Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2022-2025

Contents

Proposed Signatories

The joint Cambridgeshire and Peterborough suicide prevention strategy is the result of discussions between partner organisations and individuals. This document is an acknowledgement that members of the below organisations agree to achieving the ambitions laid out in the 2022-2025 Suicide Prevention Strategy:

Anglia Ruskin University
British Transport Police
Cambridge University
Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire and Peterborough Sustainability and Transformation Partnership STP
Cambridgeshire Constabulary
Cambridgeshire County Council
Cambridgeshire, Peterborough and South Lincolnshire Mind
East of England Ambulance Service Trust
Fullscope
GT Railway
Lifecraft
Network Rail
Peterborough City Council
Rethink Carers
Samaritans
Service User Network

Foreword

Executive Summary

The Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2022-2025 seeks to update and combine a number of existing Suicide Prevention strategies, placing a greater emphasis on working collaboratively as a system. The primary strategies informing this work are the Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2017-2020 and the CPFT Suicide Prevention Strategy 2017-2020.

This work is informed by the National suicide prevention strategy 'Preventing suicide in England' and its subsequent progress reports, chiefly the fifth progress report released in 2021.[1] Local data and collaboration with mental health services and people with lived experience have been employed in order to tailor the national approach to Cambridgeshire and Peterborough.

This strategy has determined a key ambition for suicide prevention work within Cambridgeshire and Peterborough over the next three years.

Our Ambition

Every person in Cambridgeshire and Peterborough has access to the right care and support, from both the mental health system and their communities, to ensure that they do not die by suicide

Every suicide is a preventable loss of life and a tragedy and deeply affects the family and friends connected to the individual. Together, we can recognise and address the drivers of suicide, support people to stay mentally well and offer help when it is needed.

Suicide is not inevitable.

Joint Health and Wellbeing Strategy 2022-2030

Covid has had an immeasurable impact on our lives, some of which is yet to be seen. It has already had an impact, seen in the increased demand for mental health services. While we have not yet seen a measurable impact on suicide rates nationally, we will continue to monitor suicide rates over the coming years.[2]

In the context of Covid recovery, system partners have met to consider priorities for health and wellbeing. They agreed a number of ambitions and priorities as described in Figure 1 below:

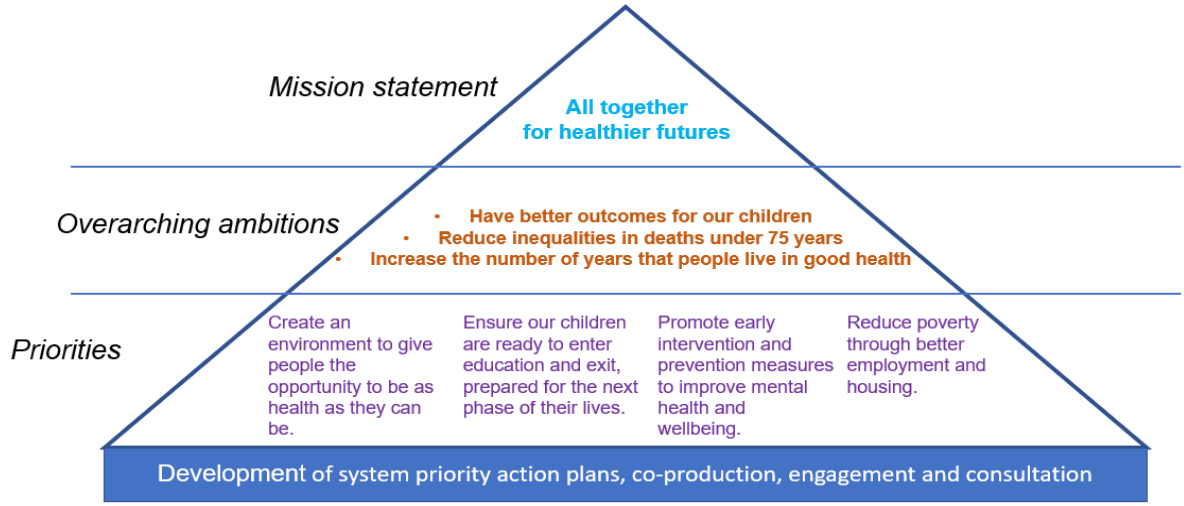


Figure 1: Health and Wellbeing Strategy 2022-2030 Ambitions and Priorities

The Suicide Prevention Strategy will sit alongside a Public Mental Health Strategy and a Children and Young People's Mental Health Strategy under the priority area to 'promote early intervention and prevention measures to improve mental health and wellbeing.'

The Suicide Prevention Strategy Implementation group has worked cooperatively with those developing the other mental health strategies to ensure that work aligns well. While each strategy clearly has an identified area of focus that it is wholly responsible for, there are clear areas of overlap, most notably in transitions between childhood and adulthood, and from community support to clinical support. Measures taken to improve the wider determinants of health and children's outcomes, as well as the proactive measures taken to improve mental well-being, will all have an impact on mental health, including reducing risk of suicide.

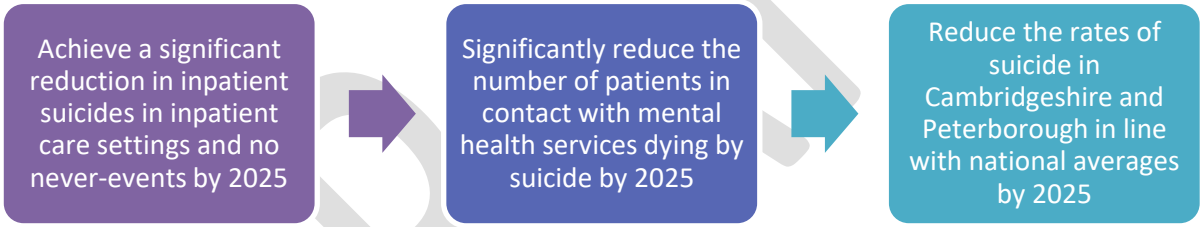
The Public Mental Health Strategy has a focus on promoting mental wellbeing amongst the general population and preventing mental ill health and the CYP MH strategy focuses on providing adequate, timely support to children and young people struggling with their mental health. While previous iterations of the suicide prevention strategy have attempted to cover the mental health needs of the entire population, co-operation with these strategies means that there can be a greater focus on those at a higher risk of mental ill

health who are likely in need of accessing, or already accessing mental health support, taking into consideration those CYP at risk of self-harm and suicide.

Key in the delivery of these strategies is ensuring there is clarity of role in governance, resulting in collaborative practice and best use of resources. In strategy development, data collection regarding mental health on a local level has been difficult to achieve, particularly in relation to children and young people. To measure the full impact of these strategies, it is important that we also address issues with data collection relating to suicide and self-harm.

Measuring Impact of this Strategy

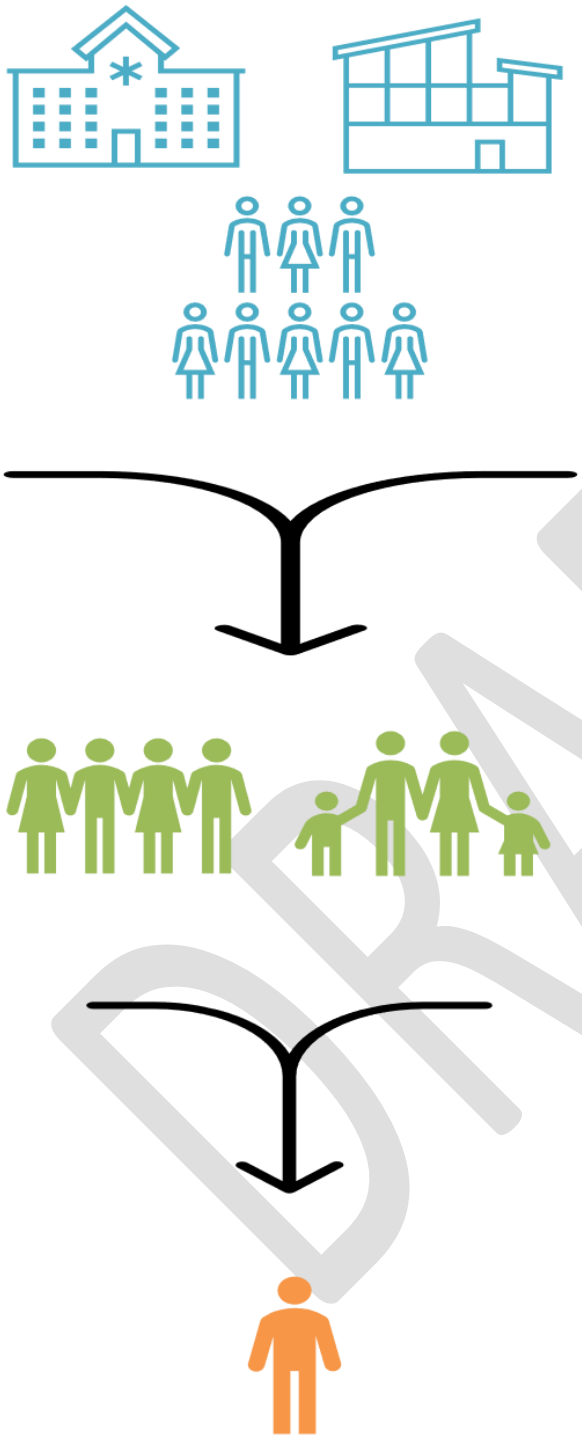
Following agreement from the multi-partner suicide prevention implementation board in 2017, Cambridgeshire and Peterborough are pursuing a zero suicide ambition, described by the Zero Suicide Alliance as "one basic principle: Suicide is preventable."[3] We acknowledge that zero suicide is ambitious and will rely on many wider structural factors that lie outside of the scope of this strategy. However, as a system we have adopted this approach as we think it is important that we do everything in our power to prevent suicide. To this end, our zero suicide ambition translates practically in the following three outcomes:



Scope of this Strategy

Before we discuss the recommendations and actions proposed by this strategy, it is also important to highlight that we are making suggestions relating to work that can be done at a local level. We are guided by national legislation and work within the scope of this. Our strategy is designed for residents of Cambridgeshire and Peterborough, and we recognise that some people may be at risk of suicide due to factors that are external to our reach. In addition, we acknowledge that the demand for mental health support is high and our services are stretched to capacity, which can have an impact on our residents. We will continue to work with partners at a regional and national level and promote a variety of available support options to ensure that we are providing a comprehensive suicide prevention offer for the people of our county.

Our Targets



*The entire mental health system employs **a consistent, joined up approach to suicide prevention** in which people at risk are able to access high quality, collaborative care at any point in the system.*

- **Establish a learning culture** in which the system is involved in reviewing the pathway of care experienced by patients in order to determine strengths and weaknesses in current operations
- Allow for **better information sharing** between organisations to ensure we are better able to support people in both clinical and non-clinical settings

***Suicide is everyone's business** and the community is engaged through promotion and increased awareness of mental health*

- ***Families and loved ones are actively involved** in the suicide prevention process, where appropriate*
- *Communities are encouraged to actively **talk about suicide** and are able to support someone in need and **signpost** to appropriate support*

*Each person is equipped with the **knowledge and access to resources needed to keep themselves safe** until they are able to access mental health care*

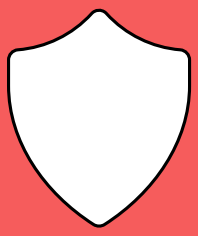
- *Encouraging the use of **safety planning***
- *Increasing **awareness of available resources** in the community and mythbusting of any concerns*

Priority Areas

To meet these objectives, a number of key priority areas have been identified, using the national suicide prevention strategy, Lifespan suicide prevention model and COVID-19 mental health and wellbeing recovery plan.

