Norfolk Safeguarding Children Partnership

What to do if you believe a child or young person might be at risk of suicide

Updated April 2023

Contents

This guidance has been produced for everyone who engages directly with children and young people in their day to day work and who may become aware of a young person's suicidal thoughts or intentions. It is specifically aimed at professionals who have no training or expertise in the field of mental health and who do not have a role in the formal assessment of risk.

The purpose of this guidance is to ensure that the wider children's workforce understands the process to be followed in Norfolk where concerns about possible risk of suicide exist. Everyone has a responsibility to identify young people at risk, including the risk of suicide, and to share information when action may be required to protect a child or young person. Professionals may also have a role in the implementation of a co-ordinated multi-agency Safety Plan or Risk Management Plan following completion of a detailed risk assessment by specialist mental health services or children's social care.

There is a link between self-harm and suicide. Please refer to Appendix 2 for further information, and follow the NSCP guidelines.

We would like to thank the Worcestershire Safeguarding Board for allowing us to adapt their guidance.

1. Introduction

In 2018 NCMD (National child mortality database) was commissioned and started to collect data on all child deaths from April 2019. Child death overview panels (CDOPs) submit data to NCMD on a daily basis via an electronic portal E-CDOP. All deaths by suicide or deliberately inflicted self-harm are now collected. There are several deaths where it is not clear whether the intent of the young person was suicide. The final decision is that of the coroner as all deaths due to inflicted self-harm will go to inquest. Using ONS data for population size the rate of suicide approximates to 0.8 suicides per 100,000 children per year for 10–14-year-olds and 5.9 per 100,000 per year for 15-17 year olds. It has been estimated that two young people take their own lives every day in the UK and that about 24,000 attempted suicides relate to children and young people aged 10–19 each year. Whilst females are more likely to attempt suicide, twice as many males die following suicide.

In the ten year period 2013-2023 there have been 17 young people under the age of 18 have died by suicide/self-inflicted harm. The number of deaths per CDOP year (April to March) varies from zero to five. Since 2019 information has been collected by NCMD and they produced a report comparing CDOPs within the eastern region. Thus, for the years 2019-2022, the proportion of deaths from suicide/self-inflicted harm was 18.7% of the child deaths between 1-17 years. The proportion of Norfolk deaths due to suicide/self-inflicted harm in 2019-2022 is more than our East of England neighbours although similar to Hertfordshire (17.1 %) . Bedfordshire had no deaths from suicide/self-inflicted harm between 2019-2022. Suffolk 14%, Cambridgeshire and Peterborough 12.1% and Essex 11.2%. Twice as many boys as girls have taken their own life. Hanging is the most frequent cause of death. It is not possible to be specific about the numbers of attempted suicides due to difficulties in establishing whether a self-harm episode is an attempt at suicide or not. Self-harm is a common precursor to suicide and children and young people who self-harm may kill themselves by accident. Please see Appendix 2 and the NSCP guidance 5.21 for further information.

The cases reviewed recently by Norfolk CDOP have similar findings to those identified in the in depth Norfolk Suicide Review (2015). In addition, the NCMD have identified common characteristics which also resonate with Norfolk CDOP. These are:

Key findings from the NCMD report(https://www.ncmd.info/publications/child-suicide-report/)

- Child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods
- 62% of children or young people reviewed had suffered a significant personal loss in their life prior to their death, this includes bereavement and “living losses” such as loss of friendships and routine due to moving home or school or other close relationship breakdown
- Over one third of the children and young people reviewed had never been in contact with mental health services. This suggests that mental health needs or risks were not identified prior to the child or young person’s death
- 16% of children or young people reviewed had a confirmed diagnosis of a neurodevelopmental condition at the time of their death. For example, autism spectrum disorder or attention deficit hyperactivity disorder. This appears higher than found in the general population
- Almost a quarter of children and young people reviewed had experienced bullying either face to face or cyber bullying. The majority of reported bullying occurred in school, highlighting the need for clear anti-bullying policies in schools

In Norfolk there was little evidence of assessment of suicide risk, multi-agency risk assessments, implementing fully informed risk management strategies or safety planning. Communication between agencies remains a significant problem.

