Review of self-harm prevalence in children and young people in Cambridgeshire and Peterborough

This report is a review of what is currently known about self-harm through national and local prevalence rates at the time of writing, April 2022. The report has been commissioned by Cambridgeshire and Peterborough Public Health, under the wider work of the Wave 4 suicide prevention programme.

Fullscope
Changing systems, improving young lives

Wave 4 funding: Fullscope

Fullscope will deliver a one-year project (2021/22) that will engage a range of experts about self-harm during adolescence in Cambridgeshire and Peterborough to co-produce a local response which is grounded in the current experiences and insights of young people, families, front-line professionals and researchers. The method will follow the Fullscope model of co-production, ensuring that a group of young people and parents/carers are empowered and equipped by access to excellent information and data to co-produce a model of support in Cambridgeshire and Peterborough.

This work has been commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), funded by NHS England Wave 4 funding.

Specific Goals of the wider Wave 4 programme of work

To further develop Suicide Prevention workstreams to meet the following ambitions by 31/3/2022

- To enhance the use of the multi-agency real time suicide surveillance tool (RTSS)
- To deliver system wide training in Safetool safety planning and risk assessment
- To design and deliver communications and STOP Suicide Campaigns
- To develop our understanding of addressing Self-harm in children and young people (to July 2022)
- To recruit a Suicide Prevention Manager to deliver on the workstreams above with other key stakeholders.

This project will deliver to point 4 in this list.

Fullscope will work with a partnership of local children and young people's mental health charities and organisations to:

During phase 1:

Undertake desk-based research and analysis to understand the available data, issues and challenges associated with self-harm in children and young people (CYP).

During phase 2:

Work with children and young people, their families and professionals to understand their experiences of self-harm support locally, and what could help them which isn't already in place/accessible.

Further understand the pathways of support for CYP, exploring ways in which we could work collaboratively across the system to improve navigation and access to information, resources and support.

Draw conclusions around what needs to be done, co-producing this work with CYP for roll-out with Wave 4 funds in years 2 & 3.

This report addresses the first phase of the above outline of work. A subsequent report and recommendations will follow phase 2 in July 2022.

Self-harm definitions

Definitions of self-harm vary across services nationally, for example:

'Self-harm is any behaviour where the intent is to deliberately cause self-harm without suicidal intent, resulting in non-fatal injury'. Cambridgeshire and Peterborough Safeguarding Partnership Board.

'An intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and...an expression of emotional distress'. NICE.

'Self-poisoning or self-injury irrespective of apparent motivation or medical seriousness.' Department of Health's Multi-Centre Study of Self-harm in England (Manchester self-harm project).

While debates over the precise definition of self-harm continues internationally, it is increasingly common to find more precise definitions of self-harm being used in academia and research.

Non-suicidal self-injury (NSSI) is one commonly used term, which is defined as a 'deliberate and voluntary physical self-injury that is not life-threatening and is without any conscious suicidal intent'.[1] Behaviours that fall under NSSI include cutting, scratching and self-battery.[2]

NSSI differs from the broader term 'deliberate self-harm' (DSH), which encompasses self-injury with and without suicidal intent.[3]

In the UK, the Adult Psychiatric Morbidity Survey (APMS) uses the term 'non-suicidal self-harm' (NSSH) to distinguish from suicide attempts. Although intent can be difficult to establish, the APMS established prevalence for NSSH from responses to the question "Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?"; suicide attempts were asked about with the question "Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?"

In the Mental Health of Children and Young People in England survey, self-harm or attempted suicide was ascertained with the question "Over the whole of your lifetime, have you ever tried to harm yourself or kill yourself?".

It's important to note that defining self-harm with or without suicidal intent can affect the treatment pathways offered to the child or young person. McManus et al. argue that "motives underpinning NSSH are multiple, fluid, and complex, [and] effective intervention is likely to depend on understanding NSSH and suicide attempts as distinct issues".[4]

National prevalence

According to the Adult Psychiatric Morbidity Survey (APMS) last conducted in 2014, the most comprehensive data set that exists for self-harm in the community, levels of self-harm are increasing for both men and women in every age group, including in young people aged 16-24.

The Mental Health of Children and Young People in England 2017 survey found that 5.5% of 11-16 year olds and 15.4% of 17-19 year olds self-reported having ever self-harmed or attempted suicide (although it is important to note that these figures combine both self-harm and attempted suicide).[5] Rates of self-reported self-harm or attempted suicide were more than double for females compared to males in both age groups.

1 Laye-Gindhu, A., & Schonert-Reichl, K.A. (2005). *Nonsuicidal self-harm among community adolescents: Understanding the "what" and "whys" of self harm.*

2 Nock, M.K. (2010). *Self-injury. Annual Review of Clinical Psychology.*

3 Skegg, K. (2005). *Self-harm.* The Lancet.

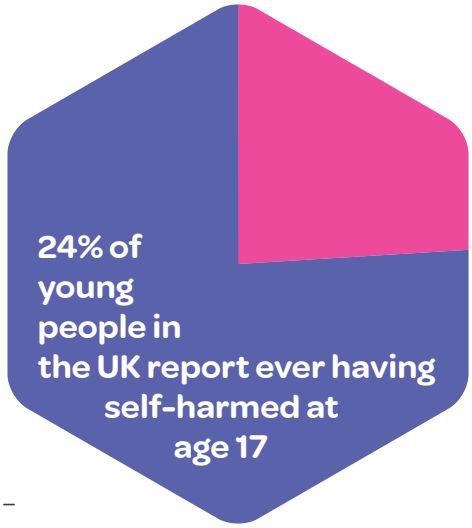
4 McManus et al. (2019). *Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population.*

5 Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital

Data collected in 2018-19, the Millennium Cohort Study (MCS) found that 24% of young people in the UK report self-harm and 7% report self-harming with suicidal intent at age 17, an increase from 16% of the cohort that reported self-harming ever at age 14.[6] More than a quarter of 17-year-old females (28%) and a fifth of males (20%) reported self-harming in the previous year. The increase in the 3 years was particularly marked for males, with rates more than doubling from 9% at age 14 to 20% at age 17, while females experienced an increase from 23% to 28% over the same period.

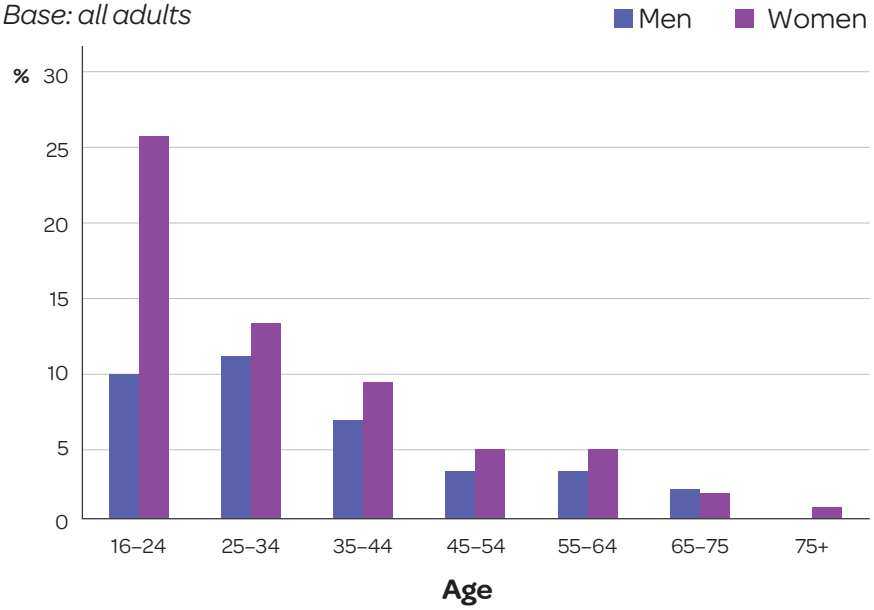
It is unclear to what extent any increases can be attributed to decreasing levels of stigma around self-harm and a society-wide shift to speak more openly about mental health issues.