Identify local risk factors for suicide and ensure approaches are considerate of different needs

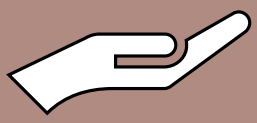
Provide high quality general and specialist support to people presenting with suicidal intent



Protect people at a time of crisis and provide continued support following de-escalation

Ensure the community is well-equipped to prevent suicide in non-clinical environments

Improve understanding of self-harm and support the promotion of healthy coping strategies



Ensure that appropriate steps are taken following a suicide to support the community

Key Recommendations

Identify local risk factors for suicide and ensure approaches are considerate of different needs

A) Identify emerging trends in suicide risk using Real-Time Suicide Surveillance and Mental Health Data Dashboard
B) Improve system learning from available data and adapt/escalate approaches where possible, taking into account intersectionality of factors that contribute to suicide
C) Deliver targeted interventions that take into consideration the different risk factors and sensitivities associated with people from diverse background

Provide High Quality General and Specialist Support to People Presenting with Suicidal Intent

A) Continue to deliver and expand Suicide Prevention Training to all healthcare professionals in Cambridgeshire and Peterborough
B) Ensure consistency between primary and secondary mental health provision
C) Promote the use of safety plans in all healthcare settings and raise awareness for individuals of how to develop their own, with the aim of keeping people safe until they can access mental health services
D) Support frontline workers, both emotionally and practically, to ensure that they are well-equipped to help patients facing suicidal thoughts, able to effectively refer people to appropriate support and not jeopardising their own mental health in the process

Protect People at a Time of Crisis and Following De-Escalation

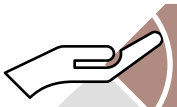
A) Ensure that people are actively engaged with crisis care and able to address underlying issues
B) Expand the support networks and resources available to people following a mental health crisis
C) Reduce access to means within the home and in a digital world

Ensure the Community is Well-Equipped to Prevent Suicide in Non-Clinical Environments

A) Support the delivery of awareness raising campaigns, particularly through the introduction of data-informed tailored approaches
B) Promote delivery of suicide prevention training to members of the community
C) Offer greater support to families and friends of people affected by suicidal thoughts to better equip them to keep their loved one safe and protect their own mental health

Improve understanding of self-harm and support the promotion of healthy coping strategies

A) Improve data collection to gain a better understanding of self-harm beyond crisis care
B) Understand and address self-harm in children and young people
C) Ensure those presenting to services with self-harming behaviours have their mental health concerns treated appropriately



Ensure that Appropriate Steps are Taken Following a Suicide to Support the Community

A) Expand the existing suicide bereavement support offer to accommodate those more widely affected by a suicide and encourage peer support
B) Ensure that professionals in contact with someone who has died by suicide are adequately supported
C) Rapidly respond to incidents of suicides that may have a greater impact on the wider community and ensure that information shared is accurate, sensitive, and guiding people towards support

Context

National Context

Preventing Suicide in England

Preventing Suicide in England is the national strategy intended to reduce the suicide rate and improve support for those affected by suicide. The overall objective of the strategy is to reduce the suicide rate in the general population in England and to better support those bereaved or affected by suicide. Since its publication in 2012, there have been several progress reports in order to reflect the current landscape of mental health in the country.

The most recent report, published in 2021 focuses on the impact of the pandemic on suicide prevention.[1] This builds on the six key areas for action to prevent suicide identified in the initial report, as well as a seventh identified in the third progress report, 2017:

Preventing Suicide in England

- Reduce risk of suicide in key high risk groups
- Improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring
- Reducing rates of self-harm as a key indicator of suicide risk

The strategy also identifies four key vulnerable populations at risk of suicide and acknowledges that these groups may have suffered from the COVID-19 pandemic exacerbating existing mental health problems or contributed to the development of new problems. The four groups at most risk are:

- Middle-aged men
- People who self-harm
- Children and young people
- People with a mental illness

The strategy outlines a range of evidence based local approaches and good practice examples are included to support local implementation. National actions to support these local approaches are also detailed for each of the seven areas for action.

National Confidential Inquiry into Suicide and Safety in Mental Health

The National Confidential Inquiry into Suicide and Safety in Mental Health provides key data regarding national suicide rates among various demographics. The 2021 annual report details how the national suicide rate increased between 2015 and 2018 for both males and females, though rates have been decreasing since 2008 in patients known to mental health services.[4] The number and rate of patients dying by suicide within 3 months of in-patient discharge, whilst lower than in 2008, appear to be increasing in recent years. The weeks immediately following discharge remain a period of high risk of suicide.

The NCISH 2021 report delivers the following key findings and messages:

- Nearly half of all patient suicides in the UK were by people living alone
    - More likely to be over 45, unemployed, single or widowed, experienced financial difficulties and relationship breakup
- The suicide risk profile of patients differs between ethnic groups – different approaches needed
- Suicides in young people (under 25) are increasing, particularly in those aged 15-17 and in female patients
- Continuing rise in hanging/strangulation among patients under mental health care
- Suicide prevention during COVID-19
    - Support for anxious, isolated or lonely
    - Focus on patients under community services
    - Minimising disruption to care through digital technology
- Use the Safer Services NCISH toolkit

Based on the evaluations completed of mental health services, primary care and accident and emergency departments, NCISH have developed a Safer Services Toolkit - a list of 10 key elements for safer care for patients.[5] These recommendations have been shown to reduce suicide rates.

NCISH Safer Services
• Safer wards • Early follow-up on discharge • No out-of-area admissions • 24-hour crisis teams • Family involvement in 'learning lessons' • Guidance on depression • Personalised risk management • Outreach teams • Low staff turnover • Services for dual diagnosis

COVID-19 Mental Health and Wellbeing Recovery Action Plan

COVID-19 has had a significant impact on the mental health of the population. Whilst initial evidence suggests that suicide rates haven't been significantly affected by the pandemic, we must be considerate of the long-term mental health impacts of the virus[2] e.g. unemployment, isolation and therefore take into consideration the COVID-19 mental health and wellbeing recovery action plan, which has three key areas of interest:[6]

COVID-19 Mental Health and Wellbeing Recovery Action Plan

- Support the general population to take action and look after their mental wellbeing
- Prevent the onset of mental health difficulties by addressing the factors that play a crucial role in shaping mental health and wellbeing outcomes for adults and children
- Support services to continue to expand and transform to meet the needs of people who require specialist support.

Local Context

Local Suicide Rates

The suicide rates in Cambridgeshire and Peterborough are statistically similar to England and the East of England region for the three-year period 2018-20. Suicide rates in all districts in Cambridgeshire are also statistically similar to England for the three-year period 2018-20. However, all have seen an increase in suicide rates from 2015-17 to 2018-20.[7]

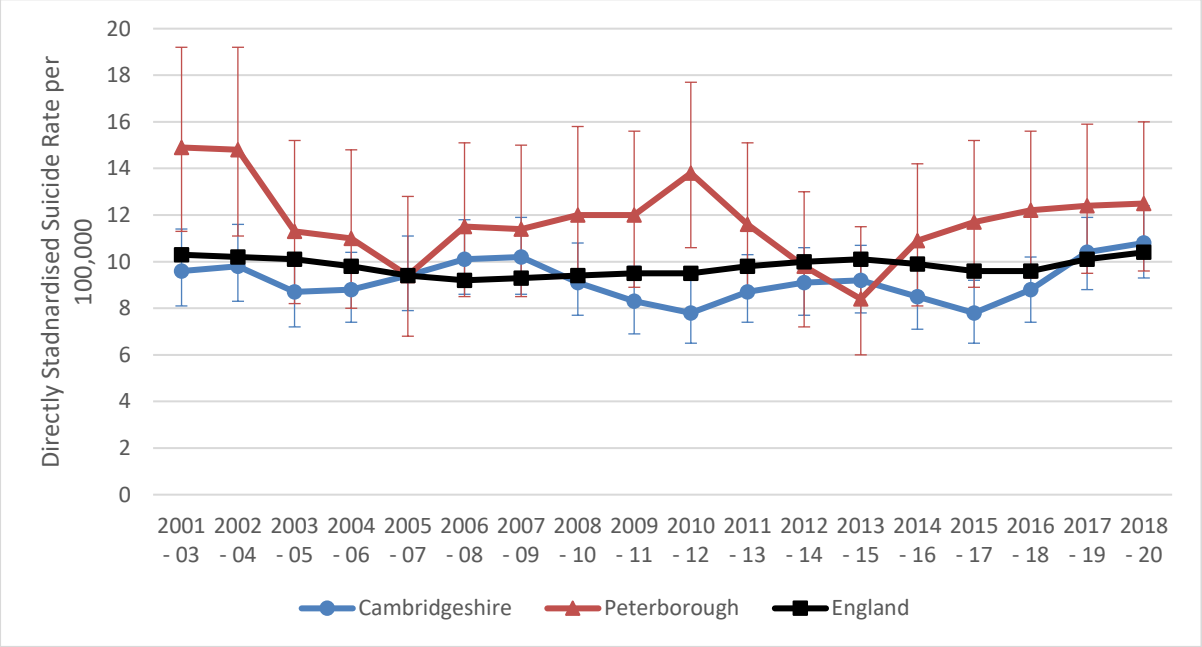


Figure 2: Directly age-standardised suicide rate per 100,000 for Cambridgeshire and Peterborough, compared to the England average[7]

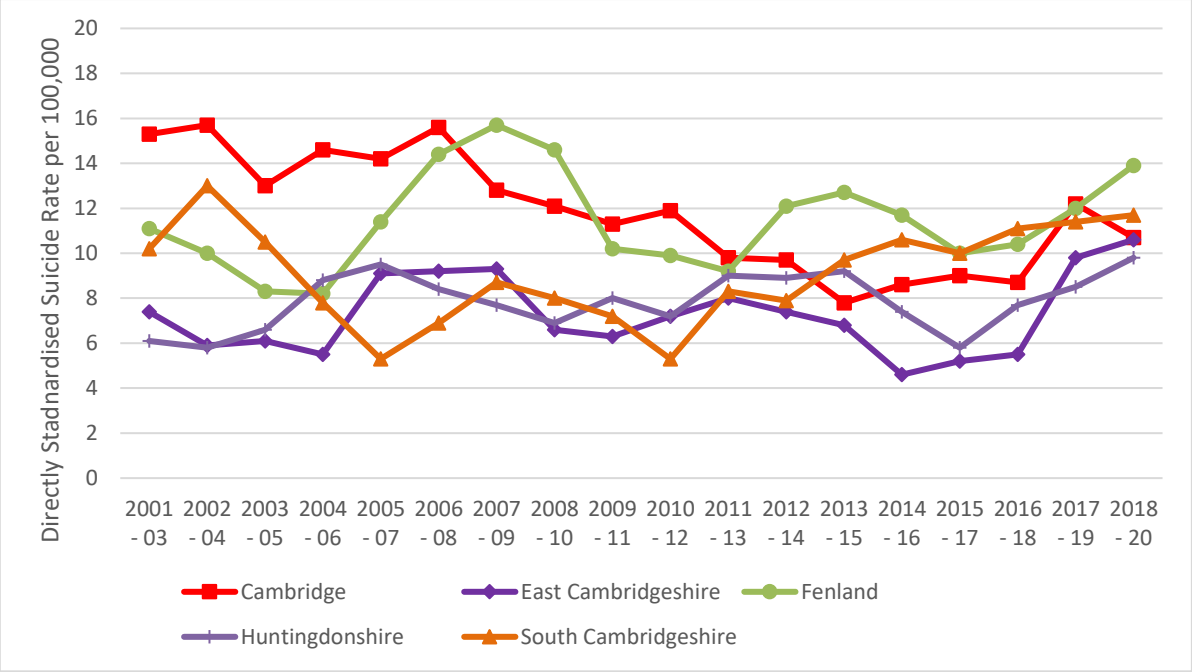


Figure 3: Directly age-standardised suicide rate per 100,000 for all districts in Cambridgeshire[7]

Local Self-Harm Rates

Rates of A&E attendance for both all ages and 10-24 year olds for self-injurious behaviour are statistically significantly higher than the RightCare10, regional and England averages. The Cambridgeshire and Peterborough CCG is the third highest in the RightCare10 comparator.[8] Cambridge City has the highest crude rate of A&E attendance for deliberate self-harm in Cambridgeshire. Crude rates of A&E attendance for self-harm have decreased in all districts in 2020/21 for both 10-24 year olds and all ages.[9]

The proportion of A&E attendances for Self-injurious Behaviour admitted to a ward bed for both 10-24 year olds and all ages in Cambridgeshire and Peterborough is average amongst RightCare10 comparators.[8] Crude rates for self-harm hospital admissions have decreased in 2020/21 in Cambridge City, South Cambridgeshire and East Cambridgeshire from 2019/20 rates. [9]

Local Areas of Concern

An audit of suicides confirmed by the Coroner's Office between 2017 and 2020, will be conducted in early 2022 and findings will be shared with the Suicide Prevention Strategy Implementation Group. The audit will not be complete at the time of publication of this strategy, but the accompanying action plan will be reviewed in line with the results of the audit in order to address any emerging trends and support vulnerable groups.