The aims of this guidance are to:

- Develop a shared language which supports effective information sharing
- Standardise the response of agencies and practitioners to identifying and responding to young people who may be at risk of suicide by providing a referral pathway
- Provide tools for practitioners to support the early identification of risk
- Provide information about the respective roles of services and referral criteria

2. Principles and values

Any child or young person, who expresses thoughts about suicide, must be taken seriously and appropriate help and intervention should be offered without delay.

- It is acknowledged that suicide issues can be extremely challenging for practitioners, family members and communities
- Assessments should be based on the unique experiences and feelings of each young person and not on the perceptions of adults
- Young people should not be stigmatised or discriminated against because of suicidal thoughts or behaviour
- It is acknowledged that belief systems can impact on individual attitudes towards suicide
- A co-ordinated response by agencies is in the interests of young people at risk of suicide
- Confidentiality and consent issues should not be barriers to effective joint working
- Creating a safe and supportive environment should be a key aim
- Conversations about suicide risk with young people should be held by those who know them best
- Staff supporting young people should be offered appropriate advice and support by their organisation

3. Definitions

Suicidal behaviour is any deliberate action that has potentially life threatening consequences, such as taking an overdose. It can also include repeated risk taking which constitutes a risk of death.

Suicidal thoughts imply that someone is thinking about taking their own life. This differs from young people who, as part of normal growing up, might explore the meaning of life. Further conversations will usually establish whether someone is thinking about suicide.

Suicide is the act of deliberately ending one's own life. It is possible to die unintentionally as a result of a serious self-harm episode.

Self-harm is the term used when someone intentionally injures, poisons or harms themselves. It is a common pre-cursor to suicide and children and young people who self-harm may kill themselves by accident.

Suicide prevention is the process of identifying and reducing the impact of risk factors associated with suicidal behaviour, and identifying and promoting factors that protect against engaging in suicidal behaviour.

4. Identifying risk factors

If a practitioner is concerned that a child or young person is at risk of suicide they should make a referral to the appropriate agency with responsibility for specialist mental health assessments. The process for doing so is set out in Section 5 of this guidance.

A risk assessment is only valid at the point that it is completed and needs to be updated in response to changing circumstances. Significant information can be obtained from the young person, but information will need to come from other sources, such as parents/carers, peers or professionals.

Risk factors give an indication of the potential for serious harm to occur, but cannot provide an accurate prediction of what will happen. Risk factors can be seen as 'alarm bells' – the more alarm bells that are ringing the greater the concern - however one significant risk factor can also trigger a young person having suicidal thoughts or behaviour.

Personal History

- Previous self-harm, suicidal thoughts or suicide attempt
- Substance use
- Evidence of mental health problems, especially depression, psychosis, post-traumatic stress disorder or eating disorder
- History of experiencing physical, emotional or sexual abuse
- Loss or bereavement – could include loss of relationships or social status (anniversaries can be significant)
- Pressure on social media
- Family factors – instability (divorce, separation, changes of care giver, repeated house moves), conflict, arguments, domestic violence
- Family history of suicide, mental illness or substance misuse
- Issues of gender or sexual orientation
- Children and young people who may have been radicalised
- Bullying

Personal functioning

- Changes in anxiety levels, problem solving skills, social withdrawal, feelings of hopelessness, personal appearance, sleeping and eating habits
- Altered mental states, e.g. feelings of agitation, hearing voices, delusional thinking, aggression, intoxication
- Statements of suicidal intent: letters, comments, Facebook status, social media messages, text messages, etc.
- Tendency to impulsive behaviour
- Running away from home

- Anger, hostility or anti-social behaviour
- Use or increased use of drugs/alcohol
- Feelings of ambivalence about the future e.g. no reason for living, no purpose in life
- Difficulty in coping with exam stress

Verbal warning signs

- 'I can't take it any more'
- 'Nobody cares about me'
- 'I can't see the point any more'
- 'Everyone would be better off if I weren't here'
- 'Nothing matters any more'
- 'I'm going to top myself'

