ST JOHN'S SCHOOL
SIDMOUTH, UNITED KINGDOM

Mental Health Policy

Contents

Mental Health Policy

1. Introduction

The Directors and Senior Management Team of St John's School fully recognise their responsibilities to support the mental health and wellbeing of students. This policy sets out to identify areas of mental health and wellbeing concerns that young people may face and clarify the management and support given to students who experience mental health and wellbeing challenges. Mental health includes our emotional, psychological, and social state. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental wellbeing describes that mental state, identifying how we are feeling and how well we can cope with day-to-day life. Strong mental health is vital if students are to be successful when they leave school so the School takes their responsibility in this area very seriously.

2. Aims

The School aims for all students and staff to realise the benefits of being part of a 'Talking School' i.e. we learn to talk through our problems and we feel supported and do not fear being stigmatised or discriminated against: our mental health is as important as our physical health.

This policy aims to:

- describe the School's approach to mental health issues;
- increase understanding and awareness of mental health issues in order to facilitate early intervention;
- alert staff to warning signs and risk factors;
- provide support and guidance to all staff dealing with students who suffer from mental health problems;
- provide support to students who suffer from mental health issues, their peers and family;
- ensure that all staff are aware of the necessary protocols and can quickly find the emergency information that they may need;
- respect a student's rights and confidentiality wherever possible;
- ensure that safeguarding remains at the forefront of our minds and to ensure that we always work in the best interests of every child.

3. Scope

This policy applies to all children at St John's School, including the Nursery (EYFS). Building positive relationships between children and adults in every stage of education is the bed-rock of a Talking School. This policy applies wherever staff or volunteers are working with students, even where this is away from the School, for example on an educational visit.

The terms 'child', 'children', 'pupil', 'pupils', 'student', 'students' and 'young people' may be used interchangeably to refer to all those in our care. Legally a child is anyone under the age of 18. Within this policy the School does not distinguish between students who are under or over the age of 18 but does accept that multi-agencies, such as CAMHS, will make such a distinction.

4. Safeguarding Responsibilities

St John's School is committed to safeguarding and promoting the welfare of children and young people.
We recognise that children have a fundamental right to be protected from harm and that students cannot learn effectively unless they feel secure. We therefore aim to provide a school environment which empowers and promotes self-confidence, a feeling of self-worth, resilience and the reassurance that students' concerns will be listened to and acted upon. Safeguarding procedures will be followed (see safeguarding policy) if a student is at risk of suffering significant harm or presents a risk of harm to others. Where the Safeguarding Team is referred to, this includes; The Designated Safeguarding Lead, The Whole School SENDCo, School Leads and The Head of School.

5. Confidentiality and information sharing

Students may choose to confide in a member of school staff if they are concerned about their own mental or emotional health, or that of a peer. In such cases, staff must make students aware that it may not be possible for staff to offer complete confidentiality. If a member of staff considers a student is at risk of causing themselves or someone else serious harm then confidentiality cannot be maintained. It is essential that staff do not make promises of confidentiality, even if a student puts pressure on a member of staff to do so. Information sharing will follow the same protocols as laid out in the School's Safeguarding Policy.

6. Background to the Policy

Recent research confirms that the number of young people in the UK suffering from mental health disorders of one form or another has increased considerably. It is therefore important that as a school we understand and seek to support young people who experience mental health conditions, as far as possible.
The most common consequences of mental health conditions in children and young people are:

- Anxiety and low mood
- Eating disorders
- Self-Harm

7. Parents/Carers/Guardians

Parents must disclose to the School, via the School medical questionnaire, any known mental health problems or any concerns they may have about their child's mental health or emotional wellbeing at present or in the past. It is helpful for parents, and guardians (in appropriate circumstances) to notify the School of any changes in family circumstances

that may impact the student's mental, emotional wellbeing, such as illness, separation/divorce or bereavement or any changes in behaviour which they have noted.

8. School Services

- Tutors

Every pupil has a tutor (a teacher in the School) with whom they will have dedicated pastoral or tutor time.

