NHS
Sheffield
Clinical Commissioning Group

Shared Care Protocol

For

Selective Serotonin Reuptake Inhibitors in children and young people (fluoxetine, sertraline, and citalopram)

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Shared Care Protocol for Selective Serotonin Reuptake Inhibitors in children (fluoxetine, sertraline, and citalopram)

Statement of Purpose

This shared care protocol (SCP) has been written to enable the continuation of care by primary care clinicians of patients initiated on selective serotonin reuptake inhibitors (SSRIs) in school age children and adolescents (up to 18 years) by a child and adolescence psychiatrist, where this is appropriate and, in the patients', best interests.

The table below lists the SSRIs covered by this shared care protocol, along with their licensed indications. It is sometimes necessary to use medicines 'off label', this is particularly common in children. This guideline also covers the use of SSRIs being used off label, where there is evidence or national guidance to support this. All indications covered by this shared care, along with references, are in the table below.

Licensed and off-label uses covered by this guideline

Selective serotonin Reuptake Inhibitor	**Licensed indication**	**Off label indication (reference, *BNFc, **NICE NG134 or NICE CG31 ***Maudsley prescribing guidelines in psychiatry)**
Fluoxetine	**Depression** 8-17 years - Moderate to severe major depressive episode, if depression is unresponsive to psychological therapy after 4-6 sessions	**Anxiety Disorders***** (excluding preschool children) 8 years and over - **Body Dysmorphic Disorder (BDD**) **
Sertraline	**Obsessive Compulsive Disorder (OCD)** 6-17 years	**Depression**[*&**] 12-17 years - Major depression (if unresponsive to psychological therapy and a trial of fluoxetine). **Anxiety Disorders*****(excluding preschool children)
Citalopram		**Depression**[*&**] 12-17 years - Major depression (if unresponsive to psychological therapy and a trial of fluoxetine) **Anxiety Disorders***** 12-17 years - (Note - Treatment not supported by RCT evidence, although evidence from local use)

Responsibilities of specialist clinician

- To initiate the SSRI in appropriate patients
- Prescribing should be initiated in line with NICE NG134 (Depression in children and young people: identification and management) and NICE CG31 (Obsessive-compulsive disorder and body dysmorphic disorder: treatment), prescribing should be alongside evidenced based psychological therapy for the main presenting condition. The specialist is responsible for organising this. In the event that psychological therapies are declined, or there is a delay in accessing therapy, medication may still be given if in the patient's best interest, in such cases regular review should take place.
- Be aware of contraindications to the specific SSRIs (e.g., citalopram - QT-interval prolongation). Carry out baseline assessment, including ECG, where clinically appropriate.
- To discuss with the patient/carer: rationale for drug treatment; benefits and side effects; delayed onset; likely duration of treatment; importance of adherence and obtain informed consent, in line with national guidance. This is particularly important for unlicensed products (see table above). To support informed shared decision making, information should also be provided in writing. (See Choice and Medication, Medicines for Children or SC(NHS)FT patient information leaflets)
- To ensure that all off-label prescribing is in line with national guidelines and that communication with primary care provides assurance that guidelines have been followed and informed discussions have taken place with patients.
- To ensure that the most cost-effective formulation choice is prescribed where appropriate.
- To assess the continued need for prescribing non-solid dosage forms (i.e., liquids or dispersible formulations). Where there is a change in formulation, patients and/or their carer(s) should be made aware and counselled appropriately on the implication of this change to the prescribed dose.
- When SSRIs are used as a treatment for depression (and potentially other indications), they can cause increased suicidal thoughts and risk of self-harm. It is not known whether this same risk occurs if being used for other indications; however, the risks should be explained to the patient, documented, and shared with the patients GP irrespective of indication.
- To provide high risk patients / carer with a crisis care plan which contains contact details for support and help if required; both in and out of hours. This should also be shared with the GP.
- **To monitor**; the response to treatment, side effects, suicidal ideation, and risks of self-harm during the initial period and until the patient has responded to treatment (defined as no symptoms and full functioning for at least 8 weeks (depression) or 12 weeks (anxiety / OCD / BDD))
    - **OCD** - carefully and frequently monitored and see patient on an appropriate and regular basis. This should be agreed by the patient, his or her family or carers and the healthcare professional and recorded in the notes.
    - **Depression and / or Anxiety** – ideally weekly contact with the child or young person and their parent(s) or carer(s) for the first 4 weeks of treatment. The precise frequency will be decided on an individual basis and recorded in the notes and communicated to the GP. Monitoring frequency should revert to initial monitoring schedule after dose titration / dose adjustments
- Once a response to treatment has been seen and the patient is stable, and the child or young person is fully functioning for 8 weeks (depression) or 12 weeks (anxiety / OCD / BDD) ongoing prescribing can occur in primary care under shared care arrangements.