Levels of risk

High Risk	• Previous suicide attempts • Frequent suicidal thoughts which are not easily dismissed • Specific plans with access to potentially lethal means, e.g. time, location and method • Evidence of current mental health problems • Significant or increasing drug or alcohol use • Situation felt to be causing unbearable pain or distress • Increasing self-harm, either in frequency or potential lethality or both
Medium Risk	• Suicide thoughts are frequent but still fleeting • No specific plan or immediate intent • Known current mental health issue • Use/increased use of drugs or alcohol • Situation felt to be painful but no immediate crisis • Previous, especially recent, suicide attempt • Current self-harm or thoughts of self-harm
Standard Risk	• Suicidal thoughts are fleeting and soon dismissed • No plan of how they would attempt suicide • Fewer or no signs of low mood • No self-harming behaviour • Current situation felt to be painful but bearable

5. Referral pathway – suicidal thoughts and suicidal behaviour

'There is no evidence that asking a young person whether they are having suicidal thoughts will put the thought in their mind if it were not there before. There is, however, a great deal of evidence to suggest that being able to talk to clients about suicide is extremely important in providing a safe space for them to explore their feelings.'
Rudd (2008), Barrio (2007)

If you have concerns that a young person has suicidal thoughts or behaviours you must follow the steps as laid out in this guidance.

Information Gathering conversation
Possible questions for an information gathering conversation are contained in Appendix 1. You will need to start the conversation by explaining the reasons for your concern, these questions aim to guide you through a conversation in which you can find out about suicide risk, which will inform your next actions. The conversation should be supportive and take account of the young person's individual situation and his/her needs. Ideally, the conversation should be held by the worker who knows him/her best. Young people say that scaling questions might also be useful.

If the young person does not engage with the conversation, then follow advice in Section 7: young people who do not engage.

If there are no concerns about suicidal thoughts or behaviour and Standard Risk of suicide is indicated:

- If the young person is standard risk in respect of suicide but has additional needs (not impacting on welfare) then consider a referral to the Early Help Hub or to other services (details Appendix 4) if appropriate.

- If the young person is standard risk in respect of suicide but has other needs which impact on their safety or welfare, please consider contacting the Children's Advice and Duty Service (CADS) (details Appendix 4).

- If the young person is standard risk in respect of suicide but is showing early signs of mental health and emotional problems, please consider contacting the Children's Advice and Duty Service (CADS) (details Appendix 4).

- Give consideration to the impact on the young person's support network

If your conversation indicate Medium or High Risk of suicide:
- Explain limits of confidentiality and consent to share issues
- Contact 111 Mental Health Option for medium risk (this is open for professionals working with people needing urgent mental health care) or direct with the Crisis Assessment and Intensive Support Team (CAIST) for high identified risk for consultation and/or referral.

You should also:

- Liaise with parents/carers (where possible)
- Inform Children's Services if you think that the child may already be open to social care
- Inform the young person's GP
- Contact CADS if the young person or parents/carers do not engage
- Give consideration to the impact on the young person's support network

Immediate Medical Attention

- If suicidal actions have been disclosed or if the level of self-harm has resulted in a significant physical injury (e.g. recent overdose or serious cutting) it is important to ensure that the young person is assessed urgently in order to ascertain whether any immediate medical treatment is required. Take the young person to the Accident and Emergency department at the local hospital or consider dialling 999 and asking for an ambulance.
- Inform the young person's parents/carers.

If a young person tells you they are imminently about to take their own life

- Do not leave the young person on their own.
- If urgent assistance is required contact the emergency services.
- Ring the Crisis Assessment and Intensive Support Team (CAIST) who will consult and triage for an emergency assessment to be arranged (office hours and out of hours).

Safety Planning

You could also consider helping the young person to put together a safety plan.

SAMPLE SAFETY PLAN

It is best to have someone complete this before a crisis so they can refer to it as a protective measure.

1. Warning signs of crisis
2. Coping strategies – what I can do to take my mind off it
3. Who or what is good in my life
4. Contact details of someone who I trust to get help
5. Contact details of agencies I can get help from
6. What makes life worth living
7.

