is three times higher than the average unemployment rate in Leeds at that time. Many people were experiencing increasing financial difficulties. Worklessness and money problems were themes present in a large proportion of the deaths.

What are we doing in Leeds?

The Leeds approach to suicide prevention combines successful local partnership working, evidence-based practice and an ambitious scale. Following publication of the 2008–10 audit, we commissioned insight work to target high-risk groups. Much of this was through community development approaches.

For example, the Green Man initiative for men at risk was led by The Conservation Volunteers (TCV, a community volunteering charity) at Hollybush with locality partners across the city including Space2, Barca and Leeds Health for All. Each agency had already been working with isolated and high-risk men within communities and so the partnership was well placed to take forward this work in areas of deprivation with high numbers of suicides. The learning from this work continues to shape local community action. Men who have identified themselves as being at risk at some point in their life have become mental health champions in their local community or place of work and engage in activity to reduce the stigma of poor mental health and help raise awareness within their own communities around men's mental health. This work also promotes and celebrates the positive role men play in their community.

The West Yorkshire Fire and Rescue Service (WYFRS) Adopt a Block initiative was initially developed two years ago to prevent fire and other incidents in high-rise blocks in the poorest areas of the city.[46] Partnership working with the Leeds Strategic Suicide Prevention Group identified men living in isolation in high-rise blocks as a high-risk group for suicide. WYFRS and Barca housing officers have identified the premises or 'blocks' associated with the highest number of incidents. Each month the nominated WYFRS watch visits the block and inspects it for fire safety from top to bottom. As they do this, officers try and do a home fire safety check at each flat and meet the occupier. The idea is that, over time, residents will come to know and trust the officers, who may then be able to engage them in talking about health and welfare issues and offer guidance about getting help, for example by providing a Crisis Card.

46 National Suicide Prevention Alliance (2017) *Case study: Adopt a Block* http://www.nspa.org.uk/wp-content/uploads/2017/10/NSPA_CaseStudy_AdoptABlock_v2.pdf

THE INSIGHT PROJECT

E is a 66 year old man who came to the attention of the Insight Project through outreach work at a local community centre. Having overheard a conversation with a Barca-Community Health Education worker in which E made self-deprecating comments about suicide, the project worker asked him if he had been suicidal. E confirmed that he had. He had not spoken to anyone about it even though it happened about six weeks earlier. E described the loss of his partner and home, and a sudden relocation to Leeds, as all contributing to his feelings. He was new to the area and felt isolated. The project worker gave him a Crisis Card and the PEP (Patient Empowerment Project) phone number and booked to meet the following week. At the end of the conversation E expressed deep gratitude and said, 'God bless you, thank you for caring'.

At the next meeting E showed interest in sports, woodwork, and sessions to help him reduce anxiety. Over the following six weeks the project worker maintained regular phone contact with E, offering him a range of information and opportunities for one-to-one support to access activities. He did not access any of these during that time, but continued to want to learn about different opportunities, and he did attend a music group at the local community centre. The project worker referred him to Armley Helping Hands. In a phone conversation a week later, E reported that he had acquired a Leeds Extra Card and said the referral had been helpful. He spoke positively about wanting to attend walking football, and expressed a desire to work sometime soon, which was a very positive step. He said that he did not feel he needed any more support from the insight project and expressed thanks for all the support he'd received.

CASE STUDY

Crisis Cards are credit card-sized leaflets containing information about local support services, including housing, welfare, debt, and emotional support. These are distributed through the Public Health Resource Centre to GP surgeries, One Stop Centres, housing agencies, West Yorkshire Police and WYFRS.

Fire crews have received suicide prevention training and have established relationships with local providers such as third-sector community-based organisations and frontline NHS mental health services. In October 2017 this work was used as a case study for the National Suicide Prevention Alliance document *Local Suicide Prevention Planning*[47] and for Public Health England's suicide prevention resources.[48]

Working with Leeds Strategic Suicide Prevention Group, the National Union of Journalists has developed media guidelines for local journalists on the reporting of suicides to help reduce the stigma around the subject. Engaging with media and communications to ensure that they report suicides sensitively and responsibly is a key priority area in the national suicide prevention strategy, as public messages around suicide have a significant impact on suicide itself.

Finally, Leeds invests in targeted delivery of internationally recognised suicide prevention training. Training is targeted at those working directly with high-risk groups and at local communities where deaths from suicide are significantly higher.