- SENDCo

The School's SENDCo is trained in Youth Mental Health First Aid.

- Counselling

The School has a visiting counsellor. The way for a student to see a counsellor is:
To get a referral through The Safeguarding Team who will then liaise with the counsellor and parents.

Mental Health and wellbeing also features prominently in the School's Personal, Social, Health and Citizenship Education (PSHCE) curriculum and Enrichment Programmes.

9. School Procedures

If there is an immediate danger to the pupil dial 999 and stay with the pupil.
Procedures for dealing with specific mental health issues are outlined as follows:

- anxiety and low mood (Appendix 2)
- eating disorders (Appendix 3)
- self-harm (Appendix 4)

School staff are fully aware of the importance of mental health awareness and are familiar with the risk factors and warning signs outlined at Appendices 2, 3 and 4.

With the support of The Safeguarding Team (and, if deemed appropriate, external agencies i.e. CAMHS) a member of the team will write a welfare plan and ensure that key pastoral staff are supported to help the individual child and possibly (if appropriate) their family. If the School considers that the presence of a student in the School is having a detrimental effect on the wellbeing and safety of other members of the community, or that a student's mental health concerns cannot be managed effectively and safely within the School, the Head of School reserves the right to request that parents/withdraw their child temporarily until appropriate reassurances have been given.
Where a student is not well enough to attend school but is able to continue studies at home, under parent/guardian supervision, teaching staff will provide resources and work to support the student's ongoing studies.
The School will work with parents/guardians and mental health practitioners to support a smooth reintegration back into school when students are ready to return; this may include a well-planned, supportive and phased return.

10. Mental Health Care Plan

Students experiencing severe mental unwellness will have a welfare plan in place to support management in school, including what to do in an emergency. Normally welfare plans are drafted by a member of The Safeguarding Team but in complex cases these will be written and reviewed by the whole team and this will normally include an external agency such as CAMHS. The DSL will decide who is responsible for drafting and managing these complex welfare plans where the child is at risk of significant harm. The School may also use a risk assessment to underpin this care. A generic exemplar of a risk assessment is shown in appendix 6.

11. Medication

Parents are required to inform the School Nurse/Matron if their son/daughter is on any medication as part of their therapeutic treatment plan. Please refer to the Health and First Aid Policy for procedures for the management of medication in school.

12. Advice to parents

Parents should not feel isolated if they know or suspect that their child (or one of their child's friends) is displaying signs of anxiety or low mood, an eating disorder, is at risk of self-harm or is actually self-harming, or is otherwise affected by mental health issues. The advice contained within this policy provides a first source of useful information and guidance. If a parent has any concerns, they should contact the School immediately for help, advice and support.

14. Complaints

Should parents or students be dissatisfied with the support provided they may discuss their concerns directly with their child's Tutor. In addition; the School has a complaints policy which is available on the internet and in hard copy format.

14. Review

This policy will be reviewed every year or sooner if practice or changes to legislation or policy so require.

15. Useful Resources and Helplines

See appendix 1

16. Glossary

Mental health and behaviour in Schools
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755135/Mental_health_and_behaviour_in_schools__.pdf

Mental health behaviour guidance to be issued to schools
https://www.gov.uk/government/news/mental-health-behaviour-guidance-to-be-issued-to-schools

Counselling in Schools; a blue print for the future (March 2015)

https://www.gov.uk/government/publications/counselling-in-schools

Understanding the Levels of Need

L4	Child at risk of significant harm whose additional care may be met through specialist services outside the School. Assessed by the Safeguarding Team. These specialist services are accessed through the DSL.
L3	Child in need whose additional care is met through specialist services. These services are accessed through the Safeguarding Team; support provided through counselling
L2	Child in need whose additional care is met through the Safeguarding Team.
L1	Students' needs are met within the existing pastoral systems such as tutor.

Appendix 1

An exemplar showing the information available to students.