6. Important things to remember

Do	• Take suicide gestures seriously • Listen, be non-judgemental and think about what you say • Ask direct questions early on to establish the level of risk • Ask about other problems such as bullying, substance misuse, bereavement, relationship difficulties, abuse, sexuality issues • Check how and when parents/carers will be contacted • Encourage contact with friends, family, trusted adults • Ensure immediate support for the young person is in place and that medical attention is provided if necessary • Consult with specialist services for advice • Make sure you record your assessment, concerns and actions in line with your agency's procedures • Make appropriate referrals • Engage with processes for developing Risk Management and Safety Plans • Ensure actions to be taken by your agency to manage risk are implemented • Consider protective factors and provide ongoing opportunities for support and monitoring • Respond to escalating concerns about the risk of suicide
Do Not	• Promise confidentiality • Make assumptions or react without considering all of the risks • Dismiss what the young person is saying • Presume that a young person who has threatened to harm themselves in the past will not do so in the future • Disempower the young person • Dismiss self-harm or expression of suicide thoughts as attention seeking

7. Young people who do not engage

If a child or young person is at risk of significant harm (S47 Children Act 1989) you have a duty to share concerns and information relevant to the risk. Some young people do not wish to engage with specialist services but may choose to engage with other professionals. If a young person is at high risk of suicide and does not wish to engage with CAMHS:

- Seek guidance from your line manager and/or safeguarding lead
- Consider contacting the young person's parents/carers (unless child protection concerns preclude this), with agreement from the young person
- Consult with Crisis Assessment and Intensive Support Team (CAIST) about what action to take next. CAIST would involve a core team if the young person was known to them.
- Consult with MASH (Children's Services) about what action to take next if young person who is at high risk of suicide will not engage with any professional

If you find yourself in this position you must share information and seek support and guidance from specialist agencies (as well as your line manager/safeguarding lead).

8. Engagement with parents and carers

Consider with the young person, how and when parents/carers can be contacted. When parents/carers are informed they can become part of the assessment, safety planning and risk management. Informing parents/carers can be very stressful for the young person. Some young people may be relieved that someone else liaises with their parents/carers and engages with them to be supportive.

Parents/Carers may need some additional advice on how to best support their child. Please see Appendix 4 for agencies that may be able to help, and Appendix 5 for national organisations/websites.

- If the young person does not wish their parents/carers to be informed then workers should explore the reasons for this so that concerns of the young person may be able to be addressed. The worker should seek the support of their manager/supervisor. A consultation with CADS about whether parents should be informed as part of safeguarding the young person may be helpful.
- If the young person has disclosed that their self-harm or suicidal thoughts/intentions are a response to alleged abuse by their parents/carers then workers should consult their line manager/safeguarding lead and follow their organisation's procedures for reporting child protection concerns without delay
- Consult with CADS about what action to take next if parents of the young person who is at high risk of suicide will not engage with any professional

9. Looking after yourself

When you are supporting young people with suicidal thoughts/feelings, it can be challenging and create a range of feelings in ourselves, such as anxiety, fear, confusion, sadness, frustration, hopelessness and powerlessness. You need to think about ways of looking after yourself when supporting young people in situations such as these.

Be sure you look after yourself by sharing your load with your manager/senior lead and ask for support when you need it.

These 'Five ways to well-being' may also be helpful to consider.

Connect…

With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Be active…

Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take notice…

Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

Keep learning…

Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give…

Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

(The New Economics Foundation, 2008)

Appendix 1 – Information Gathering Conversation and Flowchart

If a young person's presentation/behaviour causes concern that they may have suicidal thoughts or intent, have an **Information Gathering Conversation**. Feel free to adapt the questions appropriate to the young person's needs, and ask other relevant questions.

Tell me, is something troubling you (home, family, school, friends)? Or: I am aware that you have talked about xxx, tell me a bit more… How is this making you feel?
How often have you had these thoughts?
Are other people also worried about you? Who, why?
Have you ever felt like hurting yourself? Have you ever hurt yourself?
Have you ever felt like ending your life?

If the answer is no, then you will **not** need to go on with the **suicide specific questions**, but you may wish to continue with **further questions** (see below), in particular if the young person is self-harming. The **general questions** at the end are likely to be appropriate for everyone.