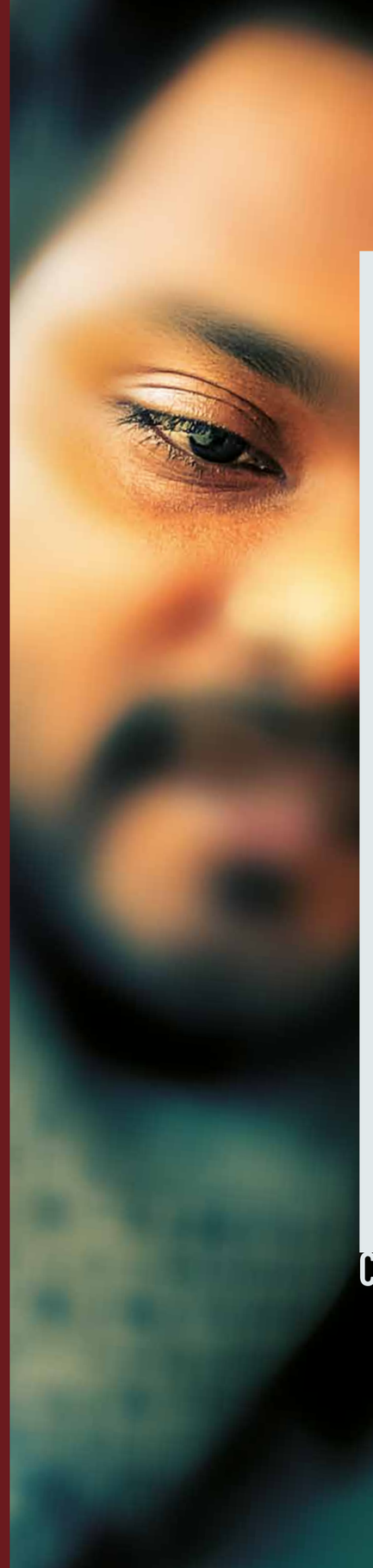
Postvention

When someone dies by suicide, they leave behind the people close to them: family, friends, colleagues, and neighbours. For every death by suicide it is estimated there are between five and ten people who are severely affected by the death. This suggests that, in Leeds, there are around 300 to 600 people affected by suicide each year. When someone is bereaved by suicide the grieving process is often heightened. Evidence suggests that being bereaved by suicide has a significant impact on mental health and is in itself a risk factor for suicide.

'Postvention' describes the range of support that can be put in place for people bereaved by suicide. There is increasing national[49] and international[50] evidence to suggest that timely and appropriate support to people who have lost someone through suicide has the potential to reduce their own risk of suicide.

The Leeds Suicide Bereavement Service was established in September 2015. It provides postvention support for anyone bereaved by suicide, through counselling as well as group and one-to-one support. A wide range of local support services refer into the service, including the police, mental health services, and other local organisations supporting people who are bereaved.

47 National Suicide Prevention Alliance (2017) *Local suicide prevention planning* http://www.nspa.org.uk/home/our-work/joint-work/supporting-local-suicide-prevention
48 Public Health England (2015, updated 2017) *Suicide prevention: resources and guidance* https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance
49 Public Health England (2017) *Support after a suicide: a guide to providing local services* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf
50 World Health Organization (2014) *Preventing suicide: a global imperative* http://www.who.int/mental_health/suicide-prevention/exe_summary_english.pdf?ua=1



LEEDS SUICIDE BEREAVEMENT SERVICE

In December 2016 my dad took his own life at 51 after suffering with mental health problems for a number of years, something that no one could ever prepare for.