Real-Time Suicide Surveillance has been used to evaluate suspected deaths by suicide in 2021 in Cambridgeshire and Peterborough. **Note:** this form of data collection is used to give a general idea of trends but is less accurate than the results of a coroner's inquest. Datasets are incomplete and may be subject to change following the result of the Coroner's Inquests. As of February 2022, the Real-Time Suicide Surveillance recorded the following information in 2021:

- There were 69 suspected suicides recorded on the Real-Time Suicide Surveillance system
- 65% of suspected suicides occurred within the home
- Most common age of death was 30-49 (45% of suspected suicides)
- 35% of suspected suicides were by females and 65% by males
- 59% of deaths were by hanging/suffocation. The next most common means of suicide involved trains
- 54% of those that died by suicide were known to mental health services
- 23% had a known history of self-harm
- Peterborough had the highest crude suicide rate, followed by Fenland, South Cambridgeshire, East Cambridgeshire, Cambridge City and Huntingdonshire:

Outcomes of the Implementation of the Suicide Prevention Strategy 2017-2020

The 2017-2020 suicide prevention strategy followed the six priority areas set out by the national suicide prevention strategy:[10]

- Reduce risk of suicide in key high risk groups
- Improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

Over the course of the previous strategies, a considerable amount of suicide prevention work has been undertaken, covering the breadth of these priority areas.

Suicide prevention training has been rolled out across primary care, CPFT and the wider community. This training has also been delivered to professionals working with vulnerable people, including substance misuse services and domestic abuse IDVAs. The STOP Suicide awareness campaigns have increased their reach, with the total number of personal pledges reaching 2750 as of February 2022.[11]

Removal of ligature points in wards is now regularly audited and the barriers erected at a Peterborough car park in 2017 have continued to prevent any suicides in this location. Greater connections between the mental health system and rail partners have been made, with representation on the suicide prevention strategy implementation group now featuring network rail and Greater Anglia Railway.

A Suicide Bereavement Support Service has been commissioned to Lifecraft.[12] The initial offer involves the provision of a part-time (18 hr/week) suicide bereavement support liaison worker. They offer emotional and practical support to Next of Kin (aged 17+) for up to a year following a suicide. The SBS service is also linked in with Real-Time Suicide Surveillance so, given consent is provided, rapid support can be offered immediately following a suicide. The 'Help is at Hand' booklet is disseminated regularly and offered as a minimum to those immediately bereaved.[13]

A Real-Time Suicide Surveillance system has been established collecting data following a suspected suicide. Stakeholders in this system are CCC/PCC, Cambridgeshire Constabulary, CPFT, CPSL Mind, Coroner, Lifecraft and CGL. This data is used to inform the approach to suicide prevention in Cambridgeshire and Peterborough, as well as contribute to national suicide reporting.

Identified Areas for Continued Improvement

Whilst a considerable amount of work has been completed across Cambridgeshire and Peterborough to address the recommendations suggested in the previous suicide prevention strategy, there are still outstanding actions that will need to be implemented alongside the proposed work in this document. In particular, the following actions are worth reviewing to ensure that we are adequately addressing any concerns.

1. Including suicide prevention in other health campaigns

   Our suicide prevention awareness campaigns have excellent reach and bring suicide awareness to the forefront. However, as there are many risk factors for suicide that coincide with other health issues, such as physical health and drugs and alcohol, we can work to create better links with other health campaigns to ensure that suicide prevention messaging is also promoted where appropriate

2. Creating a culture of learning to drive up quality throughout the system

   The Real-Time Suicide Surveillance System has pushed forward this agenda considerably and we are in a position where we are sharing information across agencies and providing comprehensive reporting to the various mental health boards in the county. However, we are yet to progress beyond this by establishing a fully embedded learning culture in which cases are reviewed, discussed by key

partners and system learning derived and implemented. In particular, the system is yet to establish learning forums where system partners and those with lived experience can share recommendations for improvement of care. This will be discussed in greater detail later as this forms a significant part of the system learning aspect of this strategy.

3. Improve pathways and support for people taken into custody at risk of suicide and for people newly released from custody.

   There is currently excellent work being delivered within prisons in relation to supporting those in custody at risk of suicide. However, more could be done to include prison representatives in wider suicide prevention work, particularly in relation to supporting those transitioning from the community into custody and vice versa.

4. Reduce the risk of suicide on railway lines in Cambridgeshire and Peterborough

   Messaging in relation to suicide awareness has been disseminated in train stations and level crossings across Cambridgeshire and Peterborough. Network Rail have put in considerable efforts to train staff in suicide mitigation, as well as in supporting frontline workers following potentially traumatising incidents. However, we continue to see suicides occurring on the railway in Cambridgeshire and Peterborough, often away from stations and level crossings. Therefore, a full audit of the rails in Cambridgeshire and Peterborough needs to be undertaken, identifying greatest areas of risk and possible opportunities to intervene and keep people safe.

It is worth noting that despite our best efforts, there has been a continuing rise in suicides in Cambridgeshire and Peterborough from 2015-17 to 2018-20. Therefore, it is important that we continue to innovate and learn from our local data to ensure that we are taking the best approaches to preventing suicide in our county.

Suicide Prevention Approach 2022-2025

Key Themes

In line with national guidelines on preventing suicide, and to oversee the implementation of the local strategy, a multi-agency suicide prevention implementation group meets on a quarterly basis with input and membership from many organisations across public, charitable, and voluntary sectors.[14]

A workshop held with this group in July 2021 identified several key areas of work that are currently being undertaken and areas of interest. Based on these discussions the following key themes, which will form the basis of the strategy, have been proposed:

1. Collaboration between services and joint up working

The introduction of the Integrated Care System (ICS)[15] and Shared Care Records (SCRs)[16] to Cambridgeshire and Peterborough present the perfect opportunity to expand the partnership working that has developed since the previous strategy. The Suicide Prevention Strategy Implementation Group is growing in membership as more statutory bodies, third sector partners and other community institutions are recognising the need to work together to prevent suicide in the county.

In development of this strategy, a great deal of emphasis has been placed on knowledge sharing; coming together as a group to discuss what work is currently being done within each service to identify areas of best practice and gaps in service provision. Whilst it is important that we work to ensure each service is providing high quality care, it is equally important that we pay attention to how our services work together.

Case Study for Multi-Agency Working – Supporting Young Offenders

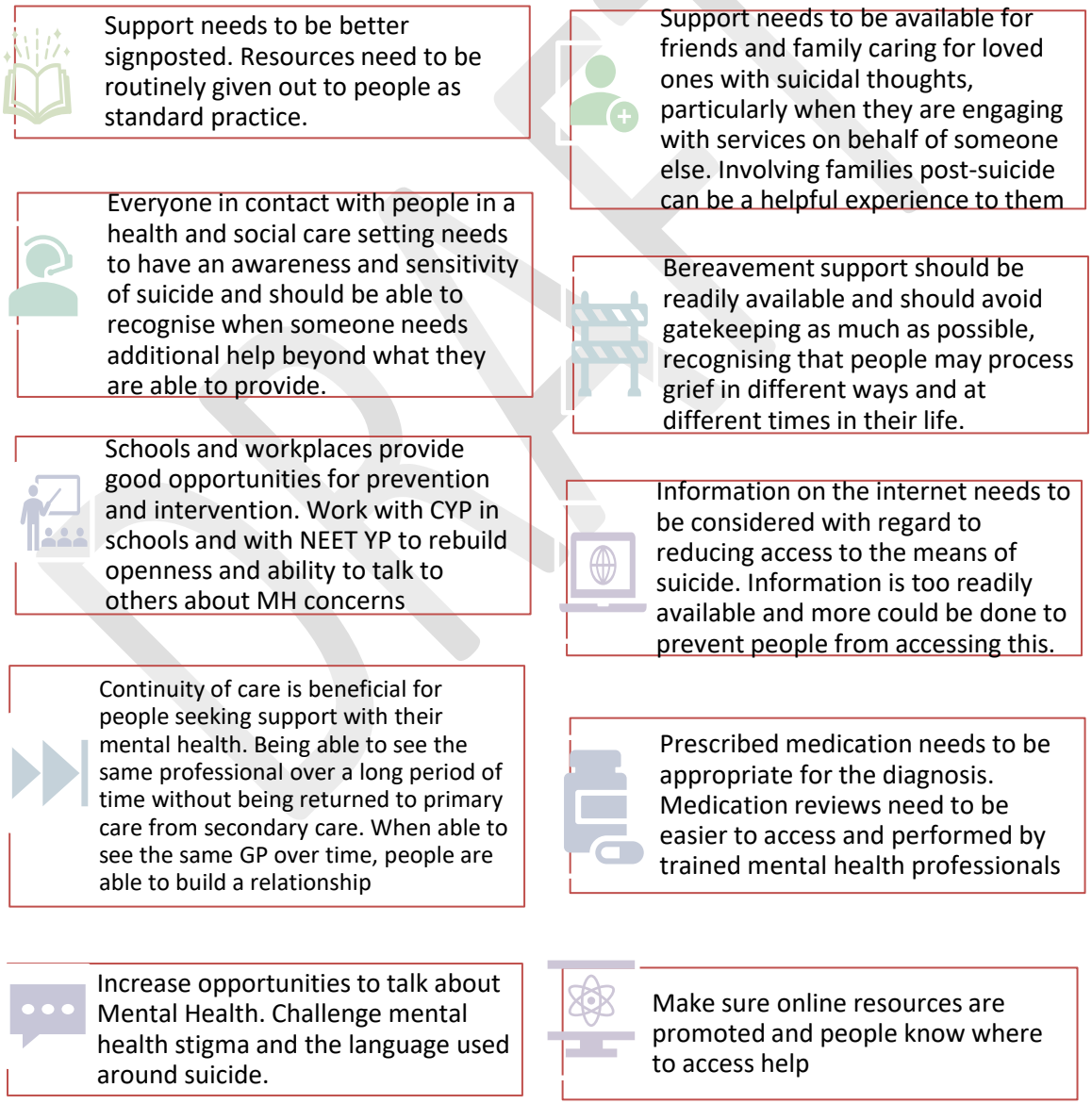
With those young people who have faced adversity and trauma, a formulation meeting gathers all professionals around the young person from the offset to understand the story. This can be done both with and without the young person. These meetings will usually include YOS, CSC, CAMHS/GP and or healthcare providers, schools, local police and sometimes but not always, parents, but often carers or placement staff. The aim here is to share information to help encourage thinking about what their story is, what the unmet needs are, what function the behaviour(s) have and what is maintaining them. Following this, an intervention plan is developed that considers what all agencies can do in a way that considers the developmental needs of the young person given their trauma. This provides consistency around the young person.

This multi-agency work should be applied across all services to ensure that all of the relevant stakeholders are actively engaged in an individual's care, communicating with each other in order to deliver a consistent approach. Multi-agency learning will also be vital following a suicide to understand why someone may have taken their own life and what additional support could be offered in the future.

2. Co-production with those with lived experience

Lived Experience of suicide can be defined as anyone whose life has been personally affected by suicide, suicidal thoughts, or self-harm. This includes anybody who has experienced suicidal thoughts/behaviour in the past, those who have cared for someone experiencing suicidal behaviour, and those that have lost a loved one to suicide.

For the purposes of this strategy, people with lived experience have been engaged in multiple consultations to identify current shortcomings in the offer of mental health care in Cambridgeshire and Peterborough. An initial consultation with a suicide bereavement support group in Peterborough was followed by a wider consultation open to anyone with experience of suicidal thoughts. From these sessions, the following key ideas have been identified:



In addition to this, a survey of frontline workers supporting people with their mental health ran during January 2022. 365 responses were recorded covering a wide range of organisations and sectors, including social/care/support workers, doctors/nurses/paramedics, crisis workers, therapists, counsellors and support/customer service staff, among many others. The survey covered topics such as preparedness for keeping service users safe from suicide, support available for staff and resources available.