Worries and Complaints – A Student's Guide

This guide explains what you should do if you feel worried about something. Much of what follows may seem obvious to you, but it is important to realise that the School will want to support you if you are unhappy or have questions which you are struggling to answer.

"What do I do if I just want to talk to someone?"

We want St John's to be a 'Talking School' where students and staff feel comfortable talking, supporting and resolving issues in a restorative and mature manner. This can be done within school - close friends, Prefects, Heads of House, your Tutor or the Matron – or outside school through your parents, family, school doctor, independent listener or many outside agencies and support groups.

- Child Abuse Investigation Team (CAIT) – **01823 363003**
- Child Line – **0800 1111**
- Domestic abuse freefone service **– 0800 6949999**
- NSPCC Child Protection Helpline – **0808 800 5000**
- Stop Hate Crime – **0800 1381625**
- The Bridge (out of hours) **- 01173 426999**
- Drink Line – **0800 917 8282**
- Frank – National Drugs Helpline – **0800 776600**
- EDP Drug & Alcohol Services - 0800 233 5444
- NHS Smoking Helpline – **0800 169 0169**
- Community Eating Disorder Service - 01392 208713
- Victim Support line – **0845 3030900**
- Samaritans – **116 123**
- NHS Direct – **0845 4647**
- Stonewall **- 020 7593 1850**
- LGBT Support line **– 0300 3300630**
- Educate and Celebrate **– 0300 3300 630**
- Pete's Dragons - 01395 277 780
- Papyrus (prevention of young suicide): **0800 0684141**
- I need help now - 0808 196 8708
- CALM (campaign against living miserably) **– 0800 585858**
- CASS (women's self-injury helpline) **– 0808 8008088**
- FCN (supporting farming families) **– 01934 712128**

You may prefer to talk on-line.

- Kooth (www.kooth.com) and Wysa (www.wysa.io) offer on-line counselling

"What happens if I want to make a complaint about something?"

Sometimes you may feel that you would like to complain about something that is worrying you. This might be about how you are being treated. The first thing you should do is speak to any member of staff you trust (e.g. your Tutor); you can take a friend with you if you wish – another pupil, an older pupil or another member of staff.

If the matter cannot be easily settled to your satisfaction then you can make a formal complaint.

Either you or your parents write to the Head of School.

You will then be asked to talk the matter through with the Head of School. You can have a friend with you, who may be another pupil, your Tutor or any member of staff. If the matter is not satisfactorily sorted out within four or five days you may contact any of the other people whose names are listed above and whose addresses and telephone numbers are given.

Whoever you contact will advise you about what course seems sensible. At that stage it will be up to you to make a decision acting on his or her advice

Appendix 2 - Anxiety and Low mood

Anxiety disorders

Anxiety is a natural, normal feeling we all experience from time to time. It can vary in severity from mild uneasiness through to a terrifying panic attack. It can vary in how long it lasts, from a few moments to many years. All children and young people get anxious at times; this is a normal part of their development as they grow up and develop their 'survival skills' so they can face challenges in the wider world. In addition, we all have different levels of stress we can cope with - some people are just naturally more anxious than others, and are quicker to get stressed or worried. Concerns are raised when anxiety is getting in the way of a child's day to day life, slowing down their development, or having a significant effect on their schooling or relationships.

Anxiety disorders include:

- Generalised anxiety disorder (GAD);
- Panic disorder and agoraphobia;
- Acute stress disorder (ASD);
- Separation anxiety;
- Post-traumatic stress disorder;
- Obsessive-compulsive disorder (OCD);
- Phobic disorders (including social phobia).

Symptoms of an anxiety disorder can include:

Physical effects

- Cardiovascular – palpitations, chest pain, rapid heartbeat, flushing;
- Respiratory – hyperventilation, shortness of breath;
- Neurological – dizziness, headache, sweating, tingling and numbness;
- Gastrointestinal – choking, dry mouth, nausea, vomiting, diarrhoea;
- Musculoskeletal – muscle aches and pains, restlessness, tremor and shaking.