The data is clearer in terms of the difference in prevalence between males and females. Reported rates of self-harm are higher among young women and girls (aged 16-24), one in four of whom reported having self-harmed at some point – more than twice the rate of young men of the same age.[7]



Self-harm without suicidal intent ever, by age and sex (APMS)

Base: all adults



Between the ages of 5–10 years, more boys than girls present to hospital for self-harm, but after age 12, the number of girls increases rapidly.

The 2021 Multi-Centre Study of Self-harm in England also shows that between the ages of 5 – 10 years, more boys than girls present to hospital for self-harm, but after age 12, the number of girls increases rapidly.[8]

This is in line with a 2017 study by the University of Manchester which found a recent sharp increase in rates of self-harm specific to 13-16 year old girls: the annual incidence of self-harm has increased in girls (37.4 per 10 000) compared with boys (12.3 per 10 000), and there has been a sharp increase of 68% among girls aged 13-16. 9

Summary

As self-harm rates often depend on self-reporting, the various definitions that are used, and at times, conflation with attempted suicide or suicidal intent, it is difficult to present definitive figures for self-harm prevalence among young people. What is clear, however, is that rates of self-harm among young people are increasing compared to previous years, although again, it is unclear to what extent any increases can be attributed to decreasing levels of stigma around self-harm and a society-wide shift to speak more openly about mental health issues. Another common finding is that rates of self-harm increase significantly for both females and males as children move into adolescent years. The surveys also consistently report higher levels of self-harm among females compared to males.

6 UCL, Centre for Longitudinal Studies. (2020). *Mental ill-health at age 17 in the UK*, available here: https://cls.ucl.ac.uk/high-levels-of-serious-mental-health-difficulties-among-17-year-olds/

7 NHS Digital. (2016). *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014*, available here: https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf

8 Galit Geulayov et al (2021). *Self-harm in children 12 years and younger: characteristics and outcomes based on the Multicentre Study of Self-harm in England.*

The impact of Covid-19 on rates of self-harm

Referrals to child and adolescent mental health services doubled in March 2021 compared to March 2020

Locally the rates of hospital attendance for self-harm in Cambridgeshire and Peterborough fell during Covid-19 lockdowns, in line with the national picture.[10] It is not known however how much of this is caused by the impact of anxiety around attending hospital at this time, as opposed to actual rates having decreased.

Nationally, referrals to child and adolescent mental health services increased in the year March 2020 - 2021: at 65,533, it is more than double the referrals in March 2020 and 68% higher than March 2019. Emergency referrals to crisis-care teams for under-18s have also increased: 62% higher in March 2021 than the previous year.[11]

Latest suicide data: reported deaths by suicide for 2020

Indications are that Covid has not – so far – had the negative impact on suicide rates that was initially feared nationally. The overall deaths by suicide registered in the UK during 2020 were 8.2% lower than in 2019. Caution is noted by the ONS in its data that this may be a result both of delays in reporting due to Covid 19, and a reduction in male deaths by suicide at the start of the pandemic.

Age-specific suicide rates in England and Wales decreased for those aged 10 to 24 years from a rate of 8.4 per 100,000 in 2019 to a rate of 7 per 100,000 in 2020.[12]

Self-harm prevalence among specific groups

We know from the data and evidence review that there are specific groups who are at particularly high risk of self-harm, summarised below.

Adolescent girls

As highlighted in the national prevalence rates above, whilst more boys attend services for self-harm injuries before the age of 10, reported rates of self-harm amongst adolescent girls rises sharply compared to reported rates amongst adolescent boys.

The Mental Health of Children and Young People in England 2017 survey found that rates of self-reported self-harm or attempted suicide were more than double for girls compared to boys across the 2 main age groups with 7.3% of girls reporting self-harm or attempted suicide compared to 3.6% of boys among 11–16 year olds. Among 17–19 year olds, the rate for girls was 21.5% compared to 9.7% of boys.[13]

A recent study notes a complex interplay between age, gender and self-harm, and found that whilst rates of self-harm are greater in adolescent girls, the pattern for rates differed between girls and boys: "in females [self-harm] seemed to rise from early adolescence, peak at mid-adolescence (age 16–17), and then gradually decline; in males, however, [self-harm] remained at similar levels at all ages...This difference in age pattern meant that the gender difference was only statistically significant at ages 16–20".[14]

This is also reflected in increasing rates of emotional disorders such as anxiety amongst girls as they increase in age. The rate of emotional disorders in boys increased from 4.6% of 5–10 year olds to 7.9% of 17–19 year olds. In girls, the rates of emotional disorders increased from 3.6% of 5–10 year olds to 22.4% of 17–19 year olds.[15]

Self-harm depends on self-reporting and it is important to note here the impact too of definitions of self-harm and whether all boys would self-report types of self-harm which might be more commonly associated with dysregulation in adolescent boys, such as hitting oneself or walls etc. Stigma attached to asking for help might also account for lower self-reporting in boys.

Rates of self-harm or attempted suicide were more than double for girls compared to boys over the age of 11 (2017)

10 Public Health England (2021). HED Tool, A&E Strategic Analysis (Chief Complaint = Self Injurious Behaviour)

11 See The Guardian, (15th July 2021). Young mental health referrals double in England after lockdowns. https://www.theguardian.com/society/2021/jul/15/young-mental-health-referrals-double-in-england-after-lockdowns

12 Office for National Statistics, Suicides in England and Wales: 2020 registrations https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2020registrations

13 Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital

14 Wilkinson et al (2022). Age and gender effects on non-suicidal self-injury, and their interplay with psychological distress.

15 Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital

LGBTQ+

Stonewall highlights that LGBT young people experience very high rates of self-harm, pointing to evidence indicating that 61% of gay, lesbian and bisexual young people have self-harmed at some point. This jumps to an alarming 84% of trans young people who reported having deliberately harmed themselves, though what constituted self-harm was not defined and therefore care must be taken not to compare rates which may include different types of behaviour.[16]

It is important to note here the dearth of good data on health impacts and inequalities amongst LGBTQ+ young people as this information has not to date been routinely collected. Information provided to this research work also points to a lack of understanding of intersectional issues for LGBTQ+ young people, highlighted in the case notes below.