Key findings from this survey are as follows:

- Less than half of frontline workers felt confident talking about suicide with at-risk patients/clients
- Suicide prevention training is a priority for many frontline workers
- Frontline workers need more time and resources to work with patients/clients on their mental health
- Frontline workers' mental health needs to be supported by their workplaces

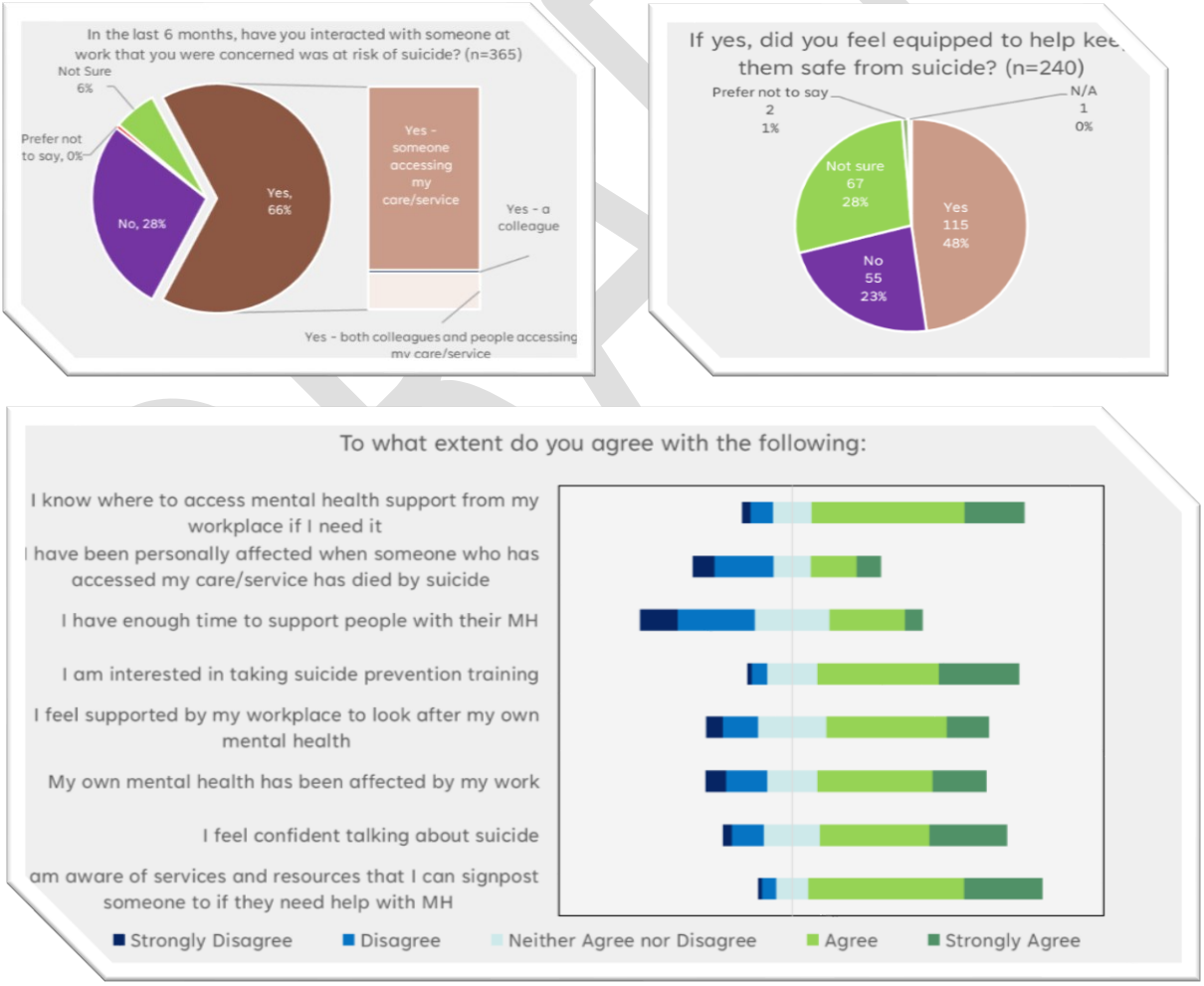


Figure 4:Results from the Frontline Workers Survey. A) Interactions with service users at risk of suicide. B) Preparation to support those at risk of suicide. C) Agree/disagree to key statements questions relating to support for staff and service users.

Moving forwards, co-production will be considered in all aspects of suicide prevention work to ensure that this important community voice is heard. To this end, a Lived Experience Panel, similar to that of the NSPA's Lived Experience Network, will be established, with recruitment of volunteers from within the community.[17] Participants of the lived experience consultations involved in the production of this strategy will be reengaged to consider continuing their collaboration with the system, and a full specification of the role of panel members and their level of influence on the system will be developed. As a minimum, the lived experience panel will be consulted at all suicide prevention strategy implementation group meetings, but ideally, they will be a valued resource in the co-production of all suicide prevention work moving forwards. This group, though initially formed specifically to focus on suicide prevention, can be consulted with on any issues relating to mental health in Cambridgeshire and Peterborough.

To ensure that this co-production is mutually beneficial, the Lived Experience panel will receive regular updates about how their contributions have led to improvements in system working, and appropriate safeguarding measures will be established to ensure that the emotional toll such work may have on participants is managed effectively and support is available. A continuous cycle of feedback will help ensure that Lived Experience is captured well in all the work that we do.

3. Information sharing and development of a learning culture

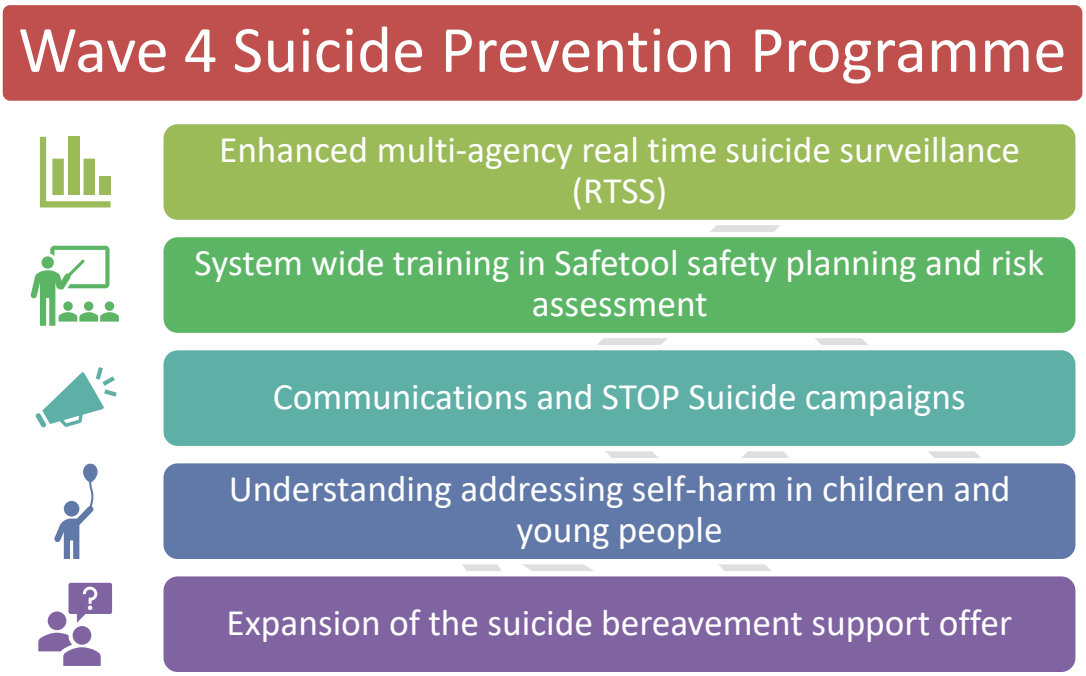
Across all partners in the mental health system, there is a wealth of information, both at the individual patient level and the population level. At the individual patient level, it is essential that all data is protected and used appropriately. Where possible, efforts should be made across services to present patients with the opportunity to share their data across services to allow for warmer handovers and a patient-centred approach.

In addition, to better understand any emerging trends, the system should regularly share population level data, with a particular emphasis on capturing the demographics of their patient-base to identify any areas or target groups requiring particular attention.

To advance the approach to suicide prevention in Cambridgeshire and Peterborough, it is important to be able to have open, reflective conversations about the current system and any gaps in service provision, or shortcomings, that need to be addressed. Therefore, it is vital that a learning culture is pursued, with a rejection of any form of blame culture. For productive discussion, services must be able to evaluate their work without fear of persecution. This can be achieved in several ways, such as reviewing cases with the mindset of "where are areas that staff/organisations could receive greater support?", rather than "what went wrong?". This approach is similar to that of Mersey Care's Just and Learning Culture.[18]

Wave 4 Suicide Prevention Transformation Funding

The Cambridgeshire and Peterborough mental health system has recently received Wave 4 transformation funding to prevent suicide. This funding has resulted in the appointment of a Suicide Prevention Manager for Cambridgeshire and Peterborough, with oversight of five key workstreams:

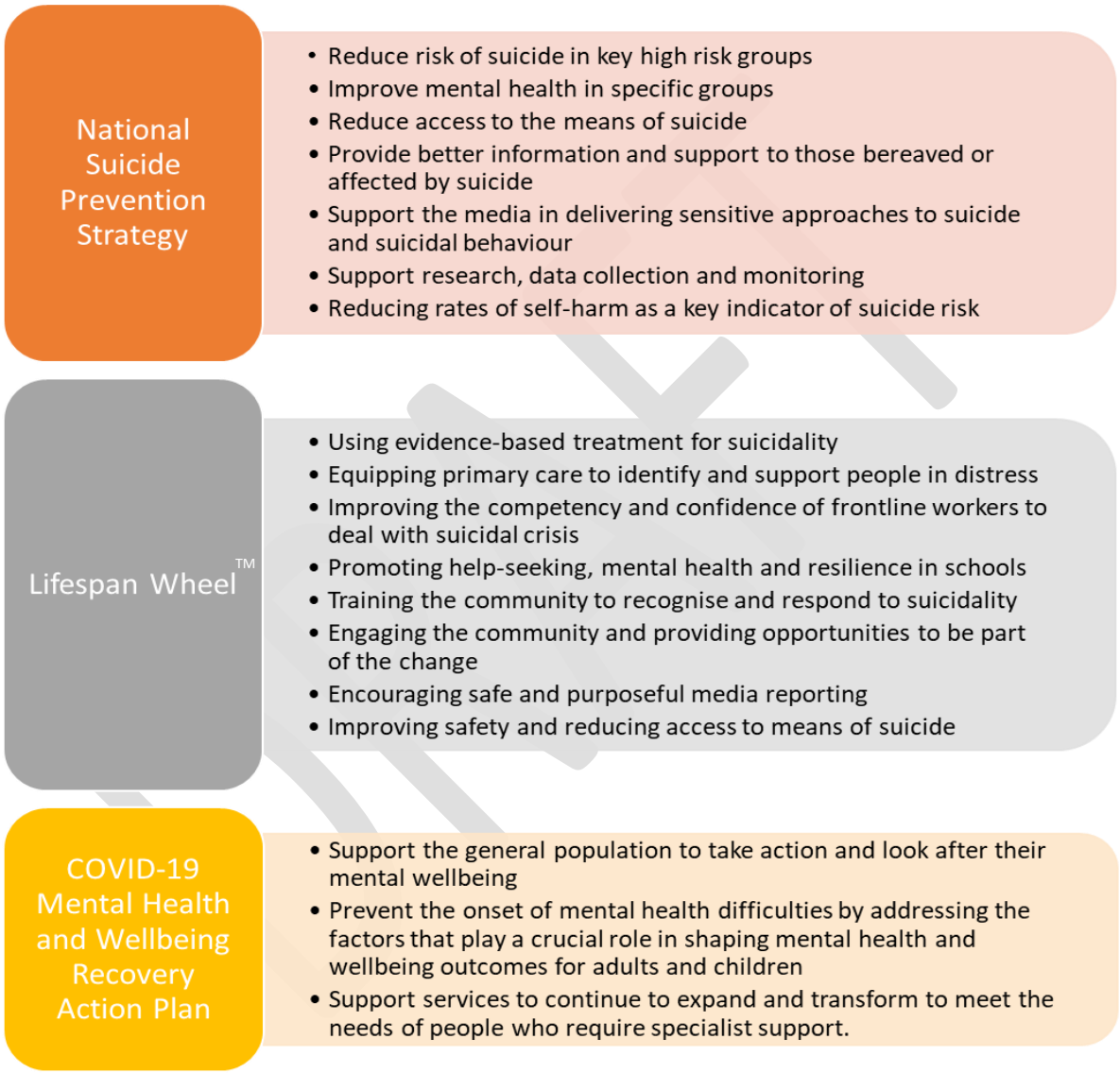


This work will guide a great deal of the suicide prevention work moving forwards and is an example of the collaborative, multi-agency approach being adopted within this strategy, with delivery of the Wave 4 programme overseen by the local authority in collaboration with CPSL Mind, Fullscope and Lifecraft.

Each of these approaches to suicide prevention for Cambridgeshire and Peterborough are evidence-based and relate closely to the recommendations made by both the national suicide prevention strategy and other related models. Therefore, these 5 workstreams can be seen throughout the strategy and touch on a variety of the priority areas in some way.

Priority Areas

Previous suicide prevention strategies have used the national strategy priority areas as a basis for targeting suicide prevention work in Cambridgeshire and Peterborough.[1] However, to reflect the local landscape and the desire to involve all members of the MH system and the wider community, additional models and strategies have been considered. These include the LifeSpan™ Wheel[19], the COVID-19 Mental Health and Wellbeing Recovery Action Plan[6] . The priority areas discussed in these are collated below.