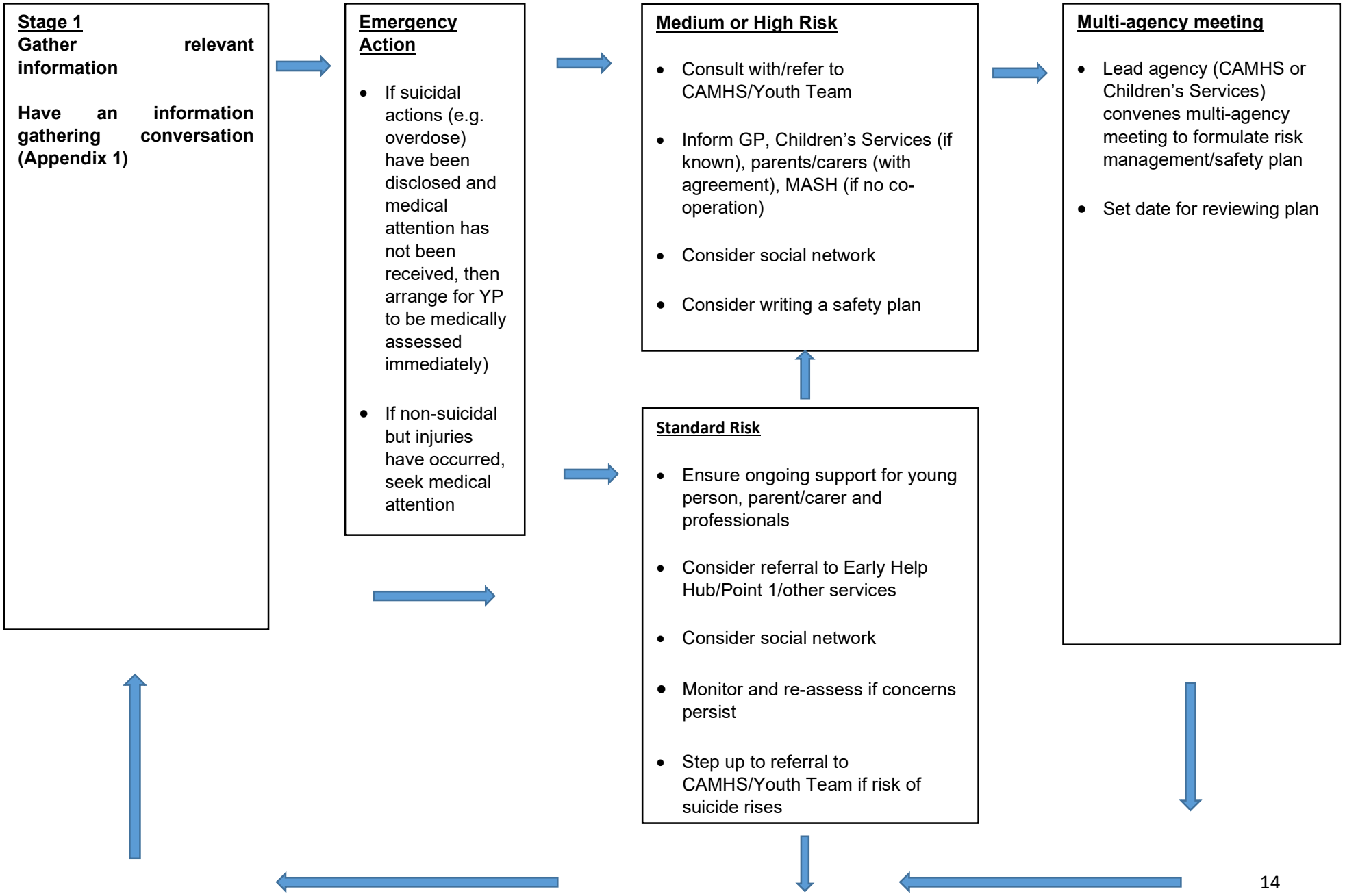
How often do you think about suicide? How long have you been having suicidal thoughts? When did you last think about suicide? Are you currently thinking of ending your life?
What makes you think of suicide (e.g. worries, fears, loss)? Have you ever made a suicide attempt?
What stops you acting on these thoughts?
Have you thought about how you would kill yourself/Do you have a plan? Do you have ways of taking your own life? (tablets, weapons, other?)
Is anyone aware that you think about suicide (family, friends, professionals)?
What helps to stop you thinking about taking your own life?