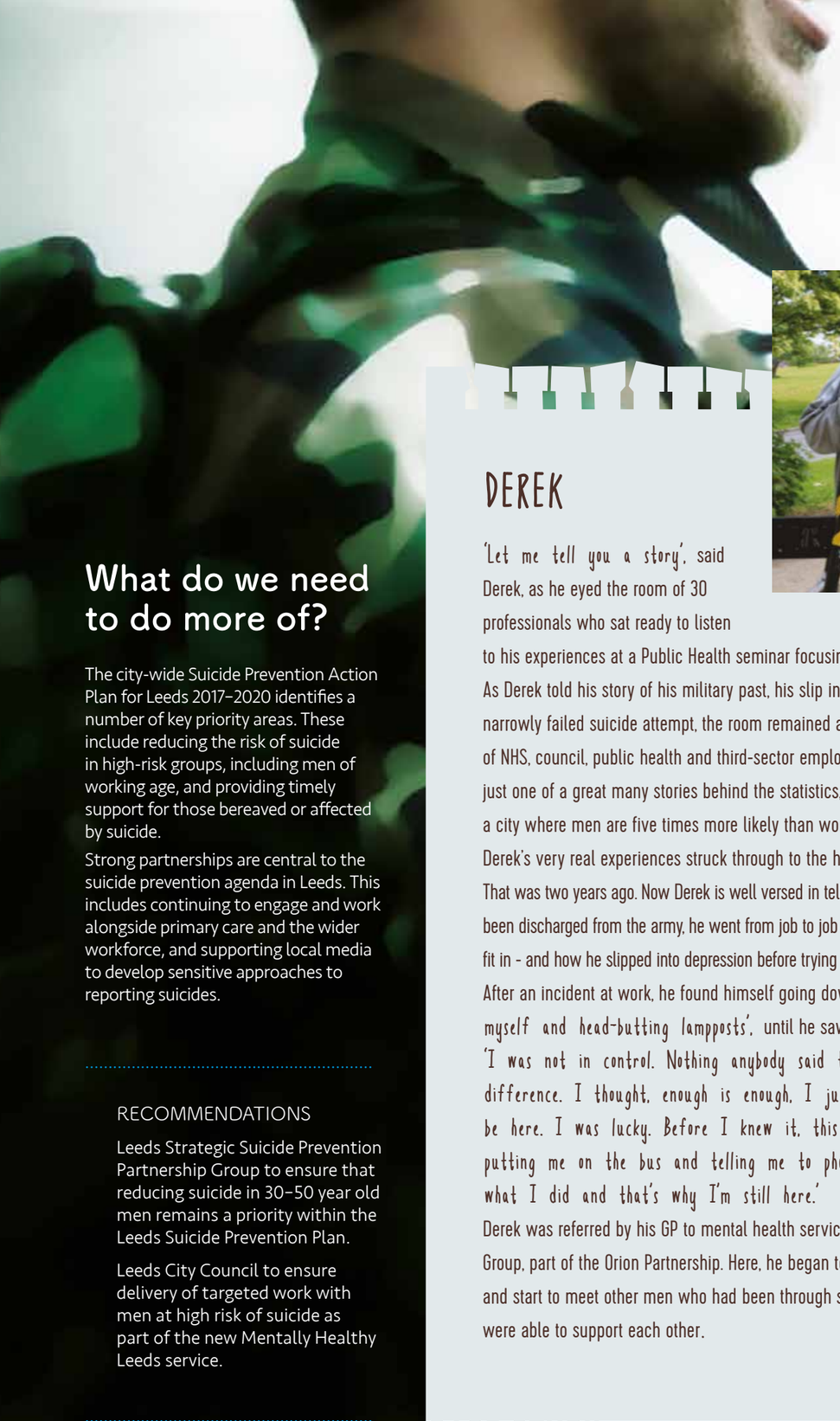
I don't think you can ever put the grief of someone so close into words, more of just a wave of sadness, heartache and loneliness that hits you when you least expect it.

The impact this has had on our family and his friends has been devastating. My dad was my hero and my best friend too and the reality is you don't realise how much you need someone until they're gone.

I'm currently away at university so leaving my family after this happened was one of the most difficult things. Knowing that I'd be alone if I returned to Leeds was a hard to choice to make. Both my Mam and my sister have also struggled, emotionally, mentally and financially. My dad had worked hard all of his life and he was always the one we would turn to if we had a problem. Although struggling with his own battles, he'd always know what to say to make our problems go away.

I've come to terms with the fact that the pain of losing someone really doesn't ever go away, just some days are harder to cope with than others.

CASE STUDY



What do we need to do more of?

The city-wide Suicide Prevention Action Plan for Leeds 2017–2020 identifies a number of key priority areas. These include reducing the risk of suicide in high-risk groups, including men of working age, and providing timely support for those bereaved or affected by suicide.

Strong partnerships are central to the suicide prevention agenda in Leeds. This includes continuing to engage and work alongside primary care and the wider workforce, and supporting local media to develop sensitive approaches to reporting suicides.

RECOMMENDATIONS

Leeds Strategic Suicide Prevention Partnership Group to ensure that reducing suicide in 30–50 year old men remains a priority within the Leeds Suicide Prevention Plan.

Leeds City Council to ensure delivery of targeted work with men at high risk of suicide as part of the new Mentally Healthy Leeds service.