The zero suicide ambition and the desire for consistent, collaborative care will provide the foundation for suicide prevention work dictated by this strategy.[3] The models above have been used to formulate six new priority areas, covering all aspects of suicide prevention within both the mental health system and the wider community. This is vital in ensuring we meet our ambition of being able to provide care to people affected by suicide/suicidal thoughts at any point of involvement with the system of care and outside of it.


Identify local risk factors for suicide and ensure approaches are considerate of different needs
Support research, data collection and monitoring
Reduce risk of suicide in key high risk groups
Improve mental health in specific groups
Using evidence-based treatment for suicidality
Prevent the onset of mental health difficulties by addressing the factors that play a crucial role in shaping mental health and wellbeing outcomes for adults and children
Provide high quality general and specialist support to people presenting with suicidal intent
Support services to continue to expand and transform to meet the needs of people who require specialist support.
Equipping primary care to identify and support people in distress
Improving the competency and confidence of frontline workers to deal with suicidal crisis
Protect people at a time of crisis and following de-escalation
Improving safety and reducing access to means of suicide
Improving the competency and confidence of frontline workers to deal with suicidal crisis
Ensure the community is well-equipped to prevent suicide in non-clinical environments
Training the community to recognise and respond to suicidality
Engaging the community and providing opportunities to be part of the change
Support the general population to take action and look after their mental wellbeing
Improve understanding of self-harm and support the promotion of healthy coping strategies
Reducing rates of self-harm as a key indicator of suicide risk
Promoting help-seeking, mental health and resilience in schools
Ensure that appropriate steps are taken following a suicide to support the community and learn
Support the media in delivering sensitive approaches to suicide and suicidal behaviour
Provide better information and support to those bereaved or affected by suicide

Identify local risk factors for suicide and ensure approaches are considerate of different needs

Priority Area 1: Identify local risk factors for suicide and ensure approaches are considerate of different needs

This priority area will focus on those who are considered at greater risk of poor mental health and suicide due to various social, relational and structural factors. It is important to note here that this doesn't exclude any specific demographics as anybody at any time can face mental distress that requires them to seek additional support. As a system, we must ensure that we are continually learning in order to provide suitable support to those who need it most.

Recommendation A - Identify emerging trends in suicide risk using Real-Time Suicide Surveillance and Mental Health Data Dashboards

Over the lifespan of this strategy, it is important that we continue to examine the available data to ensure we are aware of any emerging concerns in relation to specific demographics. Members of the suicide prevention strategy implementation group should raise any concerns within group meetings of any emerging trends they are observing, either empirically or anecdotally, with the expectation that Public Health then collaborates with the system at large to determine if this is a local, regional or national issue, and implement evidence-based interventions to address these concerns.

The Real-Time Suicide Surveillance system has been operating in Cambridgeshire and Peterborough for several years, with stakeholders including CCC/PCC, Cambridgeshire Constabulary, CPFT, CPSL Mind, Change Grow Live, Lifecraft and the Coroner's Office. This system allows stakeholders to share information following a suspected suicide, creating an opportunity to respond to emerging issues rapidly, as well as provide bereavement support within days of a suicide.

As part of the Wave 4 suicide prevention transformation programme, the RTSS system is being expanded to include a wider range of stakeholders to improve understanding following a suicide, taking into consideration the potential risk factors that may have contributed to a death by suicide.

The Crisis Concordat board, established in 2014 meets monthly to share service updates, identify areas of concern and suggest potential solutions.[20] A real-time dashboard collecting crisis data, including Real-Time Suicide Surveillance, has recently been developed and shared with the board. Future work will involve increasing engagement with the dashboard and more regular reporting to allow for a more rapid response to changes in crisis presentations in Cambridgeshire and Peterborough.

Alongside this, efforts will be made, both through the Wave 4 work and the Crisis Concordat dashboard to improve the collection and quality of self-harm data and the contributing factors that may lead to somebody self-harming. A subgroup consisting of mental health workers supporting people who self-harm and academics researching this topic has been assembled and will continue to meet on a quarterly basis to both understand the emerging trends in self-harm and work collectively to understand what support is available across the system to identify any gaps in provision.

Recommendation B – Improve system learning from available data and adapt/escalate approaches where possible, taking into account intersectionality of factors that contribute to suicide

Learning forums will be established in which cases are reviewed as a system to identify any opportunities for the system to modify its approach when working with people with a similar profile in the future. This work depends heavily on willingness of the whole system to engage in this learning, with acknowledgement that these reviews are not an exercise in assigning blame, but in coming together as a system to improve our collaborative working.

In particular, the MH system needs to expand learning into how different risk factors may compound to pose an even greater risk to an individual. It is essential when we tailor our approaches to specific groups, to not categorise people too specifically and recognise that risk and protective factors for suicide can affect different groups in different ways.[21] Therefore, design of tailored approaches should take into consideration how other contributing factors may influence the delivery of this work and account for these wherever possible. Co-production with intersectional groups will be key in ensuring the success of these programmes.

In addition, potential research into intersectionality of suicide risk factors should be explored to aid system learning.

Recommendation C – Deliver targeted interventions that take into consideration the different risk factors and sensitivities associated with people from diverse background

This strategy recommends tailoring approaches to specific at-risk groups to maximise the impact achievable when working with them. It is important to recognise the different factors that may contribute to someone experiencing suicidal thoughts, and it is important that a 'one-size fits all' approach is not used. When considering tailoring approaches to improving the mental health and reducing the risk of suicide in key high-risk groups, we must consider the wider determinants that can lead to mental health issues, as well as how we must change our approach to suit different groups, many of whom are less likely to access existing services.

In addition, it should be the expectation that any approach targeted towards a specific group of people actively includes the voices of those directly affected by this work. Co-

production with members of affected communities should be fundamental throughout the planning, delivery and evaluation of new projects or services.

Appendix 2 collects a sample of evidence-based interventions of groups identified as at-risk through national and international research. These can be explored in greater detail if local data identifies any of these groups as an emerging area of concern within Cambridgeshire and Peterborough. Whilst it is important that approaches are tailored depending on need, key themes have emerged that can be considered a general approach to delivering targeted interventions to any at-risk group.

- **Communications** – when delivering awareness campaigns or producing resources, it is important to take into consideration how likely people are to engage with different formats. For example, resources should be available in a variety of languages, available both online and in hard copy, and written in easy-to-understand language or using diagrams to communicate messages to those with low literacy rates.
- **Accessing services** – People need to be able to engage with services that are well-versed in both their subject specialism **and** suicide prevention. Likewise, those working within mental health community services need to have an understanding of the diverse needs presented by people from many different backgrounds and life experiences. Therefore, training in both mental health and equality and diversity are essential. In addition, services need to be available in multiple formats to account for physical accessibility and digital literacy.
- **Engaging with community leaders –** co-production should be explored wherever possible and through this process, community leaders should present themselves as well-respected individuals within a specific at-risk group who can champion mental health and encourage others to reach out and access support, as well as share any key communications and reassure people with any concerns.
- **Engaging with experts –** Often as a mental health system, we take a population level approach and as such, despite best efforts, it can be difficult to design services that consider the needs of everyone in our diverse communities. Therefore, it is important to engage with experts in supporting vulnerable groups to ensure that their needs are being met. These can be charities, such as the Kite Trust supporting LGBTQIA+ youth[2222], or teams within the wider MH system, such as the Gypsy, Roma and Traveller health team within Cambridgeshire County Council. It is worth exploring the potential of an 'Equality and Diversity in Mental Health' group, consisting of key stakeholders within the mental health and equality and diversity sectors.

Provide High Quality General and Specialist Support to People Presenting with Suicidal Intent

Priority Area 2: Provide High Quality General and Specialist Support to People Presenting with Suicidal Intent

This priority area will focus on both Primary and Secondary care available to people with mental health concerns in Cambridgeshire and Peterborough. The overall goal of this priority area is to ensure that a person entering the Mental Health system presenting with a risk of suicide is able to access a consistent level of care from well-informed mental health professionals.

Recommendation A – Continue to deliver and expand Suicide Prevention Training to all healthcare professionals in Cambridgeshire and Peterborough

Key to achieving a consistent, person-centred approach is the dissemination of Suicide Prevention training for all frontline professionals across the pathway of care. Community professionals, such as CGL and Domestic Abuse workers need to be able to talk openly about suicide with their clients, whilst primary and secondary care staff also need to be equipped with training that allows them to triage patients at risk of suicide and refer to the most appropriate support.

Through previous work, over 250 GPs have received training in SafeTool safety planning.[23] Moving forwards the goal will be to increase the number of primary care staff receiving the training and consequently using the SafeTool as standard practice when treating someone presenting with suicidal thoughts and behaviours. Clinicians in CPFT are also receiving the same training. The future aim is to continue delivery, increasing the percentage of staff working within mental health services who have received this training. A consistent system approach in delivering suicide mitigation training supports the development of a common language around suicide risk across both primary and secondary care. Linked to this work is the focus on the Common Sense Confidentiality training within Cambridgeshire and Peterborough Foundation Trust.[24]

In addition, it is vital that all staff involved in primary and secondary care, not just mental health clinicians and GPs, are suicide aware and able to spot symptoms and support people at immediate risk. Therefore, all staff should receive foundational training in suicide prevention. This can be delivered through a number of courses: the introductory sessions of the suicide prevention training for GPs/secondary care clinicians,[24] the STOP Suicide plus community training, the online Zero Suicide Alliance training or the 2-day ASIST suicide first aid training course.[25]

Currently employees working in adult physical health services within Cambridgeshire and Peterborough Foundation Trust complete the Zero Suicide Alliance Training. Up to January

2022, 1863 staff working in physical health services had completed the Zero suicide Alliance Training. The focus for the next three years will be to increase that number. In addition, work has started within the Cambridgeshire and Peterborough Staff Well-Being service to create and deliver training to support staff, if they are concerned about another member of staff, to ask them if they are experiencing suicidal thoughts and to respond appropriately.

Expansion of training for primary care staff and the community falls under the remit of the Wave 4 Suicide Prevention Transformation Programme.

Recommendation B – Ensure consistency between primary and secondary mental health provision

Many people accessing mental health care will begin in a primary care setting. This will most likely be their GP and / or the Primary Care Mental Health Service, with a survey run by Mind in 2018 reporting 41% of GP appointments now feature a mental health concern.[26] Based on their needs, they may be referred onto secondary mental health care. Moving forwards, it is essential that somebody accessing mental health support in Cambridgeshire and Peterborough can expect a consistent level of care when they are transferred to different services. Support should feel continuous and fluid, with patients not feeling like they have to start from scratch with each new service. To achieve this, it is important that primary and secondary care communicate effectively with each other, handovers are warm and patients are not expected to have to share their story multiple times with each new clinician they interact with.

This is particularly important when it comes to supporting children and young people as they transition into adult services, where rates of disengagement are high. Considerable effort should be made when a young person enters adult services to ensure that the quality of care that they receive is consistent and suited to their needs. One study notes the "importance of an individualized approach that takes into consideration the unique experience and pressures of entering adulthood."[27]

Whilst individual approaches may differ, it is important that the same fundamental approaches are used to work towards good mental health and protect against suicide. Consistent uptake of the training described in Recommendation A and promotion of the NCISH Safer Services toolkit will be fundamental in this.[5]

In addition to this work, to ensure that high quality care is delivered in secondary care settings, it is vital that we evaluate the care that CPFT provide to people who have a mental health condition using the NCISH Safer Services toolkit. A formal audit of these areas is planned within CPFT in order to create a baseline and identify the areas which require improvement.

Recommendation C – Promote the use of safety plans in all healthcare settings and raise awareness for individuals of how to develop their own, with the aim of keeping people safe until they can access mental health services

Safety plans are templates that can be used to support a person at risk of suicide to maintain their own mental health and refer to when facing a crisis. These are particularly important whilst someone is waiting to access health care, or at times when typical support isn't available, such as late at night or when their clinician is ill or on leave. Safety plans typically ask the person in crisis to consider ways of distracting themselves, positive things to promote staying alive, emergency contacts and ways of reducing access to things that may cause them harm. Completed in advance, these have been found to be effective in reducing suicidal behaviour.[28]

The GP training described in recommendation A teaches GPs how to use the SAFETool Safety Plan. This is an advanced triage tool embedded on SystemOne, with the expectation that all GPs who have received the training should be using this with any patients experiencing difficulties with their mental health, so that they are well-prepared should a mental health crisis arise.

While the triage section of SAFETool needs to be completed by a trained healthcare professional, the safety plan is available online and can be can used by both individuals and non-medical professionals to keep someone who may be at risk safe.[29] This should be promoted within community services where a formal triage assessment is not possible or appropriate, but the professional has responsibility to protect their client/patient's mental health.