Psychological effects

- Unrealistic and/or excessive fear and worry (about past or future events);
- Mind racing or going blank;
- Decreased concentration and memory;
- Difficulty making decisions;
- Irritability, impatience, anger;
- Confusion;

- Restlessness or feeling on edge, nervousness;
- Tiredness, sleep disturbances, vivid dreams;
- Unwanted unpleasant repetitive thoughts.

Behavioural effects

- Avoidance of situations;
- Repetitive compulsive behaviour e.g. excessive checking;
- Distress in social situations;
- Urges to escape situations that cause discomfort (phobic behaviour).

First Aid for anxiety disorders: How to help a student having a panic attack

- If you are unsure whether the student is having a panic attack, a heart attack or an asthma attack, and/or the person is in distress, call an ambulance straight away. Once the ambulance has been called, call the School Matron during the day. Do not leave the student;
- If you are sure that the student is having a panic attack, move them to a quiet safe place if possible and call the School Matron / Nurse if you are able to do so.

Help to calm the student by:

- Encouraging slow, relaxed breathing in unison with your own;
- Encourage them to breathe in and hold for 3 seconds and then breathe out for 3 seconds;
- Be a good listener, without judging;
- Explain to the student that they are experiencing a panic attack and not something life-threatening such as a heart attack;
- Explain that the attack will soon stop and that they will recover fully;
- Reassure the student that someone will stay with them and keep them safe until the attack stops;
- Accompany the student to Matron's when they are well enough to be moved.

Many young people with anxiety problems do not fit neatly into a particular type of anxiety disorder. It is common for people to have some features of several anxiety disorders. A high level of anxiety over a long period will often lead to low mood and long periods of low mood can provide symptoms of anxiety. Many young people have a mixture of symptoms of anxiety and low mood as a result.

Low mood

A clinical low mood is one that lasts for at least 2 weeks, affects behaviour and has physical, emotional and cognitive effects. It interferes with the ability to study, work and have satisfying relationships. Low mood is a common but serious illness and can be recurrent. Low mood in young people often occurs with other mental health disorders, and

recognition and diagnosis of the disorder may be more difficult in children because the way symptoms are expressed varies with the developmental age of the individual. In addition to this, stigma associated with mental illness may obscure diagnosis.

Risk Factors

- Experiencing other mental or emotional problems;
- Separation or divorce of parents;
- Perceived poor achievement at school;
- Bullying;
- Developing a long term physical illness;
- Death of someone close;
- Break up of a relationship.

Some people will develop a low mood in a distressing situation, whereas others in the same situation will not.

Symptoms

- Effects on emotion: sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, helplessness, hopelessness;
- Effects on thinking: frequent self-criticism, self-blame, worry, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see you in a negative light, thoughts of death or suicide;
- Effects on behaviour: crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation, engaging in risk taking behaviours such as self-harm, substance misuse, risk-taking sexual behaviour;
- Physical effects: chronic fatigue, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight loss or gain, irregular menstrual cycle, unexplained aches and pains.

First Aid for anxiety and low mood

Be familiar with the risk factors and warning signs outlined above and make the Designated Safeguarding Lead aware of any child causing significant concern.

Course of action may include:

- Contacting parents/carers;
- Arranging professional assessment and help e.g. doctor, nurse;
- Arranging an appointment with a counsellor;
- Consider referral to CAMHS – with parental consent;
- Giving advice to parents, teachers and other students - with appropriate consent.

Appendix 3 - Eating Disorders

School staff can play an important role in preventing eating disorders and also in supporting students, peers and parents/guardians of students currently suffering from or recovering from eating disorders.

Definition of Eating Disorders

Anyone can get an eating disorder regardless of their age, gender or cultural background. People with eating disorders are preoccupied with food and/or their weight and body shape, and are usually highly dissatisfied with their appearance. The majority of eating disorders involve low self-esteem, shame, secrecy and denial.