CASE STUDY

DEREK

'Let me tell you a story', said Derek, as he eyed the room of 30 professionals who sat ready to listen to his experiences at a Public Health seminar focusing on men's health.

As Derek told his story of his military past, his slip into depression and his narrowly failed suicide attempt, the room remained absolutely silent. This group of NHS, council, public health and third-sector employees were being offered just one of a great many stories behind the statistics, policies and procedures, in a city where men are five times more likely than women to take their own lives. Derek's very real experiences struck through to the heart.

That was two years ago. Now Derek is well versed in telling his story of how, having been discharged from the army, he went from job to job and never really managed to fit in - and how he slipped into depression before trying to take his own life.

After an incident at work, he found himself going down the street, 'hitting myself and head-butting lampposts', until he saw the No 13 bus coming.

'I was not in control. Nothing anybody said to me made any difference. I thought, enough is enough, I just don't want to be here. I was lucky. Before I knew it, this little old lady was putting me on the bus and telling me to phone my doctor. That's what I did and that's why I'm still here.'

Derek was referred by his GP to mental health services and to the Space2 Men's Group, part of the Orion Partnership. Here, he began to build back his confidence and start to meet other men who had been through similar experiences and were able to support each other.

'It's not 'Turn up and do as I tell you', it's 'Do it if you want.' You can sit if you want to, but hopefully you will interact. So when I do get up, I feel part of it.'

This approach pays dividends, with men being able to participate on their own terms and become more involved with activities and peers as their confidence grows.

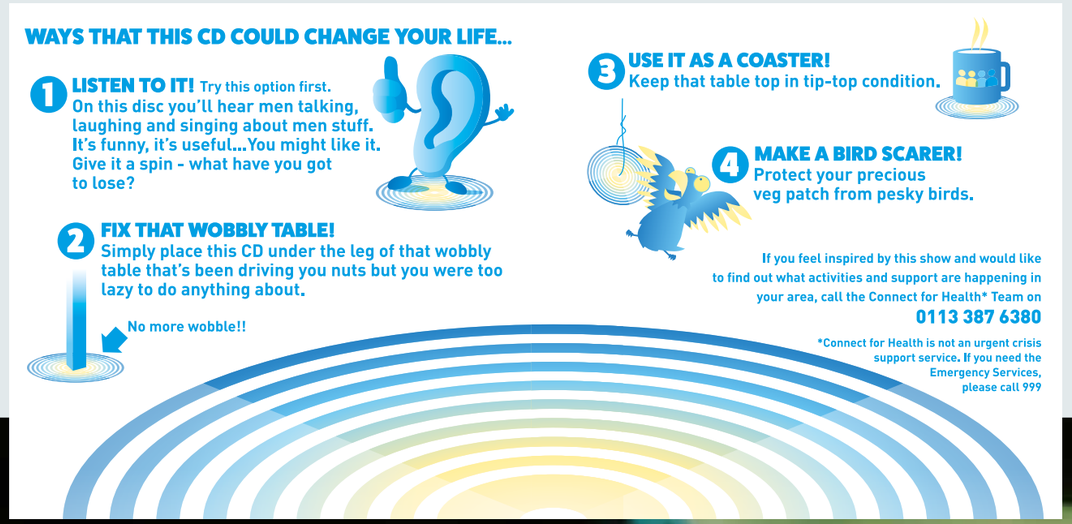
Whilst Derek still battles with depression and other health issues, he continues to play an active role in the Orion Well Man Programme. Aside from attending Space2, he has been supported in his passion to share his story with other men, including appearances on BBC Look North, BBC Leeds and at seminars and conferences.

Most recently, Derek helped to co-produce MenFM, a radio programme aimed at inspiring and encouraging inactive and isolated men to become more active. Derek is the jovial anchor man, presenting the comedians, musicians, health experts and men's groups to the audience, and encouraging the listener to get out, 'even if it's just for a walk around the block'.

'Take that lovely mind of yours for a stroll. It's always having a good day.'

It is only at the end that Derek's tone changes. As he tells his story, his integrity, passion and reason for his appearance on the show becomes clear as he appeals to his audience to seek the help they need, as he was able to do.

MenFM is available on CD from the Orion Partnership at damiand@space2.org.uk and also as a download at www.soundcloud.com/menfmleeds



RISE HIGH

In the introduction to this report I talked about the need to combine the economic with the social. Improving the health and wellbeing of people in deprived areas of Leeds is not simply a matter of economic investment. We know that factors such as loneliness, money worries, family problems and unemployment have a negative impact on health and wellbeing and quality of life. We also know that solving complex problems may involve a number of different agencies. This concluding case study shows how a broader, multi-agency perspective can improve the health and wellbeing of people living in our more deprived areas.