- To contact patient's primary care prescriber to request prescribing and monitoring under shared care arrangements, send a link to or a copy of this shared care protocol.
- To advise the primary care prescriber regarding continuation of treatment, including monitoring arrangements, ongoing support from CAMHS and other agencies
- To continue to review the patient at least every 6 months, alternating with primary care so the child /adolescent is seen every 3 months. Ensure communication is clear so reviews are staggered.
- To instigate discontinuing medication when clinically appropriate (at least 6 months post remission if indication is depression, OCD or BDD and at least 12 for anxiety). The drug should be phased out gradually, the exact titration depending on individual circumstances, taking into account; patient preferences, clinical history, duration of treatment and medication being used.
- If the patient is still on treatment around the age of transition ongoing care should be considered, in line with the trust transition protocol.
    - Patients who do not require transition to adult MH services will be discharged to primary care. CAMHS should inform relevant primary care professionals within at least 2 weeks of a patient being discharged and provide advice about whom to contact in the event of a recurrence of symptoms and when discontinuation of treatment is to be considered. Details of care plan and ongoing monitoring (including suggested dose alterations, recommendations around length of time on medication, discontinuation plans and how to titrate the medication down) required by the GP should be communicated.
    - If the patient is to transition from Adolescent to Adult Mental Health Services, it is the duty of the Specialist to instigate this referral.

- If relevant, whilst waiting for appointment with CAMHS, to offer telephone advice to the primary care clinician if requested. See contact details below
- To discuss any concerns with the primary care prescriber regarding the patient's therapy
- The patient to remain under the specialists' care, until the point of stopping medication or transition to adult age service.

Responsibilities of the primary care clinician

- To refer appropriate patients to CAMHS for assessment (see referral form and information)
- If there is a delay in the patient being seen, to offer support as per below (Contacts for Support, education and information). Contact advice can be accessed via CAMHS colleagues if required.
- Confirm the agreement and acceptance of the shared care prescribing arrangement or to contact the requesting specialists if concerns in joining in shared care arrangements.
- To report any serious adverse reaction to medication to the appropriate bodies e.g. MHRA (yellow card) and the referring specialist
- To continue to prescribe for the patient as advised by the specialist
- Ensure monitoring as indicated in monitoring section below or as per agreed care plan on a case-by-case basis.
    - To review the patient every 6 months, alternating with specialist so the child /adolescent is reviewed every 3 months (or more frequently if required/ agreed on a case-by-case basis). One review should incorporate the annual medication review.

- The specialist will normally instigate discontinuation, however if the patient expresses a desire to stop advice from the specialist can be sought (Note however patients should be offered to remain on treatment for 6 months (depression, OCD and BDD)/ 12 months (anxiety) after being in remission. However, if a patient presents with any severe symptoms such as suicidal tendencies or mania whilst on the SSRI urgent advice should be sought from the specialist as SSRI is likely to be needed to be stopped.
- To seek the advice of the specialist if any concerns with the patient's therapy
- In the event that the primary care prescriber is not able to prescribe, or where the SCP is agreed but the specialist is still prescribing certain items e.g., Hospital only product; the primary care prescriber will provide the specialist with full details of existing therapy promptly by secure method on request.
- For medication supplied from another provider prescribers are advised to follow recommendations for Recording Specialist Issued Drugs on Clinical Practice Systems

Responsibilities of Patients or Carers

- To be fully involved in, and in agreement with, the decision to move to shared care
- To attend hospital and primary care clinic appointments. Failure to attend may potentially result in the medication being stopped.
- Present rapidly to the primary care prescriber or specialist should the clinical condition significantly worsen or thoughts of self-harm or suicide
- Report any suspected adverse effects to their specialist or primary care prescriber whilst taking SSRI medication
- To read the product information given to them
- To take the SSRI as prescribed
- Inform the specialist, primary care prescriber or community pharmacist dispensing their prescriptions of any other medication being taken – including over the counter and recreational medication.