Further questions:

Are you experiencing harm from others (bullying, threats, abuse)?
Do you use drugs or alcohol? Does this make you feel better or worse?
What helps to stop you thinking about harming yourself?
What helps to stop your self-harming behaviour from getting worse?

General questions:

Are you getting support with your feelings (from family, friends or professionals)?
How are you feeling generally at the moment (mood, health, social life)?
What do you think needs to happen to improve the situation and make you feel better? (Do a safety plan – see section 5 – if appropriate). **Agree what will happen next.**


Stage 1
Gather relevant information
Have an information gathering conversation (Appendix 1)
Emergency Action
If suicidal actions (e.g. overdose) have been disclosed and medical attention has not been received, then arrange for YP to be medically assessed immediately)
If non-suicidal but injuries have occurred, seek medical attention
Medium or High Risk
Consult with/refer to CAMHS/Youth Team
Inform GP, Children's Services (if known), parents/carers (with agreement), MASH (if no co-operation)
Consider social network
Consider writing a safety plan
Multi-agency meeting
Lead agency (CAMHS or Children's Services) convenes multi-agency meeting to formulate risk management/safety plan
Set date for reviewing plan
Standard Risk
Ensure ongoing support for young person, parent/carer and professionals
Consider referral to Early Help Hub/Point 1/other services
Consider social network
Monitor and re-assess if concerns persist
Step up to referral to CAMHS/Youth Team if risk of suicide rises

Appendix 2

Links between self harm and suicide

In the majority of cases self-harm appears to be a way of coping rather than an attempt at ending life. It may be an attempt to communicate with others, to influence or to secure help or care from others, or a way of obtaining relief from a difficult or overwhelming situation or emotional state. In these circumstances, somewhat paradoxically, the purpose of the self-harming behaviour is to preserve life, although this can be a difficult concept for practitioners to understand.

A small minority of young people who repeatedly self-harm may go on to attempt suicide, although this may not what they intend to do and death can occur accidentally. The difference between self-harm and suicide is not always clear, however. Self-harm is a common precursor to suicide for the relatively small numbers of young people who make deliberate attempts to end their lives and so repeated incidents of self-harm should be considered a risk factor when assessing the risk of suicide.

In their separate forms, self-harm and suicide generally differ in terms of the intent that lies behind the behaviours.

Practitioners should feel able to communicate with young people about their self-harming behaviours. It is important to gather information about self-harm and the young person's thought processes associated with the behaviours in order to start to understand the risks; either of serious risk to the young person's health or wellbeing, of the risk of death by misadventure, or the risk of intentional suicide.

Please follow the NSCP Guidance 5.21 on self-harm.

Appendix 3:

Guidance on sharing information

The purpose of sharing information is to ensure young people who are at risk from suicidal thoughts and behaviour receive help and support appropriate to their level of need.

Seven Golden Rules to sharing information (Information Sharing: HM, March 2018)

1. Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

The most important consideration is whether sharing information is likely to safeguard and protect a child. If at any stage you are unsure about how or when to share information, you should seek advice and ensure that the outcome of the discussion is recorded. If there are concerns that a child is suffering or likely to suffer harm, then follow the relevant procedures without delay.

Appendix 4:

Roles and responsibilities

All people who come into contact with children and young people, including professionals who deliver specific services to some groups of young people (e.g. youth workers, sport coaches) are likely to meet young people who are engaging in self-harming behaviours, who are expressing suicidal thoughts or intentions, or who have attempted suicide previously. Everyone plays an important role in terms of identifying young people who are at risk of suicide, making an appropriate referral, and playing an important part in safety planning and risk management.