61% of gay, lesbian and bisexual young people have self-harmed at some point.

The Kite Trust research notes relating to self-harm, 2022 (full report 'Understanding and improving access to mental health support for LGBTQ+ young people aged 16-25' to be published Summer 2022)

Key themes:

- Self-harm as a means to presenting self in crisis to be able to get support.
- Converse worry of it being seen as very serious and put on pathway don't want to be on e.g. inpatient care.
- Different views of self-harm around generations and concern about talking to parents about from fear that they will think they've failed as parents.
- Worry that professionals knowing about self-harm would compromise access to other forms of care like gender identity clinic referrals.

Examples from interviews:

P14: Online spaces as negative for mental health (MH) – this relates back to the point that different 'self-care' or other MH support behaviours/mechanisms work differently for different people – this is an obvious point but is often not acknowledged in MH self-care and prevention conversations, advice etc – there is often an assumption that particular behaviours or practices are unequivocally 'good'. This young person was exposed to lots of pictures of self-harm in twitter/tumblr spaces and attributes it to the development of an eating disorder – it's dangerous for online spaces to be the only spaces available to young people seeking help, they need alternatives as well. Also raised points around not wanting to share info of self-harm when trying to access gender affirming care as they felt it would risk them not getting a referral to the gender identity clinic because the GP would think their mental health was too bad/unstable.

P7: explains that they're scared to talk about self-harm (because this is a 'massive' issue for them) because if the services they're accessing can't help, they feel the next step will be escalation to in-patient care and they don't want that. Also find it difficult to talk to parents about it as they don't understand why someone might self-harm.

P4: Younger sister was self-harming so P4 supported her to go to school nurse. Got a CAMHS referral but didn't 'interact' with them so was discharged. Ended up getting support through 3rd sector organisation in a different city, who P4 describes as providing appropriate support as they are a YP MH org but have an LGBTQ+ youth group where the sister could access social support and information relating to sexuality.

16 Stonewall. (2017). The school report: The experiences of lesbian, gay bi and trans young people in Britain's schools in 2017, available here: https://www.stonewall.org.uk/system/files/the_school_report_2017.pdf

Ethnic minority groups

There is a dearth of high-quality evidence examining the experiences of young people from ethnic minorities with regards to prevalence of self-harm. In terms of the general population, according to APMS data people from ethnic minorities are less likely than White people to self-harm. However, evidence looking at young women specifically shows that women from ethnic minorities are at heightened risk. Research from the Multi-Centre Study on Self-Harm in England found that rates of self-harm were highest among young Black women (16-34) compared to White and South Asian, but that young Black women were also less likely to receive a psychosocial assessment or re-present to A&E.[17] Another study found that South Asian women are significantly more likely to self-harm between ages 16–24 years than White women.[18]

The local data we have received for this project has not allowed us to draw conclusions around specific ethnic groups and self-harm in Cambridgeshire and Peterborough, however the demographic data for the local area show us that the minority ethnic population totals 18.7%, which is 3.9% higher than the East of England average. This data is not broken down further into female/male or age groupings in order for us to further analyse the information in relation to Cambridgeshire and Peterborough.[19]

Autism

There is an emerging evidence base which suggests that levels of self-harm among young people with autism are very high. According to Research Autism, part of the National Autistic Society, self-harm is 'very common in people on the autism spectrum' though there is very little high-quality research evidence on the effectiveness of most interventions for people with autism.[20]

The Cambridgeshire and Peterborough All Age Autism Strategy notes:

- It is estimated that there are 2700 children and young people aged 5 – 24 across Cambridgeshire and Peterborough with autism.
- All 13 of the children and young people on the Transforming Care Register (at risk of hospital admission) have autism, the majority of girls on the register have an eating disorder and are currently Tier 4 residents.
- Children, young people and adults are more likely to have or develop mental health conditions, such as anxiety, obsessive compulsive disorder (OCD) and depression, than neuro typical people.

There are specific targets in the strategy around early intervention and improving access to local mental health services for neurodiverse children and young people.

Socio-economic deprivation

The Multi-Centre Study on Self-harm also found that self-harm in children is strongly associated with socio-economic deprivation. "The proportion of study children [under 12 who self-harm] living in neighbourhoods ranked most deprived (43.4%) was twice the national average."[21]

In the latest Children's Society report, income was more strongly related to emotional and behavioural difficulties, and attempted suicide among those aged 17 years. A significantly higher proportion of children in the lowest income group had poor outcomes for these measures than children in the middle and two higher income groups.[22]

The University of Manchester study also notes that whilst incidence of self-harm was higher in the most deprived localities, practices in those locations were least likely to refer young patients, "an illustration of the 'inverse care law,' whereby quantity or quality of healthcare service provision is inversely associated with the level of healthcare need".[23]

"The proportion of study children [under 12 who self-harm] living in neighbourhoods ranked most deprived (43.4%) was twice the national average."

17 Cooper et al. (2010). *Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study,* available here: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/ethnic-differences-in-selfharm-rates-characteristics-and-service-provision-threecity-cohort-study/CDBA53F0AC230909E892C263781A0A51

18 Husain et al. (2006). *Self-harm in British South Asian Women: Psychosocial Correlates and Strategies for Prevention* available here: https://www.researchgate.net/publication/7065982_Self-harm_in_British_South_Asian_Women_Psychosocial_Correlates_and_Strategies_for_Prevention

19 Cambridgeshire_and_peterborough - Population - CAUTH | Cambridgeshire and Peterborough | InstantAtlas Reports (https://cambridgeshireinsight.org.uk/population/)

20 Research Autism. (2017). *Self-Injurious Behaviour and Autism*, available here: http://www.researchautism.net/issues/11/self-injurious-behaviour-and-autism/currentresearch

21 Geulayov et al, 2021.

22 The Children's Society (2021). *The Good Childhood Report*. Available here: https://www.childrenssociety.org.uk/sites/default/files/2021-08/GCR_2021_Full_Report.pdf

23 BMJ, (2017). *Incidence, clinical management, and mortality risk following self harm among children and adolescents*: cohort study in primary care, BMJ 2017; 359 doi: https://doi.org/10.1136/bmj.j4351