In addition, greater awareness within the community should be raised with a focus on safety planning. Members of the public, including children and young people, should be able to create their own, as well as encourage their GPs to talk them through a plan. This relies on successful uptake of SAFETool training by GPs but will ensure that safety plans become a fundamental part of suicide prevention in Cambridgeshire and Peterborough.

Recommendation D – Support frontline workers, both emotionally and practically, to ensure that they are well-equipped to help patients facing suicidal thoughts, able to effectively refer people to appropriate support and not jeopardising their own mental health in the process

Supporting someone struggling with their mental health and suicidal thoughts can be emotionally draining, even on those trained in mental health care. Demands on frontline workers are high, particularly as a result of increased pressures due to the COVID-19 pandemic.[30] Therefore, it is important that as a system we protect those who are directly helping our most vulnerable members of the community.

When asked what support would be beneficial, respondents to the Cambridgeshire and Peterborough Frontline Workers Survey in January 2022 considered the following priorities:

- Training and improving knowledge of mental health, suicide and resources available
- Better access to support for patients, ensuring that when a patient is transferred from their care, they are confident that they will continue to receive high quality care
- Support/ therapy for Frontline Workers, either through formal counselling offers, or better support from management
- Improved communications between services, ensuring that professional opinions are respected, and referrals are appropriately responded to

All organisations with frontline staff working with patients with mental health difficulties need to ensure that they have robust procedures in place to protect the mental health of these workers. This support should be readily available and easily accessible. The Public Mental Health Strategy will also cover looking after workforces, so work will be done to ensure that the approach to this is consistent.

Another more practical form of support is in better supplying frontline workers with mental health resources. It is important that staff are able to adequately support those presenting with a mental health issue, both for the sake of the patient and their own reassurance that they are able to provide the best possible care. This support can be offered to any frontline worker supporting someone with their mental health, including school staff and others supporting children and young people. Aside from the training above which would allow frontline workers to provide meaningful interventions during brief appointments, resource packs should be made available that they can share with patients and service users as well as more confidently refer them to the most appropriate level of care, whether that be formal secondary MH care, social prescribers or community support. These resource packs will be designed by a focus group of key mental health providers across the county.

Protecting People at a Time of Crisis and Following De-Escalation

Priority Area 3: Protecting People at a Time of Crisis and Following De-Escalation

The aim of this strategy is to provide sufficient support to services, service users and their loved ones to ensure that people are not reaching crisis point. However, for those that are experiencing a mental health crisis, we need to ensure that there is effective provision in place, both in the moment of crisis, and in the days and weeks following.

Recommendation A – Ensure that people are actively engaged with crisis care

Mental Health crises can be distressing for anyone, and some people may find it difficult to know how to access the most appropriate care. We must be able to address stigma and raise awareness that whatever form of support people access, they are going to be treated with dignity and respect. Resources should therefore be produced that outline what may constitute a mental health crisis, the potential crisis pathways of care, and expected outcomes. This can give people a clearer idea of what support is available and dispel any fears over wrongful treatment or loss of control over their own care. Similar resources can be produced tailored to children and young people, where the pathways of care are likely to differ. Promotion of crisis cards may also provide people with greater confidence that their care will be in line with their wishes if they are in a position where they are unable to communicate this themselves.

The First Response Service, operated by CPFT, is available to anyone in a mental health crisis through dialling 111 and selecting option 2.[3152] A number of options are then pursued to de-escalate the situation and help the person in distress feel better able to support themselves. This can be on-scene with the First Response team or the Integrated Mental Health Team based in the police control room. Alternatively, people can be conveyed to the Sanctuary, run by CPSL Mind, an environment in which people have a safe space to de-escalate from crisis. This now offers a virtual/telephone service as a result of the COVID-19 pandemic.[3232]

Patients accessing crisis care should feel confident that they will be treated with respect. As well as outlining the support available to them, resources should also provide guidelines of the treatment they can expect to receive from healthcare professionals. This should give people confidence to know that if they need crisis support at any time, they will not be treated unfairly.

Recommendation B – Expand the support networks and resources available to people following a mental health crisis

A discharge buddy scheme, run by CPSL Mind, is available to people in Cambridgeshire and Peterborough following in-hospital admission or contact with Crisis Home Treatment teams.[3232] Expansion of this over the course of this strategy will involve increased

collaboration between services to ensure that discharge buddies are appropriately engaged after contacts, and where consent is given, informed of any information that may help them to offer support. In addition to the formal discharge buddy scheme, it is important to ensure that where possible, a support network of the patient's choosing is engaged and able to talk openly about mental health and suicide. Everyone within this network should be equipped with the necessary resources and signposting knowledge to support their loved one should they re-enter crisis.

Greater awareness of alternative post-crisis support should be raised in addition to these. For example, Lifeline offer follow-up phone calls to people who have been in crisis, such as those who go missing and are found by the police.[33]

Recommendation C – Reduce access to means within the home and in a digital world

The previous strategy highlighted reducing access to means with a focus on ligature points in in-patient settings, rails, high spaces and medicines management. These all remain points of interest and work laid out in the previous strategy will continue to keep deaths involving these to a minimum.[10]

However, local data indicates that a major concern that needs addressing is hanging within the home. This presents complexities as the mental health system has much less control over the ligature points within individual homes. As a result, engagement with individuals facing suicidal thoughts to self-manage their safety, with support from their loved ones, is fundamental.

In addition, in consideration of reducing access to means, we must also think about how the internet, whilst a potential source of support can provide vulnerable people with information, the means and encouragement to end their lives.[34] Work should be done within the county to address this, potentially engaging with the government on a national level to request harsher restrictions on accessing such content. The Online Safety Bill (in draft form at time of writing) outlines the approach to harmful and illegal content online, with an expectation that restrictions will be placed on content related to suicide and self-harm.[35] This strategy will promote good practice outlined in the bill and ensure that where content has been defined as legal but harmful, we seek to promote alternative sources of support to drive traffic away from these sites. In addition, this strategy is mindful that a greater range of content will be deemed harmful for children and young people, so extra considerations need to be made about managing this risk. The Samaritans have also produced guidance for practitioners on the potential benefits and risks for someone searching for content related to self-harm on the internet.[36]

As a mental health system, it can be difficult for us to engage with all online content, and there may be inappropriate discussions of suicide and self-harm in private groups or pages that we unable to intervene in directly. On a local level, the focus should be on promoting healthy online behaviour and a range of positive online resources as alternatives to visit

when tempted to look for more harmful content. These websites should contain information and signposting, as well as immediate support in the online environment, such as self-help guidance and mental health apps.[34] The Keep Your Head[37] and How Are You[38] Websites are useful sources of information for self-help and accessing local services. In addition, the internet should be considered as part of suicide safety plans, with resources such as the Ripple suicide prevention tool being promoted.[39] Promotion of resources from sources such as internetmatters.org can provide guidance on how to report concerning content on various social media.[40] In addition, further resources can be produced in order to discuss the impacts of posting incorrect or harmful information on the internet regarding suicide.

Ensure the Community is Well-Equipped to Prevent Suicide in Non-Clinical Environments

Priority Area 4: Ensure the Community is Well-Equipped to Prevent Suicide in Non-Clinical Environments

A key target of this strategy is ensuring that suicide is everyone's business. Often, the people in the community surrounding someone struggling with their mental health can have the most significant impact on their wellbeing.[41] Therefore, it is important that this community has access to the necessary information and resources to support someone, as well as ensure their own mental health does not suffer as a result of helping someone else.

Recommendation A – Support the delivery of awareness raising campaigns, particularly through the introduction of data-informed tailored approaches

CPSL Mind have developed the STOP Suicide Campaign and since 2016/17 have grown the message to raise awareness and challenge stigma across Cambridgeshire and Peterborough.[11] In this time, key messages have included the Just ASK campaign, encouraging people to have open and honest conversations about suicide, as well as the delivery of targeted messages to at-risk groups, primarily middle-aged men and the Eastern European population.[42] The Stress Less campaign, aimed at 12-18 year olds, works with young people to tackle mental health stigma.[43]

As part of the Wave 4 suicide prevention transformation programme, the STOP Suicide campaigns will use data from the RTSS to identify recent trends or clusters in specific demographics and tailor messaging to deliver targeted campaigns addressing these groups directly. In addition, any messaging aimed at young people should be considerate of those Not in Education, Employment and Training.

As a final note, there may be several mental health and suicide awareness campaigns running concurrently. This strategy recommends that efforts are made, where possible, to collaborate and promote concurrent messages.

Recommendation B – Promote delivery of suicide prevention training to non-medical professionals and members of the community

Priority Area 2 discusses in detail the need for healthcare workers to be able to discuss suicide confidently and openly with someone they believe may be at risk. However, this is only possible if that person is already actively seeking support for their mental health. Therefore, it is equally important that members of the community are able to spot symptoms in the people around them, talk to them about suicide, and be able to signpost them to support. CPSL Mind's Stop Suicide workshops, the Zero Suicide Alliance's Online Training and the ASIST two-day suicide intervention course are all able to support members of the community in this.[25] The message that "suicide is everyone's business" should be

communicated out to the community and people are encouraged to take the training to support loved ones, neighbours, colleagues, or strangers, who may be in a crisis.

In addition, those working with people who are considered vulnerable should also be encouraged to take up training, such as housing officers, school staff, police and anyone else that may work with someone at risk of poor mental health.

Recommendation C – Offer greater support to families and friends of people affected by suicidal thoughts to better equip them to keep their loved one safe and protect their own mental health

The message that "suicide is everyone's business" is important and being suicide-aware is something that everybody can do. Having access to information, resources and sign posting is important in creating an accessible, supportive community for everybody and to reduce situations in which one person feels solely responsible for another person's wellbeing.

Carers are people who provide help and (unpaid) support to a family member, friend or neighbour who would otherwise not be able to manage. We use the term 'carer' in its broadest sense to include the most significant people in the life of the service user, including spouses, parents and young carers. They provide important information that may help doctors, nurses, social workers and therapists to have a better understanding of the needs of service users. In order to be effective, partners, carers and family members need clear information about the service user's care and treatment

Family members and friends who are caring for people with mental illness (and are commonly referred to as carers) tell us that three things are important to them.

1. The cared for person receives the best care possible to support them in their recovery.
2. The carer receives training on how to best support their loved one in their recovery.
3. The carer is supported in maintaining their own wellbeing.

Consent and confidentiality is one of the most important and complex areas of mental health care. It is important to recognise that even in the absence of consent the provision of general information about mental illness, emotional and practical support does not breach confidentiality. General information can include information about the condition and behaviour it may cause, advice on managing it, particularly in a crisis, and contact details of the team responsible for the service user / patient's care.

The Department for Health and Social Care have recently published and updated their consensus statement on Information sharing and suicide prevention.[44] In addition to this statement the Zero Suicide Alliance, on behalf of DHSC, has also published guidance for frontline staff on how to use the consensus statement, which aims to support staff regarding when and how to share information about patients where this may help prevent suicide.[45]

Cambridgeshire and Peterborough Foundation Trust prior to the pandemic ran a Common Sense and Confidentiality course for staff working in mental health. In response to the pandemic this course has now moved online and will be relaunched. In addition, it is anticipated that at the Trust induction all staff will receive information about Consent and Confidentiality and information about consent and confidentiality is now available on the CPFT public website.[24]

However, as important as it is to ensure that carers are actively involved in their loved one's care (where appropriate), no one individual is wholly responsible for anyone else's mental health. To avoid anybody taking on too much responsibility when it comes to the mental health of somebody around them, it is important to create a community support approach. Service users should be encouraged to build support networks of loved ones that can help keep them safe when facing suicidal thoughts and all messaging with regard to supporting someone should highlight that they are only one part of a much wider system.

Improve understanding of self-harm and support the promotion of healthy coping strategies

Priority Area 5: Improve understanding of self-harm and support the promotion of healthy coping strategies

Recommendation A - Improve data collection to gain a better understanding of self-harm beyond crisis care

On a local level, the most widely used indicator of prevalence of self-harm is presentations to A&E and admittance into ward beds. However, this only represents a minority of incidences of self-harm, with one 2017 study estimating that whilst 21,000 12-17 year olds in England present to hospital for self-harm each year, 200,000 self-harm in the community without presenting to hospital.[46] Therefore, it is difficult to accurately determine how severe the issue of self-harm is in Cambridgeshire and Peterborough. In addition to this, it is not enough to aim for decreasing presentations to A&E as an indicator of improvement. As discussed above, the majority of self-harm incidents do not result in A&E attendance. Also, self-harm can take many forms and may not present as a physical injury, but may resemble risky or obsessive behaviours.[47]

As part of the Wave 4 suicide prevention transformation programme, the Fullscope collaborative have been commissioned to review the self-harm data available in Cambridgeshire and Peterborough to improve our understanding of how this affects our community. Early findings have highlighted the significant difficulties in collecting this data across services, primarily due to the variations in methods of data collection relating to self-harm.