Indication and dosage

This guideline covers the use of SSRIs in depression, anxiety disorders, obsessive compulsive disorder and body dysphoric disorder as per table below. All prescribing should be initiated in line with relevant NICE guidance and alongside evidence based psychological therapy. In the event that psychological therapies are declined, or there is a delay in accessing therapy, medication may still be given, however regular review should take place.

Selective serotonin Reuptake Inhibitor	Preparation (cost effective preparation in bold)	Dose in depression	Dose in anxiety, OCD and BDD
Fluoxetine	**20mg Capsules** **20mg/5ml Solution** **20mg dispersible tablets** 10mg capsules and tablets available should be reserved for when	For Child 8–17 years - Initially 10 mg daily, increased if necessary up to 20 mg daily, dose to be increased after 1–2 weeks of initial dose, daily dose may be administered as a single or divided dose. Higher doses may be considered in older children of higher body weight and/or	Initially 5-10mg. Dose range 1-40mg daily (ref - Maudsley – max dose adjusted based on clinical opinion)

	above formulations not suitable.	when, in severe illness, an early clinical response is considered a priority (doses above 20mg are off-label).	
Citalopram	**10mg, 20mg and 40mg tablets** Citalopram 40mg/ml oral drops sugar free available if liquid preparation required	For Child 12–17 years - Initially 10 mg once daily, increased, if necessary, to 20 mg once daily, dose to be increased over 2–4 weeks: maximum 40 mg per day (off label)	12 years and over - The starting dose of medication for children and young people with anxiety, OCD or BDD should be low, especially in younger children. A half or quarter of the normal starting dose may be considered for the first week. See BNFc for further information
Sertraline	**50mg and 100mg tablets**	For Child 12–17 years - Initially 50 mg once daily, then increased in steps of 50 mg at intervals of at least 1 week if required: maximum 200 mg per day (off label)	

Selection of patients

The decision to start prescribing will be made by the psychiatrist and patient / carers. Patient will only be started in line with NICE guidance that is after psychological support has been offered / tried and not been successful. Prescribing however should be alongside continued psychological support. In the event that psychological therapies are declined, or there is a delay in accessing therapy, medication may still be given, however regular review should take place.

Discontinuation of treatment

Patients should remain on treatment after remission from presenting condition.

Indication	Duration of treatment
For depression	Medication should be continued for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks); in other words, for 6 months after this 8-week period.
For OCD and PDD	Medication should be continued for at least 6 months post-remission (that is, symptoms are not clinically significant, and the child or young person is fully functioning for at least 12 weeks); in other words, for 6 months after this initial 12-week period.
For anxiety disorders	Continue medication for at least 12 months of stable improvement.

Stop earlier and consider other treatment options if; patient presents with adverse effects, psychotic episode occurs, or patient wishes to stop. If the GP picks up these adverse effects early referral or advice should be sought from the specialist.

Discontinuation of antidepressants would normally be instigated by the specialist. It should involve the dosage being tapered or slowly decreased to reduce the risk of discontinuation symptoms, at a reduction rate that is tolerable for the patient. Whilst the withdrawal symptoms which arise on and after stopping antidepressants are often mild and self-limiting, there can be substantial variation in people's experience, with symptoms lasting much longer and being more severe for some patients.
Ongoing monitoring is needed to distinguish the features of antidepressant withdrawal from emerging symptoms which may indicate a relapse of depression.

Contra-indications

The details below are not a complete list and the BNFC and the relevant SPC remain authoritative

Hypersensitivity to the active substance or to any of the excipients

Poorly controlled epilepsy.

SSRIs should not be used if the patient enters a manic phase

Concomitant treatment with irreversible monoamine oxidase inhibitors (MAOIs) is contraindicated (see citalopram SPC for further specific information around concomitant prescribing)

Until further evidence is available it is advised not to use citalopram simultaneously with 5-HT agonists e.g., sumatriptan.

Citalopram is contraindicated in patients with known QT-interval prolongation or congenital long QT syndrome or if co-prescribed with medicinal products that are known to prolong the QT-interval

Although SSRIs are not contra-indicated in pregnancy manufactures advises to avoid unless potential benefits outweigh the risks.