Summary

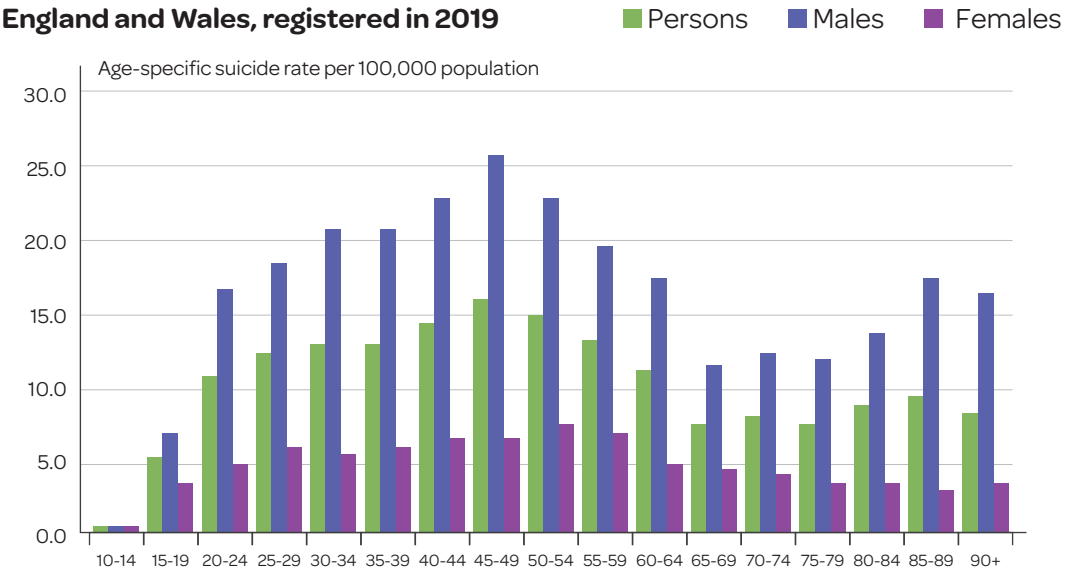
It is widely recognised that certain groups have higher rates of self-harm, including adolescent girls, autistic young people, LGBTQ+, some ethnic minority groups and those living with socio-economic deprivation. However, there is a widespread lack of high-quality evidence on self-harm prevalence, the specific risk factors that contribute to higher rates of self-harm, and on the effectiveness of interventions around self-harm for these specific groups. There is also the issue of barriers in access to mental health services for many of these groups, which points to a need for services in Cambridgeshire and Peterborough to develop targeted initiatives to improve access and carefully consider how care pathways can better meet intersecting needs and risk factors.

Self-harm and Suicide: national prevalence

It's a source of huge debate internationally as to whether there is a distinction between non-suicidal self-injury and suicide attempts. What is agreed amongst academics though is that people who self-harm are at increased risk of suicide attempts and so should be taken seriously. Self-harm is one of the strongest risk factors for completed suicide and around half of all people who die by suicide have a history of self-harm.[24]

Rates of self-harm are greater in females in the under 20s age ranges, however rates of suicide amongst males are much higher than in females across all age groups, showing a rapid increase in rates between the ages of 15-19 and 20-24 years:

Age-specific suicide rates by sex and five-year age groups, England and Wales, registered in 2019



Source: Office for National Statistics - Suicides in England and Wales: 2019 registrations

The Office for National Statistics notes: "Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly 10 to 24 year old females where the rate has increased significantly since 2012 to its highest level with 3.1 deaths per 100,000 females in 2019."[25]

The Good Childhood report (2021) shows that there appears to be a relationship between life satisfaction at age 14 and having ever attempted suicide (reported at age 17). The report found that a significantly greater proportion of young people who had low life satisfaction at age 14 later said that they had hurt themselves on purpose in an attempt to end their life, and notes that whilst females are more likely to attempt suicide at this age, males are more likely to end their lives in adolescence.[26]

Whilst not all young people who self-harm will go on to attempt suicide, the link between the two should not be ignored, and young people displaying distress through self-harm should always be taken seriously.

24 Hawton K, Zahl D, Weatherall R. (2003). *Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital.* British Journal of Psychiatry. 2003;182(6):537-42.

25 Suicides in England and Wales - Office for National Statistics ons.gov.uk

26 The Children's Society (2021). *The Good Childhood Report.*

Self-harm prevalence: Cambridgeshire & Peterborough

A study of self-harm rates in Cambridgeshire found that 12% of young people had engaged in non-suicidal self-harm.

There are less definitive data on self-harm prevalence rates at a regional level with figures available from different datasets that are difficult to compare.

Prevalence rates from longitudinal research studies

One study analysed for self-harm prevalence rates in Cambridgeshire using data collected as part of Roots, a larger longitudinal study of risk factors for the development of psychopathology, with first wave data collected from secondary school age students in 2005. The study found that by age 14, 12% of young people had engaged in non-suicidal self-harm. By age 17, a further 6% had engaged in new instances of self-harm.[27]

Another study based on longitudinal data collected from young people aged 14-25 in Cambridgeshire, Peterborough and North London found that 20% had engaged in non-suicidal self-harm in the first wave of data collection in 2012.[28]

By age 17, a further 6% had engaged in new instances of self-harm.

The figures from both these studies roughly reflect the national prevalence rates from the Millennium Cohort Study cited earlier.

Prevalence rates from hospital admissions data

Rates of self-harm prevalence are often presented in the form of hospital admissions for self-harm injuries, with national numbers of people presenting to hospital emergency departments after self-harm increasing over the years.

However, as McManus et al. (2019) found, using data from the Adult Psychiatric Morbidity Survey, **most people who self-harm do not present to hospitals**, with 59% of people who participated in non-suicidal self-harm reporting no consequent medical or psychological service contact. McManus et al. (2019) also found that people presenting to hospitals or primary care present different profiles from the wider population engaging in self-harm, with those presenting to hospitals more likely to attempt suicide or overdose, but less likely to engage in non-suicidal self-harm.[29]

From Public Health England datasets, we know that in the past 3 years, Cambridgeshire & Peterborough (C&P) CCG has had the top 3 highest rate of A&E attendance for self-injurious behaviour in its RightCare10 comparator group for all ages and for 10-24 year olds.

In 2020/21, the rate of A&E attendance for self-injurious behaviour for young people was 477 per 100,000. This is:

- 30% higher than the RightCare10 average
- 49% higher than the regional East of England average, and
- 60% higher than the England average.

While C&P CCG has some of the highest A&E attendance rates for Self-Injurious Behaviour in its comparator group, it is ranked third lowest in the % of these attendances being admitted to a ward bed, particularly for 10-24 year olds: 22.7% of A&E attendance for Self-Injurious Behaviour were admitted, 30% lower than the RightCare10 average.

At a district level, over a 5-year average, Cambridge City has by far the highest A&E attendance rates for deliberate self-harm for 10-24 year olds among the C&P districts. Further data for analysis is not available, however we might summise that a high university student population could account for these rates and further work might be required to examine this in more depth.

27 Cassels et al. (2018). *Poor family functioning mediates the link between childhood adversity and adolescent nonsuicidal self-injury.*

28 Cassels et al. (2020). *Prospective Pathways From Impulsivity to Non-Suicidal Self-Injury Among Youth.*

29 McManus et al. (2019). *Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population*

Data from the Urgent and Emergency Care dashboard on the NHS England Future platform shows that between December 2020 – November 2021, there were approximately 800 A&E attendances for self-harm in CYP aged under 18, and approximately 1,000 A&E attendances for self-harm for young people aged 18-25.

A common finding across hospital and A&E attendance data for self-harm is the lack of differentiation between self-harm without suicidal intent and self-harm with suicidal intent.

Distinguishing between non-suicidal self-injury and self-injury arising from suicide attempts in the data logged in acute care and A&E settings would allow for a more accurate picture of need and presenting issues related to these incidents, which may lead to improvements in care pathways.