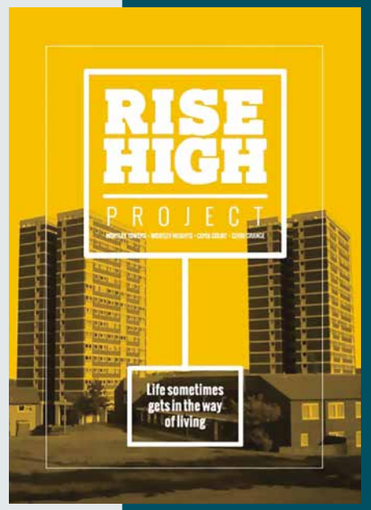
New Wortley is one of the council's priority neighbourhoods for change. It has lots of community assets and positive things happening, despite being in the poorest 1% of neighbourhoods nationally based on deprivation figures. The local GP practices, primary school and new community centre are all fantastic assets for the community. And the recent Our Place initiative has brought together a number of partners and local people keen to make a difference.

Leeds City Council's housing department has historically faced a number of problems in the Clydes and Wortleys tower blocks, however. There are four blocks: Clyde Court, Clyde Grange, Wortley Heights and Wortley Towers. These blocks house around 400 people altogether, mainly in one-bedroom properties. Resident turnover is high and there are high levels of crime, drug use, rough sleeping and prostitution. Under-reporting of crime has been a long-term problem. Over 70% of residents in each block are single males aged between 30 and 50. More than half of residents are receiving Housing Benefit and so are unlikely to be working. The Leeds Suicide Audit for 2011–13 has identified that LS12 has one of the highest levels of recorded suicides in the city. The people in the flats have many of the risk factors for suicide: men with high levels of unemployment, single occupancy, social isolation, as well as alcohol and drug abuse.

The multi-agency Rise High project aimed to improve the perception and reputation of the Clydes and Wortleys blocks.

The project approached this in three main ways:

- economic investment in the physical fabric of the blocks, such as more affordable biomass heating, a new lift and access to free Wi-Fi
- improved support to tenants while also doing more to challenge anti-social behaviour on the part of some tenants
- integrated partnership working across the third sector, housing, police and health services.



Leeds Adults and Health services and Housing Leeds worked in partnership with the charity Barca–Leeds to provide support to improve people's health and wellbeing. The involvement of different agencies made it possible to treat people holistically and address the complexity of their needs, rather than approach each need individually from a single-service perspective. Many of the people who engaged with Rise High were not accessing the services they needed. The team worked with residents to identify their specific problems, develop goals to improve their health and wellbeing and put them in touch with the appropriate local services and agencies to support their needs.

The project aimed to build on people's strengths rather than simply identifying shortcomings. Anyone who asked for help got it – no thresholds – so that interventions could happen at an early stage before problems got worse.

In total, over 65 of the 400 residents engaged with the service between November 2015 and the end of March 2017 when the project ended. Half of these clients didn't speak English as their first language and many struggled to communicate in English. There was also a lack of understanding of UK systems. For example, one household was spending £10–15 per day on topping up their electricity card because they didn't realise that they had to inform the supplier of their new tenancy. This meant that they were paying off the arrears left on the account by the previous tenants. The team fed this information back to Housing Leeds so they could address this problem when developing pre-tenancy training.

Eight of those assessed, six of whom were male, stated that they currently had suicidal thoughts, or had had such thoughts in the past. Three of the eight had actually attempted suicide.

The project delivered noticeable outcomes and improvements for tenants. The measure of overall self-rated health improved. Over half (53%) of clients reported an increase in housing satisfaction. They also reported reducing debt, finding employment and volunteering. Problems with self-care (washing and dressing) dropped by 11%, from 33% to 22%.

The learning from this project is now being used to inform the Engage Leeds city-wide supported housing contract as well as the Adopt a Block project described earlier in this report.

'I feel happy again.'

'I wouldn't have got any of this (support) if it wasn't for your help'

'I've received more support from you in the past two weeks than I have from any other service.'

'You're a superstar, thank you for your help.'