Side –effects

The details below are not a complete list and the BNFC and the relevant SPC remain authoritative

Commons side effects of SSRI medication are;

Anxiety; appetite abnormal; arrhythmias; arthralgia; asthenia; concentration impaired; confusion; constipation; depersonalisation; diarrhoea; dizziness; drowsiness; dry mouth; fever; gastrointestinal discomfort; haemorrhage; headache; hyperhidrosis; malaise; mania; memory loss; menstrual cycle irregularities; myalgia; mydriasis; nausea (dose-related); palpitations; paraesthesia; QT interval prolongation; sexual dysfunction; skin reactions; taste altered; tinnitus; tremor; urinary disorders; visual impairment; vomiting; weight changes; yawning.

The use of antidepressant drugs has been linked with suicidal thoughts and behaviour. Where necessary, children should be monitored for suicidal behaviour, self-harm, and hostility, particularly at the beginning of treatment or if the dose is changed.

Hyponatraemia is rare but should be considered in all children who develop drowsiness, confusion, or convulsions while taking an antidepressant.

Serotonin syndrome or serotonin toxicity - this is a relatively uncommon adverse drug reaction, caution if being co-prescribed with other medication that may increase serotonin.

Monitoring

Initial monitoring

- **Depression and general anxiety**– Specific arrangements must be made for careful monitoring of adverse drug reactions, as well as for reviewing mental state and general progress and suicidal ideation or self-harm thoughts/ actions; for example, weekly contact with the child or young person and their parent(s) or carer(s) for the first 4 weeks of treatment. The precise frequency of monitoring will need to be decided on an individual basis and communicated to the GP. **Monitoring will be the responsibility of the psychiatrist / CAMHS until the patient is considered to have responded to treatment and to be stable.**

  The self-report Mood and Feelings Questionnaire (MFQ) may be considered as an adjunct to clinical judgement to monitor progress. It should be used in context with clinical picture. See link for sample questionnaire which is also available in different languages - https://devepi.duhs.duke.edu/measures/the-mood-and-feelings-questionnaire-mfq/

  Note, the short version does not ask about self-harm or suicidal thoughts. The longer version does not ask about self-harm.

- **OCD / BDD -** Children and young people with OCD or BDD starting treatment with SSRIs will be carefully and frequently monitored and seen on an appropriate and regular basis by the specialist service. Monitoring should include response to symptoms, side effects to medication, suicidal ideation or self-harm thoughts/actions. The details will be agreed with the patient, his or her family or carers and the healthcare professional on a case-by-case basis and communicated to the GP. **Monitoring will be the responsibility of the psychiatrist / CAMHS until the patient is considered to have responded to treatment and to be stable.**

Ongoing monitoring

Once a response to treatment has been seen and the patient is stable, and the child or young person is fully functioning for 8 weeks (depression) or 12 weeks (anxiety / OCD / BDD) ongoing prescribing can occur in primary care under shared care arrangements. CAMHS will keep the GP up to date about progress and coordinate the need for any monitoring of the child or young person in primary care. The patient should be reviewed at least every 3 months. This will be agreed on a case-by-case basis, but typically the patient will be reviewed by both the GP and the specialist, alternating between the GP and specialist each reviewing the patient 6 monthly. Clear communication should be in place to coordinate this.

CAMHS will also work with the patient at transition and those not requiring transition to adult MH services will be discharged to primary care. CAMHS should inform relevant primary care professionals within at least 2 weeks of a patient being discharged and provide advice about whom to contact in the event of a recurrence of symptoms and when discontinuation of treatment is to be considered. Details of ongoing monitoring required by the GP should be communicated.

Interactions

Refer to the current BNF and the SPC for details of interactions.

Additional information

For further support around the depression, OCD and BDD in children the following resources may be useful.

https://cks.nice.org.uk/depression-in-children

https://cks.nice.org.uk/obsessive-compulsive-disorder

Re-Referral guidelines

Children and adolescents who are being prescribed SSRI treatment will remain under the care of the specialist, but they may still need an interim review (i.e., before next scheduled review) should problems arise.
Refer / or discuss with specialist if:

- Toxicity suspected
- Non-compliance suspected / known
- Marked deterioration in symptoms
- GP thinks a dosage adjustment may be required (up or down)
- GP thinks patient is not benefiting from treatment
- The patient is a risk to themselves or others.