Suicide: Cambridgeshire and Peterborough

Deaths reported on Real-Time Suicide Surveillance[30] for CYP aged 0-25 in Cambridgeshire and Peterborough:

Year	Total deaths	Male	Female
2019	11	9	2
2020	11	10 (1 trans male)	1
2021	8	3	5

Case study: Inquest into the death of Daniel France, age 17

Danny was 17 years old when he died by suicide in April 2020. The subsequent inquest into his death highlighted the circumstances around his death:

Danny was a vulnerable teenager: he had left home and was living in hostel accommodation; he had changed his GP practice; he was trans, had changed his name and had been referred to the Gender Identity Clinic; he had recently been discharged from secondary mental health services in Suffolk and had been referred to mental health services in Cambridge; he had previously been under CAMHS and was now being referred to adult mental health services; he had diagnoses of anxiety and depression and had been prescribed medication; he had made previous suicide attempts and had long term suicidal thoughts; he had sought counselling from IAPT but this was declined because he was considered too high risk; he had been assessed by First Response Service but had been considered as not requiring urgent intervention.

Safeguarding referrals about Danny were made to Cambridgeshire County Council in October 2019 and January 2020. Both referrals were closed and it was accepted that the decision to close both referrals was incorrect.

In December 2019 Danny's new GP referred him to Cambridgeshire & Peterborough NHS Foundation Trust (CPFT). He had been seen by the Primary Care Mental Health Services but was still awaiting assessment by the Adult Locality Team at the time of his death.

The Prevention of Future Death report highlighted the following concerns:

- Problems with the GP's access to information from mental health services
- The training on LGBTQ+ issues and the steps taken to prevent deadnaming and misgendering in IT systems
- Whether Cambridge County Council's policy on the need for parental consent has been sufficiently updated
- The transfer between secondary mental health services
- Whether the YMCA has sufficient guidance and policies on welfare checks, suicidality, and escalation of concerns to other agencies.

30 Cambridgeshire and Peterborough Public Health. Note: this system relies on suspected suicide data so the numbers may vary following a coroner's inquest. In addition, data for children and young people may be slightly distorted as these are not reported through suspected suicide notifications so relies on the coroner's office to flag any deaths in under 18s.

Prevalence rates from schools

The most comprehensive local survey of school aged children is the Cambridgeshire Children and Young People's Wellbeing Survey. The 2018 survey collected data from 3266 year 8 boys and girls, and 3005 year 11 boys and girls. Whilst the survey includes a comprehensive section on Emotional Health and Wellbeing and includes questions around worry, self-esteem, resilience and support systems for general advice (not specific to support for mental health), it no longer asks any specific information from young people around self-harm or suicidal thoughts.

CASE STUDY

Astrea Academy

Astrea Academy are the partner school for Fullscope's wider Wave 4 project 'Understanding self-harm in children and young people in Cambridgeshire and Peterborough'. They were able to provide data for the Autumn Term 2021 from four of the academy schools. Disclosures about self-harm and suicidal thoughts to school staff members are recorded on CPOMS, a safeguarding data system. Data on referrals are not recorded. External referrals and sources of support include: GP, Early Help Assessment, Centre 33, in-school Counsellor, YOUnited, Kooth, Chat Health and CAMHS. However, due to long waits for external support, the schools reported that the majority of cases are managed in-house by school wellbeing teams.

Data about self-harm and suicidal thoughts among students at Astrea present much smaller figures than data from local services presented to us, but this is to be expected as students may not readily disclose these issues in school; figures about self-harm and suicide ideation from local services also present a subset of young people who are already receiving support for their mental health, whereas the figures from schools are a subset of the whole student population. Across the four schools, 1.3% - 3.5% of the students presented to school staff with self-harm, and 0.2% - 1.3% of students presented to school staff with suicidal thoughts. In total, 1.8% of the students in all four schools discussed self-harm with teachers and 0.7% of students discussed suicidal thoughts.

3 times as many girls than boys discussed self-harm with school staff, while twice as many girls over boys presented with suicidal thoughts. Due to a change in reporting systems across the academy, it is not possible to compare with historic data.

Help seeking at school

With many schools under resourced for mental health support provision on site, and without clear processes or procedures in place for students to understand what will happen if they disclose self-harm, many young people may feel reluctant to disclose to teaching staff. The GW4 report highlights the importance of making clear to all students who the safeguarding and pastoral leads are so students are clear about who they can turn to for support for issues such as self-harm. Teachers surveyed also felt they would benefit from training to help them understand self-harm better, identify the signs of a young person self-harming, and learn how best to respond. **Many participants highlighted teaching staff feeling ill-equipped to have the difficult conversation about self-harm with pupils and feeling nervous or reluctant for fear of making the situation worse.** Parents might also feel that a disclosure to the GP rather than school is more appropriate when seeking help.[31] A joined-up approach across services would be beneficial here.

Reference should also be made here to gender, and whether boys might display dysregulation differently, and/or be more reluctant to ask for help.

31 Rhiannon Evans, Abigail Russell, Frances Mathews, Rachel Parker (2016). *The Self-harm and Suicide in Schools GW4 Research Collaboration, and Astrid Janssens.*

Self-harm data from local services

This project also collated self-harm data from local mental health services across the voluntary and statutory sector to provide 'snapshots' of self-harm prevalence within these services. These figures are not meant to provide any generalizable data about local self-harm rates but rather to present case studies of the different services that deal with self-harm issues.

Cambridgeshire & Peterborough Foundation Trust (CPFT) CAMHS

Data from CPFT CAMHS was limited to top-level figures across the service. Available data for accepted referrals between October 2020 – October 2021 showed that 786 referrals (6.5%) had self-harm as primary reason for referral out of a total of 12,038 referrals.

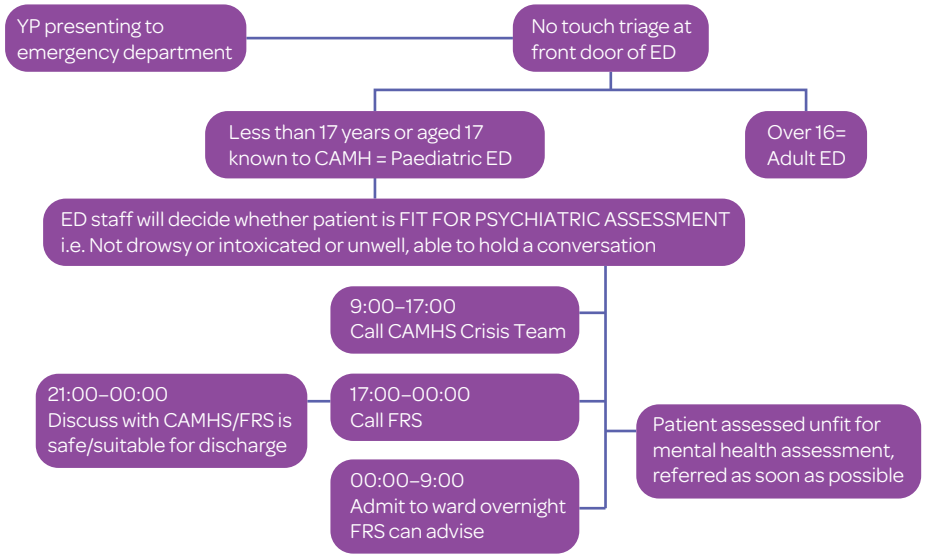
However, as this data reflects only a single primary reason for referral, it is likely that more referrals may have involved disclosures of self-harm but were not considered the primary reason for referral.