To achieve a unified approach and ensure services are consistent in how they recognise and record self-harm amongst their service users, we need to establish clear definitions of self-harm including how it relates to suicidal intent and the many different forms it can take. This messaging needs to be consistent across services to ensure not only that we are accurately recording numbers, but that professionals are able to confidently provide people who self-harm with appropriate support. In addition to this, it is important that self-harm is acknowledged as a distinct presentation in health services, and not absorbed into a wider 'mental health/anxiety/depression' note. Likewise, when a patient is being treated for physical wounds in relation to self-harming behaviour, it is also important that the underlying mental health reasons for the self-harming behaviour are recorded, beyond the immediate medical presentation. Finally, greater research needs to be conducted into how self-harm affects different communities, with particular concern being placed on neurodiversity and gender where differences in presentation may result in self-harm being overlooked, and LGBTQ+ and ethnicity, where data is lacking.[4848]

Recommendation B - Understand and address self-harm in children and young people

As part of the Wave 4 Suicide Prevention Transformation Programme, the Fullscope Collaborative have been commissioned to understand and address self-harm in young people through the delivery of pilot programmes co-produced by young people and parents. They will work with local schools, guided by a steering group of self-harm experts, key stakeholders and people with lived experience, to determine the best ways to support children and young people who may be at risk of, or are currently, self-harming.

The Public Health Team will propose a research project with Cambridge University into better understanding how mental health issues are presenting in young people aged 18-25, including self-harming, as part of the Cambridge University Science and Policy Exchange (CUSPE).[49]

A subgroup consisting of mental health workers supporting children who self-harm and academics researching this topic has been assembled and will continue to meet on a quarterly basis to both understand the emerging trends in self-harm and work collectively to understand what support is available across the system to identify any gaps in provision.

In addition to these, public health intends to commission work to support families of children and young people who self-harm.

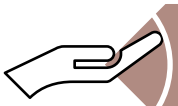
Recommendation C - Ensure those presenting to services with self-harming behaviours have their mental health concerns treated appropriately

When someone discloses that they self-harm to a family member, friend or professional, there may be concerns that this person has a potential risk of suicide. There are various definitions of self-harm, some of which include self-harm with suicidal intent. There are also many different motivations for people to self-harm, and in most cases the motivation is not suicidal. It is important not to conflate self-harm without suicidal intent, which is often a way for people to cope with difficult feelings, with suicidal thought and intent. However, we must also acknowledge that for some people who self-harm there is also suicidal intent and that there is a higher risk of death by suicide for people who use self-harm as a coping strategy.[50]

Increased understanding and awareness of self-harm, how it presents and how to support people who are self-harming, should be pursued. This will primarily be through the promotion of existing resources providing guidance for professionals working with those at a higher risk of self-harm, such as children and young people.[51] In addition, self-harm training should be considered, either as part of existing suicide mitigation training or in addition.

It is important to discuss the care available to people who self-harm both in the short and long-term. We must challenge stigma against people who self-harm as they present to healthcare services, to avoid adverse treatment outcomes.[52] Recognising that this is a

symptom of a wider mental-health concern, staff should be sensitive towards patients and where possible, seek mental health support to be offered in collaboration with any physical injuries that need addressing. Many view self-harm as a coping strategy and therefore our priority should be encouraging alternative strategies, as opposed to removing their existing coping strategies that may lead to greater harm.[47]



Ensure that Appropriate Steps are Taken Following a Suicide to Support the Community

Priority Area 6: Ensure that Appropriate Steps are Taken Following a Suicide to Support the Community

The aim of this strategy is to prevent suicide and, following the Zero Suicide Ambition, we are taking the stance that every suicide is preventable. However, this is a long-term goal and, in the meantime, it is important that we ensure whenever a suicide does take place, we recognise the impact this can have on the surrounding community and the mental health system.

Recommendation A – Expand the existing suicide bereavement support offer to accommodate those more widely affected by a suicide and encourage peer support

The existing suicide bereavement support offer is currently limited due to small capacity. With the addition of wave 4 postvention transformation funding, the service is set to double in capacity, thus expanding the scope of the service to include a wider cohort of people able to access support for a greater period of time.

In addition, investment will be made into suicide bereavement counselling which will be offered in collaboration with the suicide bereavement support offer as part of a wider model with a greater emphasis on community and peer support. To further the reach of support available to those bereaved by suicide, greater links will be made between the initial suicide bereavement support service and longer-term support groups, to allow for warmer handovers.

Finally, a suicide bereavement support offer for children and young people will be developed. In addition to this, in the tragic circumstance that a child or young person does take their own life, it is vital that support is offered to schools in how best to support young people through the complexities of grief by suicide. Samaritans currently offer support to schools if they are aware of a suicide involving a young person – this is primarily in rail-related deaths. Therefore, effort should be made to connect any school experiencing the suicide of a child or young person to the Samaritans to provide rapid support.[53]

Recommendation B – Ensure that professionals in contact with someone who has died by suicide are adequately supported

Beyond the next of kin, there are many others who may be impacted by a suicide in some capacity. In particular, where a person who has died by suicide has been known to mental health services, there may be feelings of grief, self-doubt or guilt.[54] It is integral that all staff are well-supported and any reviews into potential failings are handled with sensitivity. There are also many resources available to mental health professionals, such as 'If a Patient

Dies by Suicide: A Resource for Psychiatrists'.[55] [54] These should be promoted within mental health trusts as well as in community mental health services, if deemed appropriate.

In addition, there are many professionals who may not have previously had contact with someone who has died by suicide but may be affected by the incident itself. This includes rail staff where a death on the rail has occurred, or first responders including the police and paramedics. Therefore, resources and other support should also be available to identified 'first responders,' where possible and particularly if not offered internally within an organisation, with efforts made to establish such processes in the future.

Recommendation C – Rapidly respond to incidents of suicides that may have a greater impact on the wider community and ensure that information shared is accurate, sensitive and guiding people towards support

High-profile suicides, for example celebrity suicides or those that are particularly public or graphic in nature, can generate a great deal of attention and the risk of contagious suicide is increased.[56] From the previous strategy, considerable effort has been made to meet the national priority of encouraging the sensitive reporting of suicides in local media.[10] Connections are well established between the MH system and local media, such that suicides are generally carefully reported in line with Samaritans guidance, with careful monitoring to ensure that any insensitive reporting is swiftly corrected.[57]

However, it is important to mention that in a society where almost half of people consume news through social media, it is vital that we ensure that the information being shared through the likes of Facebook, Twitter and Instagram is also accurate and sensitive towards those who have died by suicide and their families.[58] Suicide prevention leads should work with communications teams within their organisations to encourage monitoring of social media and the preparation of statements that focus on dispelling harmful rumours and guiding people towards support.

Monitoring and Evaluation

The Suicide Prevention Strategy Implementation Group will meet twice a quarter to discuss the progress of the Joint Suicide Prevention Strategy for Cambridgeshire and Peterborough.

An Action Plan based on the recommendations above has been drafted and shared with the Suicide Prevention Strategy Implementation Group. All actions are assigned lead organisation(s) and key partners. Progress for each action will be reviewed at group meetings, with risks and opportunities discussed and addressed. Annual reports based on the outcomes of the action plan as it pertains to the strategy will be produced and shared with mental health boards in Cambridgeshire and Peterborough.

Due to the efficiency of the RTSS platform, local suicide rates will be a clear outcome of ongoing work. These rates can be broken down into demographics to determine the impact of targeted work. Whilst data will be available for each month, the impact of some actions will only be seen in the long-term. In addition, suicide rates can fluctuate throughout the year. Therefore, monitoring will occur monthly, but evaluation should occur annually. The zero suicide ambition and accompanying targets should always remain the focus of this strategy.[3]

In addition to the rate of completed suicides, the number of attempted suicides and incidences of self-harm will provide useful data as to the progress of the Suicide Prevention Strategy. However, in order for this data to provide an accurate picture of the work, procedures for accurate reporting of these figures must first be established. Therefore, suicide attempts and self-harm data will not formally be included in evaluations initially.

Another key outcome of this strategy is the impact of work on the people most affected. In addition to regular consultation with people with lived experience, evaluation will also involve consultations with GPs and other mental health professionals delivering the work outlined in this strategy to determine the impact on their workloads, patient outcomes etc.

In evaluation of this strategy there is a real opportunity to also consider specific interventions in greater detail to determine their individual effectiveness in preventing suicide. This is particularly important when we are adopting novel approaches in preventing suicide to confirm whether they should be pursued further, adapted or retired in favour or alternatives.

The Wave 4 Suicide Prevention transformation programme in particular will be evaluated in terms of the individual impact of each workstream, the overall impact of the programme, and its multiagency approach. External evaluators will review the programme, providing intermediate and final reports measuring the success of the programme and indicating areas of improvement. This will be fed back to the Suicide Prevention Strategy Implementation Group and be an essential part of the overall evaluation of the strategy.

In addition, when the strategy calls for new work to be delivered, evaluation will be built into the overall project design in order to build an evidence base of local interventions proven to have an impact on suicide prevention.

Implementation of the Strategy

The implementation of the strategy will require a mixture of input and work from the entire mental health system in Cambridgeshire and Peterborough, as well as the wider community. Beyond addressing the priority areas, cultural and organisational changes will be needed to accommodate the key themes of collaboration, co-production and information sharing.

Implementation of the recommendations and action plan will be managed by the joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged to utilise expertise from these organisations to implement the proposed initiatives.

Improved engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area.

Through co-operation, coordination and community engagement, we can all work together to reach our ambition of zero suicides in Cambridgeshire and Peterborough.

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Appendix 1: Available Resources for People Struggling with their Mental Health

Services for people with mental health problems

NHS Cambridgeshire and Peterborough CCG currently commission services for people with mental health problems on a pathway basis from the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). In addition, NHS Cambridgeshire and Peterborough CCG along with Cambridgeshire County Council and Peterborough City Council commission mental health services from a range of local independent and voluntary sector organisations. Some mental health services are commissioned as part of the mental health crisis care work. In addition, there are voluntary sector organisations that provide mental health support in Cambridgeshire and Peterborough with funding outside the statutory sector.

- Cambridgeshire and Peterborough Foundation Trust (CPFT) Locality Teams; Psychosis, Affective Disorders, Assertive Outreach
- Improving Access to Psychological Therapies (IAPT) services (through CPFT) – providing psychological or talking therapies for people experiencing common mental health problems.
- Group Therapy Centre - commissioned by Cambridge & Peterborough NHS to provide therapy groups for local people experiencing emotional and mental health worries.
- Acute Care Pathway (including crisis resolution and home treatment (CRHT) and Psychiatric Intensive Care Pathway). The acute pathway may include contact with liaison psychiatry services
- 111 (option 2) - mental health crisis telephone line with First Response Service (FRS) support into the community.
- Sanctuaries - run by CPSL Mind in Cambridge and Peterborough for people to be referred to by the FRS if in mental health crisis
- CAMEO - NHS service that provides specialised assessment, care and support to young people experiencing psychosis
- ChatHealth - secure and confidential text messaging service for young people aged 11-19 across Cambridgeshire and Peterborough
- Discharge Buddy Service – run by CPSL Mind, supporting people following discharge from hospital or community-based Crisis Team support
- Lifecraft – a user-led organisation for adults in Cambridgeshire who have experience of mental health difficulties in their lives. Lifecraft offers a wide range of free services to help and support its' Members in their wellbeing and recovery. Lifecraft have produced a Mental Health Handbook that serves as a directory of services for people with mental health problems

- Lifeline is provided for people in Cambridgeshire and offers telephone support to people experiencing mental health crisis, available 11am-11pm every day on 0808 808 2121
- Cambridgeshire, Peterborough and South Lincolnshire Mind (CPSL MIND) - provide a wide range of services across the county to support those recovering from mental health challenges, promote positive mental health and tackle mental health-related stigma and discrimination within our communities. CPSL MIND also hosts the STOP Suicide campaign and website
- Centre 33 – Cambridge based charity supporting young people. Drop-in sessions for children and young people in Cambridge Tues-Fri 12pm-5pm and Sat 10am-1pm, in Wisbech Thursdays 12pm-5pm, and in Ely Tuesdays 1-5pm
- Kooth- an online counselling and emotional well-being platform for children and young people (aged 11-19), accessible through mobile, tablet and desktop.
- Keep Your Head website - provides information on mental health and wellbeing, including services that are available as well as self-help guides and professional resources. There are now three versions of this site: one for children and young people, one for adults and one for professionals.
- Suicide Bereavement Support – Emotional and practical support, offered by Lifeline, in the immediate aftermath of a death by suicide
- YOUnited – Support for young people's mental health and emotional wellbeing
- Cambridge and Peterborough Samaritans - provide confidential emotional support to people in distress or despair in the local area. Support is provided over the telephone or by email: 116 123 / jo@samaritans.org
- PINPOINT offers parent-to-parent support for children with additional needs including mental health problems, particularly around self-harm
- Choices in Cambridge - Offers a confidential counselling service in Cambridge and surrounding areas for women and men whose lives are affected by childhood sexual abuse
- Relate - relationship counselling available in Cambridge, Eaton Socon, Ely, Girton, Huntingdon, Melbourn, Newmarket, Peterborough, Sawston, Stamford and Wisbech
- The Richmond Fellowship - a specialist employment service providing support for people recovering from mental health problems to find paid employment, voluntary work, education and training or to retain their current employment
- Rethink Carers - The Cambridge and Peterborough Groups help the carers of those with severe and enduring psychotic illnesses including schizophrenia
- CRUSE bereavement - provide bereavement support to anyone who needs it. This includes a Cambridge based group specifically for people affected by suicide.