- Anorexia: People with anorexia live at a low body weight, beyond the point of slimness and in an endless pursuit of thinness by restricting what they eat and sometimes compulsively over-exercising.
- Bulimia: People with bulimia have intense cravings for food, secretively overeat and then purge to prevent weight gain (by vomiting or use of laxatives, for example).
- Binge Eating Disorder: People experiencing Binge Eating Disorder have recurrent episodes of binge eating with feelings of loss of control.

Risk Factors

The following risk factors are only a guide and not necessarily present; however, they are factors that may make a young person more vulnerable to developing an eating disorder.

Individual Factors:

- Difficulty expressing feelings and emotions;
- A tendency to comply with others' demands;
- Very high expectations of achievement.

Family Factors:

- A home environment where food, eating, weight or appearance have a disproportionate significance;
- An overprotective or over-controlling home environment;
- Poor parental relationships and arguments;
- Neglect or physical, sexual or emotional abuse;
- Overly high expectations of achievement.

Social Factors:

- Being bullied, teased or ridiculed due to weight or appearance;
- Pressure to maintain a high level of fitness requiring low body weight.

Warning Signs

Physical Signs (not exclusively associated with eating disorders)

- Weight loss;

- Dizziness, tiredness, fainting;
- Feeling cold;
- Hair becomes dull or lifeless;
- Swollen cheeks;
- Callused knuckles;
- Tension headaches;
- Sore throats / mouth ulcers;
- Tooth decay.

Behavioural Signs:

- Restricted eating;
- Skipping meals;
- Scheduling activities during lunch;
- Strange behaviour around food;
- Wearing baggy clothes;
- Wearing several layers of clothing.

Excessive chewing of gum/drinking of water

- Increased conscientiousness;
- Increasing isolation / loss of friends;
- Believes s/he is fat when s/he is not;
- Secretive behaviour;
- Visits the toilet immediately after meals.

Psychological Signs:

- Preoccupation with food;
- Sensitivity about eating;
- Denial of hunger despite lack of food;
- Feeling distressed or guilty after eating;
- Self-dislike;
- Fear of gaining weight;
- Moodiness;
- Excessive perfectionism.

Advice for staff

- School staff may become aware of warning signs which indicate a student is experiencing difficulties that may lead to an eating disorder. These warning signs should always be taken seriously and staff observing any of these warning signs should report concerns to the Safeguarding Team immediately as early treatment is vital.

- The Safeguarding Team will liaise with parents, counsellor and healthcare professionals (as agreed). Other staff members will be informed on a 'need to know' basis and subject to confidentiality obligations.
- Students with eating disorders/suspected eating disorders should NOT be weighed by any member of staff.

When an Eating Disorder is suspected:

- Students will be encouraged to speak to parents/guardians about any issues or concerns that have arisen;
- It is important that students understand the benefit of The Safeguarding Team speaking with parents in order to maintain continuity and support between home and school;
- Parents of day students will be advised to arrange an initial individual assessment with their GP;
- With permission from the student/parents, The Safeguarding Team may liaise with the student's GP to develop a treatment plan that will support the student both at home and school;
- Boarding students will be seen by their GP, who will support the development of a treatment plan alongside the Safeguarding Team. The Safeguarding Team will refer students to Child and Adolescent Mental Health services (CAMHS) where further treatment is needed;
- If the student refuses any parental notification/involvement, the on-going well-being of that student will be closely monitored and supported by The Safeguarding Team in school. However, if a developing eating disorder is clearly identified, this puts the student at risk and parents/guardians will almost certainly be informed;
- Students are encouraged to be a part of this process;
- When a student or parents are uncooperative and the School is unable to ensure the dietary health of the student whilst in school, The Safeguarding Team will meet to discuss future management;
- Full responsibility for the student's diet, health and well-being may fall to the parents, who will need to make satisfactory provision for that student's well-being;
- If provision is not made and deterioration is noted, safeguarding procedures will be followed.

Appendix 4 - Self-Harm

The School is committed to supporting the mental and emotional wellbeing of students who self-harm, recognising that self-harm is almost always a symptom of some underlying emotional or psychological issue.

What is self-harm?