The new children's and young people's mental health hub service YOUnited does not have specific data around referrals for self-harm.

Addenbrookes

Data received from Addenbrookes show that between Jan 2020–Dec 2021 (2 years), 1,557 young people aged 0–18 presented to A&E with a mental health issue. Out of this group, 58% included self-harm (not differentiated between self-harm with or without suicide intent) as a presenting issue and 23% of those were admitted to the hospital due to self-harm.

Addenbrookes has a standard operating procedure (SOP) to ensure that a consistent process is in place to adhere to when a patient requires emergency treatment for self-harm, suicidal ideation or following an overdose. Children and adolescents presenting to the ED with self-harm and suicidal ideation follow the pathway below:



Patients who attend ED with medical and mental health needs should have parallel medical and mental health assessments whenever possible.

All children and young people presenting to A&E with self-harm and/or suicide ideation receive a mental health assessment, with an aim to discharge home once they are deemed medically fit.

Follow up interventions are then offered by the First Response Service (FRS) or CAMHS where appropriate.

Kooth

Kooth is a national online support platform which is also offered to young people on the YOUnited waiting list in Cambridgeshire and Peterborough. Quarterly reports from 2020/21 show that self-harm was consistently in the top three prominent issues that Kooth service users presented in chat sessions or messages with counsellors, closely followed by suicidal thoughts.

CASE STUDY
Early Help District Team – Huntingdon and St Ives – Deep Dive

The EHDT provides targeted services to children and young people aged 0–19 and their families. Families with children aged under five access our Child and Family Centre services.

Children, young people and families accessing services delivered by EHDT must have an up-to-date Early Help Assessment (EHA) that is triaged via the Early Help Hub. Any professional working with a child, young person and family can complete an EHA using the Early Help Module on Liquid Logic. The EHDT also accepts requests for support for families where Children Social Care end their interventions with families but identify ongoing needs that can be met by EHDT. These are sometimes referred to as step-down cases.

The EHDT supports children, young people and families with a variety of needs and risks. This includes children and young people with behavioural difficulties, emotional and mental health needs, disabilities, and neurodevelopmental needs. In many cases, children and young people's needs and risks include a combination of two or more factors. This makes their challenges more complex and require a coordinated multi-agency response. For example, a child or young person may have emotional and mental health needs as well as neurodevelopmental needs. The EHDT offer consists of family workers, young peoples' workers and transition advisors.

Practitioners refer children and families to specialist services where the needs cannot be met by EHDT. Examples include referrals to Children Social Care, YOUnited and various counselling services.

At EHDT, self-harm, suicidal thoughts or attempted suicide are regarded as safeguarding issues. Our practice standard is to advise children, young people and families that safeguarding disclosures must be discussed with the practitioner's manager to seek guidance. The primary aim is to keep children and young people safe.

Information about children or young people who self-harm or at risk of suicide is recorded on Cambridgeshire County Council's Liquid Logic Early Help Module (EHM). This information is captured in a child or young person's record of interactions with practitioners.

Practitioners record exactly what the child, young person or family member said. They record when and where the information was shared as well as who was present when the information was shared. They also record their observations and reflection. Practitioners explore if a child or young person is accessing support such as an NHS service or other counselling services.

Where a child or young person is already accessing a service, practitioners liaise with the appropriate professional from that service to coordinate support. Where a child or young person is not accessing a service, practitioners will encourage the child, young person and their family to speak to their GP. Practitioners will ask for consent to make a referral to YOUnited or A Mindful Paws. Where the family declines to be referred, they are encouraged to speak to their GP. Practitioners also share information about services they can access such as Young Minds, ChildLine etc.

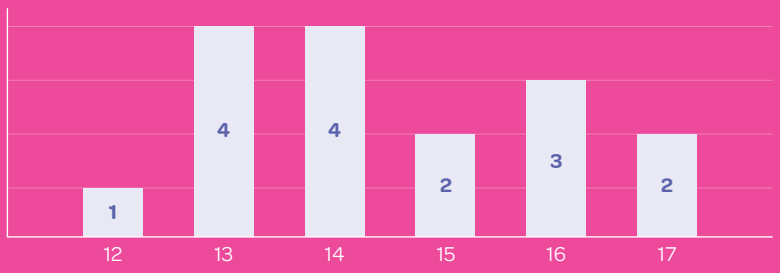
A desktop exercise was carried out to review new requests for support from 1st September 2021 to 30th November 2021. Whilst the deep dive data is a small

proportion of cases open to EHDT, it gives a helpful snapshot of issues at a specific time. Its findings were as follows:

a. There were 87 requests for support of which 16 (18.4%) families had one child who was reported to self-harm or had suicidal thoughts.
b. 25% (4 out of 16) of young people were self-harming and had suicidal thoughts.
c. 3 out of the 16 (18%) young people took an overdose. Children's records do not always specify the type of tablets or drugs that young people used to overdose.
d. One young person left home with the intention of attempting suicide.
e. 68.75% (11) were female, 6.25% (1) were non-binary and 25% (4) were male.
f. There were no children aged 11 and below who were reported to be self-harming or to have suicidal thoughts. All young people who were reported to have self-harmed or had suicidal thoughts were aged 12 to 17.
g. 50% (8 out 16) had current or previous CAMHS involvement.

Table 1 below shows the number of young people by age.

Number of young people by age



All referrals for children who self-harm and/or were at risk of suicide were accepted by the EHDT. 50% of the referrals came from the Multi-Agency Safeguarding Hub (MASH) in response to referrals made to Children Social Care by various agencies including CAMHS, Ambulance Service, Hospital, Police and other health services. 31.25% (5 out of 16) were stepdowns from Children Social Care.

18.75% (3 out of 16) were Early Help Assessments completed by schools.

The ways in which EHDT supported these young people and their families varied, with some receiving onward referrals to other services such as Children Social Care, YOUnited, A Mindful Paws or PALS.

Case Study
The Kite Trust

Our Vision

We envisage an inclusive society where LGBTQ+ young people are healthy, successful and celebrated.

Our Purpose

We support the wellbeing and creativity of LGBTQ+ young people in Cambridgeshire, Peterborough and surrounding areas through information, support and groups. We build inclusive communities to tackle inequalities through consultancy, training and education to all sectors.

Case Notes – young person aged 21 (a typical representation of approach to self-harm at The Kite Trust)

During a scheduled 1:1 (4th of 6) the young person (YP) was less chatty, their voice was quieter and appeared to be more withdrawn than they had been on previous 1:1 sessions.

The YP shared that their mental health had been taking a downward spiral recently due to a combination of a few different things and that they hadn't had their regular therapy sessions for several weeks.