Appendix 2: Evidence Base for Tailoring Approaches to Specific At-Risk Groups

In this section, we explore in more detail each group identified as being at greater risk of suicide, identified either in the previous suicide prevention strategy, national guidelines and data, or through conversations with key stakeholders in the system. For each group, efforts have been made to collate current understanding of why there is a greater risk and evidence-based approaches for preventing suicide within these cohorts (or suggestions where the evidence is lacking). This is not a comprehensive needs assessment, and information is limited for many identified groups, but this has been compiled to illustrate the different needs of our diverse communities and recognise the variety of approaches we need to take in order to best support everyone in preventing suicide.

Alcohol/drug users

Alcohol and drug use presents two major issues with regard to suicide. Firstly, people with a substance misuse problem are at greater risk of suicide than the general population.[59,60] Secondly, even in cases where an existing problem may not be seen, alcohol and drugs can play a part in suicide due to an increase in impulsive behaviour.[61]

Key considerations to be made involve early intervention, access to services, suicide awareness training and use of tools across the system, and risk management across partner organisations.

Bereaved people and those bereaved by suicide

Research has shown that those bereaved by suicide are 65% more likely to die by suicide than those bereaved by sudden natural causes, regardless of whether the person who died by suicide was a blood relative or not.[62] Suicide prevention interventions for those bereaved by suicide are discussed in greater detail in Priority Area 6.

Children and young people

Suicide is one of the leading causes of death in young people worldwide, with particular risk factors including the presence of mental disorders, previous suicide attempts and triggering psychosocial stressors.[63] The national suicide prevention strategy's fifth progress report names children and young people as a key high-risk group.[1] For more information regarding supporting the mental health of children and young people, please refer to the Cambridgeshire and Peterborough Children and Young People's Mental Health Strategy 2022-2025. With regards to young people and self-harm, please refer to Priority Area 5.

Gypsy, Roma and Traveller Community

Data for suicides within the GRT community, both nationally and locally, are severely lacking. Extrapolating from the fact that Irish Travellers are six times more likely to die by suicide than the general population, this is a particularly at-risk group and it is key that we work to protect the sizeable GRT community in Cambridgeshire and Peterborough.[6464] In

studies that do consider the mental health of the GRT community, concerns such as acceptance, life prospects and access to services are suggested as risk factors.[65]

Particular effort needs to be made into engagement with the GRT community, which is seldom heard compared to the rest of the population.[66] In production of awareness raising materials and resources, services need to be aware that alternative materials may need to be produced to account for lower literacy rates and access to digital technology within GRT communities. Initiatives from within the community, such as the One Call Away support lifeline,[67] should be promoted by the wider mental health system, with new ideas encouraged and supported.

The Public Health Lead Nurse for Travellers is part of the Suicide Prevention Strategy Implementation Group and can feed back to the group about issues affecting the GRT community. The RTSS system has been adapted to allow for more accurate recording of GRT ethnicity in those who have died by suicide.

LGBTQIA+ people

LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Asexual) young people are at greater risk of experiencing suicidal feelings, thought to be in part due to discrimination, societal norms and feeling unable to talk.[68] For similar reasons, many are reluctant to access formal mental health services, though will often seek support online.[69] Moving forward, work should be done into creating better connections between mental health support services and LGBTQIA+ support services, challenging stigma and raising awareness of the mental health risks faced by members of the LGBTQIA+ community. Resources such as Toolkits for Nurses on preventing suicide in LGBT young people can be promoted for good practice.[70,71]

Middle-aged men

As of May 2021, Men aged 40-54 have had the highest suicide rates in the UK since 2013. Of considerable interest is that 91% of middle-aged men dying by suicide in 2017 had at least some contact with a frontline service, with primary care being most common (82%).[72] Therefore, it is important that when men reach out for help, they receive adequate support from services that are best suited to them. A report published by national MIND identified counselling and exercise as the most popular prescribed treatments for low mood/anxiety in middle-aged men.[73] Improving links to social prescribing would therefore be beneficial for this cohort.

New Migrants – Polish and Lithuanian People

A recent study of Polish people within the UK found limited uptake of mental health services despite exhibiting need. *"Reasons for underutilisation of services include limited knowledge and trust of the National Health Service (NHS), previous negative experience, poor language skills and perceived cultural differences related to how migrants describe their mental health*

problems," as well as *"stigma."*[74] However, it should be noted that migrants are not a heterogeneous group and that this study is only representative of one community.

Moving forwards, efforts should be made across the system to improve accessibility of mental health services by taking a more active approach to understanding the different cultures of our diverse population. Resources and awareness campaigns should be translated into different languages as needed, particularly with regard to helping new migrants navigate a health service that they may not be familiar with. In addition, community groups/leaders should be engaged as mental health champions to encourage greater communication between mental health services and the migrant population in Cambridgeshire and Peterborough.[75]

People in contact with mental health services

People in contact with mental health services are at a particularly high risk of suicide compared to the general population (approximately a 10-fold risk)[1], but we have the greatest opportunity of intervention as a system as they have engaged with our care. Most notably is the increased risk in the weeks following discharge from inpatient care.[4]

Care planning and continued engagement can be complicated due to a variety of factors in a service user's life, including socioeconomic factors such as housing and debt, refusal of treatment related to psychiatric symptoms strain on the mental health workforce.[76]

Therefore, it is essential that we utilise every single contact effectively in order to keep people in contact with services safe. Awareness and suicide prevention training needs to be undertaken by anyone in the system likely to come into contact with patients, not just healthcare professionals but support staff and those offering social and practical support.

In addition, we need to pay careful consideration as to how we can keep people safe from suicide in the periods between formal contact. This can include promotion of safety planning and encouragement of the individual to support their own wellbeing, as well as referrals into community support groups/helpline services. In addition, those recently discharged should be made aware of formal points of support, such as Discharge Buddies.[32]

People in custody

There are three prisons in Cambridgeshire and Peterborough. There is an increased risk for people in prison custody than the general population, with this risk remaining high following release from prison, with those recently released being 7 times more likely to die by suicide.[77]

It is important that prison estates are "psychologically informed environments" where staff receive mental health training and are equipped to provide support to people in custody showing signs of distress or changes in behaviour.[78]

In addition, approaches to keep prisoners safe should take into consideration how to maintain support after they have served their sentence. This will involve greater collaboration between the mental health system and the probation service. 2017 research into probationers at risk of suicide identified several key recommendations to protect the mental health of people in contact with the probation service, such as suicide prevention training for probation officers, and increased support at high-risk times, such as re-entering custody or completing probation.[79]

People facing loneliness and isolation

Loneliness is a major risk factor for suicide[80] and those living alone, in rural communities or working in more isolated professions need to be taken into consideration as they will lack many support networks others in the general population may have, such as colleagues and community groups. This has become a particularly pressing issue due to COVID-19 and the increase in self-isolation.[81]

It is important that we address stigma associate around mental health and aim to maintain social connectedness. Expansion of the newly formed Network for Addressing Isolation and Loneliness in Cambridgeshire and Peterborough (NAILCAP) will ensure that community groups across the county will be linked into the wider mental health system.[82]

People who self-harm

Self-harm has been identified by the national suicide prevention strategy as one of the key risk factors for suicide,[1] with one long-term study reporting that suicide was over 55 times more likely in people in the year they were discharged from hospital for non-fatal self-harm than in the general population.[83] Suicide prevention interventions for those who self-harm are discussed in greater detail in Priority Area 5.

People with autism

The links between people diagnosed with autism and dying by suicide are strong, with one Danish study finding a three-fold higher rate of suicide and attempts compared with the whole population. Protective factors such as marriage, educational level and employment were also found to be less protective in people with autism.[84]

The Cambridgeshire and Peterborough All Age Autism Strategy 2021-2026 has identified barriers in people with autism accessing mental health support, including long waiting times and difficulties related to transition between CYP and Adult mental health services. The strategy makes a number of recommendations to address this, including training for mental health staff, reasonable adjustments in care pathways and improving the accessibility of signposting information and resources.[85]

Students

Cambridge University and Anglia Ruskin University house a sizeable student population in Cambridge City, with an additional campus now open in Peterborough. Students are at risk

due to difficulties with academic studies, financial problems, transitions and social pressures, in addition to other risk factors facing people under 25 including self-harm, alcohol misuse and psychological factors.[86]

Universities UK and Papyrus have co-authored guidance for universities to keep their students safe, taking into account prevention, intervention and postvention. Key recommendations involve addressing stigma, encouraging training and signposting to internal and external resources.[87]

CU and ARU mental health and wellbeing teams are now represented on the Suicide Prevention Strategy Implementation Group and can feedback any areas of concern to the wider mental health system.

Unemployed people and those in financial difficulties

A 2015 study attributed 1 in 5 suicides worldwide are due to unemployment, with an increase in times of economic recession.[88] Rates of unemployment in the county are currently at 3.2% as of June 2021[8989] (lower than both the regional and national average). Mental health should be an important consideration when providing financial or employment support.

The Zero Suicide Alliance has guidance for supporting unemployment benefit recipients, two thirds of which have thought about taking their own life. These recommendations include embedding social prescribing in practical support services and improving access to welfare advice, as dictated by the Citizens Advice Bureau.[90] Therefore, efforts should be made to connect employment services with mental health services to ensure a consistency in approach.

Veterans

In general, data on veteran suicide is lacking. A 2014 report noted that whilst the suicide rate is lower in those serving in the Armed Forces than the general population, and the overall suicide rate in veterans is similar to that of the general population, there is an increased risk in young men (under 20) serving in the Armed Forces and Young Veterans (16-24) and those classified as early service leavers. Evidence suggests this increased risk is due to pre-service vulnerabilities.[91] Rates of veteran suicide will be reported nationally by 2023, but efforts are being made to report on veteran suicides in Cambridgeshire and Peterborough *via* the RTSS system by early 2022.[92]

Public Health are working with the county's Armed Forces Covenant Officer to ensure a collaborative approach, working with experts in veteran's mental health, such as Project Nova.[93] A suicide prevention representative sits on the Armed Forces Covenant board meetings for Cambridgeshire and Peterborough.

Victims of Domestic Abuse

Research conducted by Refuge in 2018 noted the 83% of their clients felt 'despairing or hopeless' at intake, with at least 24% feeling suicidal at some point in their life. They identified the need for timely, trauma-informed support available for victims of domestic abuse.[94]

It is important that all Independent Domestic Violence Advocates (IDVAs) are trained in suicide mitigation and can confidently discuss suicide in a trustworthy environment with their clients. Conversely, all mental health professionals must have an awareness of domestic abuse and appropriate referral destinations. This can be done through foundational training or through the use of the briefing paper for professionals working with those suffering from domestic abuse that has been co-produced by the DASV Partnership and CPSL Mind.[42]

Young offenders

It has been reported that the suicide rate in male young offenders (aged 15–17) may be as much as 18 times higher than the rate in non-offenders.[95]

All YOS staff complete mandatory training which aims to focus on what has happened to a young person and not just their presenting problem. This in effect challenges stigma around youth offending, with the offence as the tip of the iceberg. Youth Offending Services have also adopted a multi-agency approach, discussed in a Case Study 1 earlier in the strategy, to best suit the needs of children and young people in contact with their care.