- **Accident and Emergency Department**

Accident and Emergency Departments at local hospitals can treat young people who have self-injured or taken overdoses. Generally speaking young people who are expressing suicidal thoughts or behaviours, but who have not physically injured themselves or taken an overdose, should not be taken to Accident and Emergency Departments in the first instance, but CAMHS should be contacted for the initial risk assessment. When young people attend due to injuries/overdoses, A & E Doctors can undertake immediate risk assessments where there is a risk of suicide and, if required, access advice from CAMHS or the all-age out of hours mental health services.

- **Children's Social Care Services**

Children's Social Care is the lead agency for responding to children and young people for whom there are welfare concerns or where there is a risk of significant harm. Young people who demonstrate self-harming behaviours or who express suicidal thoughts or intentions will not automatically require a service from Children's Social Care, however consideration should always be given to making a referral.

A referral should always be made where there are concerns about the reasons for the young person's suicidal thoughts or intentions, such as abuse or neglect, or where young people are at high risk of suicide and do not want CAMHS support, and/or when parents or carers are not engaging.

If you are uncertain as to whether a referral should be made to Children's Services you are encouraged to seek advice from the Children's Advice and Duty Service (CADS) on 0344 800 8021.

- **Child and Adolescent Mental Health Services (CAMHS) and Youth Services (under 25's)**

CAMHS and Youth Services provide support to children and families where the young person is experiencing emotional, behavioural or mental health difficulties. Young people who are demonstrating self-harming behaviours and are at medium or high risk, or who are expressing suicidal thoughts or intentions may require a service from CAMHS.

The Provider will accept referrals from Primary Care, Norfolk's Targeted CAMH Service (Point 1), Midwifery, Community Paediatrics, School Nursing, Health Visitors, LD CAMHS providers (Starfish), Acute Hospitals (incl. Emergency Departments), Norfolk Constabulary, Norfolk's commissioned Substance Misuse Service (Under 18), SENCOs and Schools' safeguarding leads, and any professional competent to undertake an initial mental health assessment (screening). CAMHS do not accept direct referrals from parents or carers.

Referrals are made via the Access and Assessment Team: 0300 790 0371

Professionals can also call their local CAMHS service for consultation:

Central Switchboard: 01603 421421 and ask for Central Norfolk, West Norfolk or Great Yarmouth.

- **Early Help Hub**

The Early Help Hub is about ensuring help and support is available as soon as needs emerge. It is also about strengthening support for communities and universal services, enabling families to be more resilient and reduce the need for intrusive crisis level interventions. It is a partnership made up of voluntary and statutory agencies.

Breckland – 01362 654515
East – 01493 448188
Broadland – 01603 217612
North – 01603 217612
Norwich – 01603 224101
South – 01508 533933
West Norfolk and
King's Lynn – 01553 669276
or the central number: 01603 223161.
Email: earlyhelp@norfolk.gov.uk

For further information about an Early Help response please visit the Early Help website at: www.norfolk.gov.uk/earlyhelp

- **First Response**

First Response is a new 24/7 helpline offering immediate advice, support and signposting for people with mental health difficulties. The helpline is open to social care colleagues as well as other healthcare professionals who may need advice when working with individuals who are undergoing mental health difficulties or who need to refer someone. It is also available to members of the public of any age.

If you are experiencing something that makes you feel unsafe, distressed or worried about your mental health, call the helpline on 0808 196 3494. If you want to remain anonymous and would prefer that the person answering your call doesn't see your telephone number, you can turn off your caller ID in your phone's settings.

- **General Practitioner (GP)**

GPs are trained to consider the mental health of patients in primary care consultations and play a significant role in the prevention, detection and management of mental health issues in respect of their patients.

A young person's GP will be able to make an initial assessment of the risk of suicide and take the appropriate action to address this risk. They will also take responsibility for making a medical assessment of the need for treatment following a serious self-harm incident or suicide attempt. Out of hours responses are available and information about how to access these will be publicised by the GP's surgery. Professionals do not need to contact the GP to access CAMHS/Youth service support for a young person.

- **Kooth**

Kooth is an online counselling service for 11 – 25 yr olds in Norfolk & Waveney which offers:

A free, confidential, anonymous and safe way to receive support online.