When asked about self-harm the YP quietly said that they had been self-harming, that up until recently the self-harm had decreased, the YP shared that over the past few weeks they had been self-harming regularly, that they had 3 specific drawing pins that they used which they kept on their bedside table. The YP shared that they usually scratched their arms with the drawing pins, however, their intention was to never draw blood, but that they sometimes did go in too deep and make themselves bleed. The YP went on to share that they didn't want to end their life, that was never their intention.

The youth worker (YW) had a conversation around how to clean and dress the wound if there was one, how to sterilise the safety pins, what to look out for if the area becomes infected and what to do if an infection appeared. The YW also shared with the YP that the information they had shared will be logged on their system.

The YW encouraged the YP to contact their therapist to continue their therapy sessions, scheduled in another 1:1 session with the YP. The YW had a video call with their line manager to discuss and debrief on the 1:1 session and a logged concern and risk assessment was completed on Charity Log.

Following on from the conversation with the YW, the YP contacted their therapist and arranged further therapy sessions.

CASE STUDY
Centre 33

Centre 33 is a charity that provides a range of services to support young people aged 13–25 through free advice, assessment and advocacy support. Centre 33 supports young people on a range of issues such as emotional health, sexual and physical health, gaining safe and secure housing and gaining employment, education and training. Centre 33's services also include support for young carers up to age 18 who take on practical and/or emotional caring work in their families as well as counselling in secondary schools.

Centre 33 accept self-referrals from young people directly at a face-to-face drop in, over the phone, or via email. Young people can also access mental health support at Centre 33 via referral at the YOUnited hub.

Any young person can access the self-referral route, without appointment, without the consent of a parent or carer provided they are over 13 years old. A typical client might come to one of our face-to-face drop ins to seek support. They would then be offered a private, one-to-one session discussing what brought them to Centre 33, what support they would like, and assess any risk they may be presenting with. We would then discuss what options are available around support, whether it be provided by Centre 33 or we can support them to access external services also.

Young people are routinely asked about risk at point of triage (the first session at drop in), including if they are self-harming at all, if they have suicidal thoughts. This prompts a risk assessment which explores any risk-taking behaviour, history of suicidal attempts, support networks, ideation and intent. Young people are then asked at each appropriate interval to check in on this risk, whether it's a specifically arranged check-in call on the risk, or their next booked appointment with us. Depending on the severity of the risk presenting and the individual circumstance, we may consult and share this information (with the knowledge and consent where appropriate of the young person) with GP, parents, school. The risk is logged on our internal CRM database and discussed at internal MDT meetings.

In 2021, 2689 young people received a general needs assessment from Centre 33 (685 through the Young Carers programme and 2004 through the Someone To Talk To service).

Of these 2689, 742 (27%) talked about self-harm, and 265 (10%) explicitly wanted help with self-harm. 9% of young carers talked to Centre 33 about self-harm, while 52% of those in the Someone To Talk To service brought up self-harm.

75% of those who talked about self-harm also talked about suicide ideation. Only 19% of those who talked about suicide ideation did not also talk about self-harm.

CASE STUDY
Blue Smile

Blue Smile is a Cambridgeshire charity, offering expert arts-based therapeutic support to vulnerable children aged 3-13 who are struggling with mental health difficulties or emotional problems. Blue Smile works in schools across Cambridgeshire with around 200 children each week. Data about self-harm or suicide ideation are collected at referral from teachers and parents and during the initial therapy sessions with the child.

Any concerns about the child's safety, including disclosure about self-harm or suicide ideation, triggers a safeguarding Cause for Concern procedure, in which the practitioner reports the concern to the school's Designated Safeguarding Lead and they together decide on the course of action required. It is the school's responsibility to respond to the safeguarding concerns reported by Blue Smile, and Blue Smile keeps an internal record of all safeguarding and child protection concerns. Blue Smile continues to provide therapy for the child, alongside any safeguarding actions or decisions made with the school.

Among the 253 children who received 1:1 therapy from Blue Smile in the 2020/21 school year, around 5% (13) of the children presented with self-harm and 5% (13) presented with suicide ideation (symptoms may overlap). Overall, 8.7% (22) of children presented with self-harm and/or suicide ideation.

Among the 1250 children who have received 1:1 therapy since Blue Smile's services started in 2010, 3.8% (47) of children have presented with self-harm and 3.1% (39) have presented with suicide ideation. 6.3% (79) of children have presented with self-harm and/or suicide ideation.

The table below shows a comparison between the demographic and referral data of children who presented with self-harm and/or suicide ideation and all children who received therapy in 2020/2021 (ages 3–13)

2020/2021	Children presenting with self-harm and/or suicide ideation	All children who received therapy
Average age at start of therapy	8.5	8.7
Gender	82% male, 18% female	64% male, 36% female
Average # of presenting symptoms at referral	6.55	4.06
% of Parent SDQs above clinical threshold	82%	61%
% Teacher SDQs above clinical threshold	62%	53%

While the overall ages of the children in the two groups are similar, there are significantly more males than females who have presented with self-harm and/or suicide ideation. The average number of presenting symptoms at referral and the percentage of parent and teacher SDQ scores above the clinical threshold (indicating high to very high level of emotional and behavioural difficulties) show that children presenting with self-harm and/or suicide ideation are more likely to have more complex presenting needs.

CASE STUDY
Young Peoples' Counselling Service (YPCS)

YPCS is a charity providing free counselling services to CYP aged 11-18 as well as counselling services under Service Level Agreements and Statutory Contracts for CYP aged 5-18. YPCS receives referrals from parents, schools, GPs, statutory services, as well as self-referrals for CYP aged 13 and over. The charity's free services provide 12 1:1 therapy sessions with options for extension and the charity also offers group support.

Any disclosures about self-harm or suicidal ideation/intent during assessments or counselling sessions are recorded within a safety plan and risk assessment that are completed with the young person/family/school. These risk and safety plans are revisited with the young person in each session to support them with the aetiology of the concern alongside wider support to families and schools as needed. When self-harm has become a coping strategy, young people are supported to identify alternative strategies. Session numbers are increased if risk or self-harm remains a concern. For example, 7 YP in 2021 had over 24 sessions, which enabled the young people to be supported while receiving additional risk support from CAMHS and also attending additional support groups or services such as family therapy.

Self-harm and suicide ideation concerns are recorded in a safeguarding and concerns log within the charity's database and are updated by therapists and safeguarding leads. When relevant and necessary, the charity will seek risk support from CAMHS or FRS and the charity will only signpost to other services if risk of harm is significant or risk to life is immediate (only 6% of those reporting self-harm or suicide ideation were referred onto CAMHS or CAMEO).

Of the 475 CYP that were supported by YPCS from January–December 2021, 287 (60%) reported self-harm and 89 (19%) shared suicidal thoughts or feelings. Additional data show that:

- 9 CYP had been to A&E having taken excessive medication in a suicide attempt
- 19 attended A&E with serious incidents of self-harm or suicide ideation
- 22 had contact with the First Response Service outside of sessions with YPCS
- 4 senior schools reported significant increase in self-harm among their students.
- From these schools, 42 young people were referred to YPCS for self-harm, and of these 42, 27 (64%) were also presenting with suicide ideation.