If a dose or drug change is needed, then monitoring responsibilities will revert to the specialist.

Contacts for Support, education, and information

Support for the patient

Patients may have their own 'keeping safe plan' which will have in contact details for if they have a crisis or need support. See sample - appendix 2.

Support for the individual patient

Organisation and contact details	Service they offer
Sheffield CAMHs wellbeing support line	People in the city aged 12 – 18 can now access support with issues such as low mood and anxious thoughts by calling **0808 275 8892**. The support line is open Monday to Friday 9am to 9pm and Saturday 9am to 9pm.
Sheffield Mental Health Directory See children and young people support	Signposting guide to a wide range of resources on offer in Sheffield
Kooth Young people can self-refer by visiting the website and signing up at www.kooth.com/	Online counselling service for 11–18-year-olds. The service is free for young people to use and is suitable for anyone with low to mediate mental health needs.
Door 43	Young people can self-refer. Offers support to 13-25 year olds on a range of emotional wellbeing issues in a young person centered environment

Golddigger trust	Young people can self-refer (see link) or be referred in (see link). They offer support for YP aged 11-18 in Sheffield including mentoring, various courses and drop-in sessions.
Young Minds	Information and support for young people with mental health issues, including a medication guide(see link)
MIND	Information and support, including downloadable booklets for young people with mental health problems.
Childline - 0800 1111 or https://www.childline.org.uk/get-support/contacting-childline/	Free 24-hour helpline for children and young people in the UK
NSPCC - helpline (children and young people): 0800 1111 or help@nspcc.org.uk	Specialises in child protection and the prevention of cruelty to children.
Papyrus - helpline: 0800 068 41 41	Provides information and support for anyone under 35 who is struggling with suicidal feelings, or anyone concerned about a young person who might be struggling.
Samaritans - 24-hour helpline: 116 123 (freephone) or jo@samaritans.org	Emotional support for anyone feeling down, experiencing distress or struggling to cope.

Support for the carers / family/Friends

Organisation and contact details	**Service they offer**
Sheffield Mental Health Directory See children and young people support	Signposting guide to a wide range of resources on offer in Sheffield
Positive parenting	Locally ran parenting classes
NSPCC - helpline (adults): 0800 800 5000 or help@nspcc.org.uk	Specialises in child protection and the prevention of cruelty to children.
Parenting and Family Support- Family Lives (formerly Parentline Plus) - Helpline: 0808 800 2222	Support to anyone parenting a child.
Young Minds 020 7089 5050 (general enquiries) 0808 802 5544 (parents' helpline, for concerns around a child or young person)	National charity committed to improving the mental health of all babies, children, and young people. Provides information for both parents and young people.
Epic friends	This site is all about helping you to help your friends who might be struggling to cope emotionally

Apps and other self-help resources	**Additional information**

NHSapps Library (mental Health)	The apps are assessed against a range of NHS standards; however, you should make sure the app is age specific for the individual using it.
CAMHs resources	This site was created by young people, carers and professionals to pool together lots of helpful resources from across the intranet that are available to support mental health and wellbeing
BlueIce app Calmharm	These apps are specifically aimed for those who self-harm
ChillPanda *Headspace *Clearfear	For those aged 4 and up and is free; it's good for helping with anxiety, family friendly relaxation and breathing/activity exercises. is helpful for teens and adults struggling with stress and worry and can be found here. Includes meditation and help with sleep too. Headspace is an app for helping with anxiety and is free. For helping with anxiety and is available free
Sleepio	A programme for teens and adults using cognitive behavioural therapy principles to help with sleep and is free
Mental Health Foundation - Podcasts	The Mental Health Foundation has a long list of podcasts for your general wellbeing, probably best suited for older teens and parents.
Psychology tools	A wide range of self-help tools for a variety of mental health difficulties.
*Happy not perfect	Includes meditation and lets you set goals. Includes a 'grateful diary'
Physical Health support	
Sheffield Health Trainers	Sheffield Health Trainers are available to anyone over 16 years of age
Zest – Youth services	They deliver a range of youth services, with support from Children in Need, which includes free weekly activities.
Shine Health Academy	SHINE is a community-based weight management programme that helps young people aged 10-17 years not only lose weight but also to gain in self-esteem and confidence.
Smoke free Sheffield	See link for specific support for under 18's.