53%
of Rise High clients reported an increase in housing satisfaction

11%
drop in problems with self-care

CASE STUDY

CONCLUSIONS

My report this year has focused on a worsening life expectancy for women and a static life expectancy for men in our city. The individual sections around alcohol mortality in women, self-harm in women, drug misuse in men and suicide in men each carry important recommendations. There are also recommendations around Best Start and the Inclusive Growth Strategy. However, taking a step back, there are some broader conclusions to be drawn – namely the importance of local public health information and intelligence. Yes, we need Public Health England for a national picture and for a picture of Leeds as a whole. But we are also seeing the benefits of a strong Leeds Public Health intelligence function that can analyse public health issues within the city. The recent decision to combine the Public Health intelligence function with the NHS Clinical Commissioning Group intelligence function will only help this ability further and is to be welcomed.

The skill of our Public Health Intelligence Team at getting beneath the headlines has been crucial to a better understanding of the real areas of concern for Leeds. We will continue to monitor the health status of our population. However, there are emerging health issues that are different for men and for women. There is an urgent need to better understand the particular health needs of men and of women. Professor Alan White and Amanda Siems from Leeds Beckett University, in conjunction with Public Health, have undertaken what is so far the largest health needs assessment for men in this country. We now need to undertake similar work on the needs of women, recognising that this will uncover both need and information gaps. So I have two more recommendations and these are set out below.

My report highlights a number of public health issues that are causing the health of men and women to get worse. Reversing these worrying trends needs to be a priority. Our actions must be based on a greater understanding of underlying gender issues than we have had in the past. I do realise that there is increasing awareness about those who cross traditional gender boundaries (trans) whether permanently or otherwise. In the future, there will be a need to better understand the health and wellbeing issues and challenges that trans people face in their lives.

I know these are challenging times, and it is perhaps inevitable that this will have a negative impact on the health of the people in our city. However, partnership working on health and wellbeing has never been stronger. The city's Health and Wellbeing Strategy and Inclusive Growth Strategy set out a clear direction of travel. I have no doubt we have the right priorities. I retain my optimism that, by working together for the city, we can return to improving life expectancies and reducing health inequalities.

RECOMMENDATIONS

Leeds City Council to undertake a comprehensive health needs assessment for women.

Leeds City Council Public Health Intelligence Team to continue to monitor life expectancy and report back to the Leeds City Council Executive Board and Leeds Health and Wellbeing Board.

RECOMMENDATIONS 2017-18

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Leeds City Council Public Health Intelligence Team to continue to monitor life expectancy and report back to the Leeds City Council Executive Board and Leeds Health and Wellbeing Board.

Leeds City Council to identify a broad range of indicators to assess progress on Inclusive Growth through the new Inclusive Growth Strategy, reflecting different geographies and populations within the city.

Leeds City Council to ensure that its new Leeds Inclusive Growth Strategy improves the socio-economic position of the most deprived 10% of communities in the city.

The Leeds Best Start Strategy Group to help ensure that parents are well prepared for pregnancy and that families with complex lives are identified early and supported.

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Forward Leeds to use local insight to develop a social marketing campaign targeting young women and aimed at reducing alcohol consumption and promoting access to services.

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Leeds NHS Trusts to increase identification and brief advice (IBA) in primary and secondary care with a particular focus on areas of deprivation with highest alcohol harm.

Leeds City Council and Forward Leeds to review alcohol treatment services for females and ensure services are appropriate to the needs of women.

Leeds City Council Public Mental Health team to lead insight work with local communities to explore and understand self-harm behaviours.

Leeds City Council Public Health teams to review and further develop targeted early interventions to promote positive mental health and reduce self-harm risk in girls and young women.

Leeds City Council to use the drug misuse death audit findings to better target interventions to prevent drug deaths in Leeds.

Leeds City Council and Forward Leeds to review routes of opiate drug treatment for males and ensure that interventions occur at times of greatest risk and that treatment services are appropriate to need.

Leeds City Council and Leeds Drug and Alcohol Board members to ensure that partners work collaboratively to address the physical and mental health needs of heroin/opiate users, enhancing access and support with employment, housing and other services that promote sustained recovery.

Leeds Strategic Suicide Prevention Partnership Group to ensure that reducing suicide in 30–50 year old men remains a priority within the Leeds Suicide Prevention Plan.

Leeds City Council to ensure delivery of targeted work with men at high risk of suicide as part of the new Mentally Healthy Leeds service.

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A warm thank you to everyone who has contributed to this year's annual report, particularly the Public Health Intelligence Team and Richard Dixon. Without them, our understanding of the changes in life expectancy would not be possible.

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