- Out of hours' availability. Counsellors are available from 12noon to 10pm on weekdays and 6pm to 10 pm at weekends, every day of the year on a drop-in basis.
- Online Counselling from a professional team of BACP qualified counsellors is available via 1-1 chat sessions or messaging on a drop-in basis or via booked sessions.
- Discussion Boards which are all pre-moderated allow young people to access peer to peer support.
- Online Magazine full of moderated articles many of which are submitted by young people offering advice and guidance on a huge range of topics.
- No referral required. Young people can register for Kooth independently at www.kooth.com

To use the service or find out more visit www.kooth.com , or watch this short video to find out more: Kooth Video

- **Norfolk Police**

The Police will respond when there is an imminent risk of suicide or serious self-harm. In any such emergency police should be called on 999.

Police are able to use their powers of Police Protection under The Children's Act 1989 or utilise s.146 of the Mental Health Act to detain any person who is at significant risk of harm and detention is required either to protect that person or for the protection of others.

In specific circumstances, where the risk of suicide is identified following a missing person investigation, Police will conduct a post-missing visit in conjunction with a Mental Health Nurse.

When CADS process concerns in the MASH, Police will, where appropriate work with partner agencies to ensure that information is shared to assist in making a robust safety plan for any young person at risk of suicide.

- **Point 1**

Point 1 offer professional support for infants, children and young people experiencing the early signs of mental health and emotional problems.

The emotional wellbeing service is available to any child or young person living in Norfolk or registered with a Norfolk GP. It offers short-term interventions to address the early signs of mental ill-health, to ensure infants, children and young people go on to achieve their full potential in life. Services are delivered by Ormiston Families, working with the youth charity MAP and Norfolk and Suffolk Foundation Trust (NSFT).
http://point-1.org.uk, Tel. 0800 977 4077

- **JustOneNorfolk / Norfolk Healthy Child Programme**

The Norfolk Healthy Child Programme provides universal health services for all children aged 0-19 in Norfolk, alongside their parents and carers. The skill mix teams include health visitors, family public health nurses, school nurses, assistant practitioners, healthy lifestyle coaches, resilience and emotional health practitioners, staff nurses, teenage parent practitioners and family nurses.

Professional referrals for 5-19 year olds are made by calling **Just One Number** on **0300 300 0123**. Telephone referrals enable an informative conversation at the point of contact to ensure all the required information for early triage and assessment is gained.

They also offer a service for 11–19-year-olds in Norfolk, they can text **ChatHealth** on **07480 635060**.

ChatHealth is an easy way for young people to confidentially seek help about a range of issues and find out how to access other local service. Messages sent to the dedicated number are delivered to a secure website, and responded to by the 0-19 team. Out of hours, anyone who texts the service will receive a bounce back message explaining where to get help if their question is urgent, and when they can expect a response. Texts are usually replied to within one working day.

- **Voluntary Services**

There are a number of voluntary agencies that may offer support to children and young people who self-harm. www.voluntarynorfolk.org.uk

Appendix 5:

Useful national organisations/websites

Charlie Waller Trust 01635 869754 http://www.cwmt.org.uk/
The Trust was set up in 1997 in memory of Charlie Waller, a young man who took his own life whilst suffering from depression. Shortly after his death, his family founded the Trust in order to educate young people on the importance of staying mentally well and how to do so.

Childline 0800 1111 www.childline.org.uk, https://www.childline.org.uk/info-advice/your-feelings/mental-health/coping-suicidal-feelings/

Mindinfoline 0300 123 3393 or text 86463
http://www.mind.org.uk/information-support/

NHS Direct 111 www.nhsdirect.nhs.uk

Papyrus 0800 684141 www.papyrus-uk.org/
Confidential support and advice for prevention of young suicides
Mon – Fri 10-5pm and 7-10pm

Royal College of Psychiatrists
http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/feelingoverwhelmed.aspx

SelfharmUK is a project dedicated to supporting young people impacted by self-harm, providing a safe space to talk, ask any questions and be honest about what's going on in your life.It also has an online course that gives you an opportunity to think more about self-harm and work out what your next step might be: www.selfharm.co.uk

Young Minds Parent information service 0800 018 2138 www.youngminds.org.uk for anyone concerned about a child's mental health