*Apps recommended by local specialists, but not listed on the NHS app library.

See the Sheffield Suicide Prevention Plan for children and young people in Sheffield for support and information around suicide prevention. Also see educational resources from the Suicide and self harm prevention PLI

Equality and Diversity

This shared care guideline supports equality and diversity.

References

NICE NG134 –Depression in children and young people: identification and management

NICE CG31 - Obsessive-compulsive disorder and body dysmorphic disorder: treatment

BNFc

Electronic Medicines Compendium

https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf

The Maudsley Prescribing Guidelines in Psychiatry – 13th edition 2018, David Taylor, Thomas Barnes, A H Young; Wiley-Blackwell (paper copy)

RCPsych - Position statement on antidepressants and depression

Appendix 1 – Template letter to primary care prescriber

Please note: Aspects of this letter may be copied into the clinic letter to support shared care arrangements

Dear Prescriber

RE: ________________________ **DOB:** ___/___/______ **NHS:** ____________________

Address: ____ **Postcode:** ___________________

Diagnosis:

Medication:

Your patient is on [enter product details] and currently stabilised on this treatment.

Therefore, this treatment can now be prescribed by primary care prescribers under "shared care" arrangements which has been approved by the Sheffield Area Prescribing Group. Please see a link to the agreed shared care protocol.

We have chosen to use [enter product details, **including formulation**] because [insert reasons].

Please could you prescribe and monitor physical parameters, adherence, and side effects to therapy every 6 months as per shared care protocol arrangements? We will continue to see [enter patient's details] every 3 months or sooner if required.

Please acknowledge you are happy to take on shared care by completing or wish to decline and returning the slip below to above address or by secure email to ____________________________

Do not hesitate to contact us if you have any concerns.

Yours sincerely

Clinician's Name

Clinician's Title

IMPORTANT REMINDER

The prescriber is responsible for monitoring the patient on the medication being prescribed

RE: ________________________ **DOB:** ___/___/______ **NHS:** ____________________

Address: ____ **Postcode:** __________________

☐ I AGREE to take on shared care of this patient

☐ I DO NOT AGREE to take on shared care of this patient

Signed ________________________________

Practice____ Date_______________

Appendix 2

Keeping Safe Plan

Sometimes when I am struggling with difficult feelings, I have thoughts about harming myself. In the past I have acted on these thoughts/not acted on these thoughts.

When I am feeling well, this is what I'm like…

What support I will need to keep me feeling ok….

Things that are difficult for me and may make me struggle to stay safe...

Signs that I'm struggling with difficult feelings and thoughts of harming myself…

What I don't want people to do when I'm struggling as it won't help me….

What people can do when I'm struggling to help me…

People can tell when I'm no longer struggling as…

What I need to do in an emergency

- Tell an adult I trust who will be able to keep me safe (e.g. a parent, teacher, CAMHS worker or doctor). The person I am most likely to tell is:
  ………………………………………………………………………………………..

- I can ring CAMHS on 0114 271 6540. Someone from CAMHS will answer the phone on Monday- Friday 9am-5pm. I can ask to speak to a clinician who knows me or leave a message for them if they aren't available. If I need to speak to someone urgently and can't wait, I will let the receptionist know and they will advise me what to do.

- If I feel like I am going to hurt myself at the weekend, in the evening, bank holiday or at night and there is no one to help me immediately around, there are a few things I can do to get help:

  - I could ring the Samaritans on 116 123. This number if free to call and there will be someone available 24 hours a day, every day of the year.
  - I could also use the Calm Harm App on my phone or tablet to help me cope until the feelings pass.
  - I can use the Young Minds Crisis messenger text service. This service is also available 24 hours a day. I can access the service by texting YM to 85258. Someone will aim to get in touch within 5 minutes to provide support. Texts are free from EE, O2, Vodafone, 3, Virgin Mobile, BT Mobile, GiffGaff, Tesco Mobile and Telecom Plus.

- If none of the above have worked or I cannot talk to anyone about it, I can go to the A and E department at the children's hospital/ Northern General (or any A and E department outside of Sheffield) and tell the staff there that I need help. I can ring 999 if I am unable to get to the hospital or do not think I can get there safely.

- If I do something to hurt myself deliberately (like cut myself, swallow something dangerous or take an overdose) then I am going to tell …………… or ring 999 and ask for help.