CASE STUDY
YMCA Trinity

YMCA Trinity is a youth charity that provides a wide range of programmes and services to support young people and their families with aspects of life such as youth engagement, youth offending projects, mental health support, domestic violence and crisis support. Young people can also access counselling from YMCA Trinity therapists through a school setting. YMCA Trinity is a provider of safe, supported accommodation for young people across Cambridgeshire, Peterborough, Cambridgeshire and Sussex. Every resident receives an allocated number of key worker sessions for the duration of their stay in accommodation, including support with education, employment, physical and mental health. Every 3 months, residents have a risk assessment, needs assessment and outcome stars meeting, which allows the charity to tailor support to individual need.

For clinical work in schools, self-harm or suicide ideation may be disclosed in the initial referral form and the young person is routinely asked about self-harm when routine outcome measures are taken. Disclosures about self-harm or suicide ideation follow the individual school's safeguarding policy, which usually involves the

therapist reporting to the school's SENCO/safeguarding lead about the disclosure. The therapists will also fill in a report for MyConcern, YMCA Trinity's internal safeguarding management database. The therapist then continues to work with the client for the agreed number of sessions or until they are no longer at risk. In some cases, the client may be referred onto another service such as YOUnited.

Data on YMCA Trinity's clinical work in schools is available from September 2021 to January 2022, following the implementation of their new client management system, Charitylog. Since September 2021, 384 new referrals have been received from children and young people aged 5 - 18, with 51 (13%) reporting a reason for referral as self-harm.

Data for the full range of YMCA Trinity's other services besides clinical work is available for 2021. 688 young people were supported by YMCA across the programmes and services, with 73 (11%) reporting self-harm. Other data available for the YP who presented with self-harm include:

56% male; 40% female; 4% undisclosed

Age distribution:

16-18 years old – 42%

19-21 years old – 34%

22-25 years old – 18%

25+ years old – 5%

49% had a mental health diagnosis.

Case Study
Primary Care Network: Fullscope GP Project

The Fullscope GP pilot project has been running since June 2021 and gives GPs in two Primary Care Networks quick access to a single session therapeutic intervention for CYP presenting with mild to moderate mental health or wellbeing issues.

Out of the 31 referrals received up until 31 December 2021, 10 (32%) referrals involved self-harm and 8 (26%) CYP disclosed suicide ideation. Any CYP who presented with self-harm or suicide ideation received a safeguarding assessment as part of the assessment call.

Case note: Fullscope received a referral concerning a non-binary young person aged 12, who was presenting with anger issues, behavioural issues at school, and anxiety. The young person presented with self-harming behaviour such as scratching or biting themselves and pulling own hair. The therapist discussed methods of managing these self-harming behaviours with the young person and alternative coping methods. The young person shared that their parents have been supportive but sometimes get things wrong around the young person's gender identity, which upsets the young person. They also talked about gender dysphoria. The young person said they would like to try in-person counselling and a link was sent to the young person's parents for self-referral to The Kite Trust. A follow up call to the CYP and their family three months later showed that the YP was presenting much better since the session and that they are less angry and not as low. The YP attended a session at The Kite Trust and was offered group sessions, but since attending the session, the young person realised that they feel generalised anxiety and they did not want to focus specifically on gender in the support they received. The family has decided to approach Centre 33 for help instead and the YP is happy to follow this route for potential support.

Conclusion and recommendations

Data collection

It has not been possible to extrapolate specific data about self-harm from all local statutory or voluntary services due to the ways in which different services collect data or information about self-harm from their service users. For example, in conversations with some services, it was found that whilst a presenting need of anxiety and/or depression might be noted, the service may not note on their database system if there was a presenting need for self-harm or suicidal intent in addition to the above, often because their systems did not allow for this additional detail.

Recommendations

- Alignment of statutory and voluntary service data collection to allow for self-harm or suicidal intent (ideally separately) to be noted as a secondary/additional concern, where it is not noted as the primary concern.
- Ongoing collection and review of local data by Public Health to ensure understanding of local rates of self-harm amongst children and young people beyond A&E attendance.

Safeguarding

Disclosures of self-harm or suicide ideation generally fall into services' safeguarding or risk management processes, rather than a service having a specific intervention approach for self-harm.

Recommendations

- Services and schools should consider implementing a specific process for disclosures of self-harm.

Definitions

Where definitions of self-harm differ across services, (i.e. with or without suicidal intent, the specific behaviours considered as self-harm, etc), approaches to data collection, referrals and/or interventions were also therefore different.

Recommendations

- A more unified approach across services would allow for clearer assessments of risk to be undertaken.

Gender

Data collection around children and young people identifying as non-binary or a gender that is different to sex registered at birth, is currently patchy. Data on sexuality at this age is not routinely collected. This meant that we were not able to make any definitive statements around prevalence for LGBTQ+ young people locally.

Many services did not provide a breakdown of gender when reporting self-harm data to us. Where gender breakdown was provided, there were differences in rates across the services and it was not possible to draw conclusions around prevalence rates for boys/girls in Cambridgeshire and Peterborough.

As noted in the Early Help deep dive, self-harm amongst boys and young men might be missed as a result of dysregulation and/or anxiety presenting itself more often in the form of challenging behaviour and aggression, and as such not noted by services on their data collection systems as 'self-harm'. This also relates to the points around definitions of self-harm.

Recommendations

- Services should follow new NHS guidance on collecting gender identity/ sex at birth information.
- Workforce development around presentation of anxiety and dysregulation in boys.
- A review of coding of self-harming behaviours.

Risk factors

As noted in the review of national prevalence rates, certain groups have higher rates of self-harm, including autistic young people, LGBTQ+ and those living with socio-economic deprivation. The Early Help deep-dive also identified that most of the young people identified as self-harming, having suicidal thoughts including attempted suicide, had complex and varied childhood experiences and personal trauma. Examples included a combination of one or two factors such as domestic abuse, child sexual abuse, living with a parent with a mental health condition and having neurodevelopmental conditions that impact on social and communication skills.

Recommendations

- Services should consider the monitoring of young people in their care who are known to have one or more of the above risk factors, and routinely ask about recent self-harming behaviours, under guidance of mental health supervision.
- There is also the issue of barriers in access to mental health services for specific vulnerable groups, which points to a need for services in Cambridgeshire and Peterborough to develop targeted initiatives to improve access and carefully consider how care pathways can better meet intersecting needs and risk factors.

Ethnicity

It was not possible to draw any conclusions around prevalence rates based on ethnicity due to a lack of specific data provided.

Recommendations

- Services should routinely collect ethnicity data to develop targeted initiatives to improve access and carefully consider how care pathways can better meet intersecting needs and risk factors.

Local strategies

The recommendations included in this report should not be taken in isolation, and should be considered alongside the following strategies, due to be published in 2022:

- Children and Young People's Mental Health Strategy (commissioned by Cambridgeshire and Peterborough CCG)
- Suicide Prevention Strategy (Cambridgeshire and Peterborough Public Health)
- Mental Health Prevention Strategy (Cambridgeshire and Peterborough Public Health).

Nard Choi and Katie Edwards, for Fullscope.
April 2022

www.fullscopecollaboration.org.uk