Self-harm is any deliberate behaviour that inflicts physical harm on someone's own body and is aimed at relieving emotional distress. Self-harm may include:

- cutting themselves;
- scratching themselves;
- burning or scalding their body;
- banging and bruising themselves;
- scrubbing or scouring their body;
- deliberate bone-breaking;
- punching themselves;
- sticking things into their body;
- swallowing inappropriate objects or liquids;
- taking too many tablets (overdose);
- biting themselves;
- pulling their hair or eyelashes out;
- attempting to terminate an unwanted pregnancy.

Less obvious self-harm behaviours also include:

- controlled eating patterns – anorexia, bulimia, over-eating;
- indulging in risky behaviour / risky sexual behaviour, destructive use of drugs or alcohol;
- an unhealthy lifestyle;
- getting into fights.

Warning signs

Self-harm may present as visible or invisible signs. The latter can include ingested materials or cuts/ bruises under the clothing.

Warning signs may include:

- visible signs of injury (e.g. scarring);
- a change in dress habit that may be intended to disguise injuries (e.g. an unexpected / sudden change to wearing long sleeved tops);
- changes in eating or sleeping habits;
- increased isolation from friends or family; becoming socially withdrawn;

- changes in activity or mood (e.g. becoming more introverted or withdrawn);
- lowering of academic achievement;
- talking or joking about self-harm or suicide;
- abusing drugs or alcohol;
- expressing feelings of failure, uselessness or loss of hope;
- changes in clothing / image.

Links to emotional distress (including abuse)

- Those who self-harm are usually suffering emotional or psychological distress and it is vital that all such distress is taken seriously to assist in alleviating that distress or to minimise the risk of increasing distress and potential suicide.
- Any young person who suggests they are experiencing suicidal feelings must be taken seriously and safeguarding procedures put in place immediately**; a young person showing this level of distress must NOT be left unattended.**

Emotional/psychological risk factors associated with self-harm can include:

- Bullying;
- abuse – sexual, physical, emotional or through neglect;
- sudden changes in behaviour and/or academic performance;
- relationship difficulties (with family or friends);
- learning difficulties;
- pressure to achieve (from teachers or parents);
- substance abuse (including tobacco, alcohol or drugs);
- issues around sexuality.

Other causes or risk factors:

- inappropriate advice or encouragement from internet websites or chat-rooms;
- experimentation, 'dares' or bravado, 'copycat behaviour';
- concerns by a girl that she may be pregnant (including an attempt to terminate this);
- a history of abuse of self-harming in the family;
- parental separation;
- domestic abuse and/or substance misuse in the home;
- media influence;
- issues surrounding religious or cultural identity.

Staff action

- Staff, parents and fellow students may become aware of warning signs that might indicate that a student is experiencing difficulties that may lead to self-harm or suicide. Within the School, The Safeguarding Team work

in partnership when managing self-harm matters. Anybody concerned about a student must liaise with the The Safeguarding Team who will follow up with sensitivity, discretion and in line with the Safeguarding Policy.

Prevention

- The risk of self-harm can be significantly reduced by the creation of a supportive environment in which the individual's self-esteem is raised and healthy peer relationships are fostered.
- The School aims to achieve this through the development of good relationships by all members of the School community, effectively managing student issues and concerns, and through a PHSCE programme that fosters positive direction for students.

School Procedures for dealing with self-harm / mutilation

- If there is concern that a student may be self-harming or is thinking of self-harming, this should be reported to The Safeguarding Team immediately.
- The Designated Safeguarding Lead will liaise with The Safeguarding Team, and a plan put in place in line with school self-harm and safeguarding policy and procedures.
- If physical harm has occurred the student should be taken to the Matron's for medical assessment and care. (In an emergency an ambulance must be called.) Parents will be notified and will attend as soon as able.
- Students must not display open wounds/injuries in school - these must be dressed appropriately.
- The Safeguarding Team will monitor the young person and put a framework of intervention in place. This may include organising counselling for the student within School or supporting the student and their family by signposting or making contact with appropriate support agencies or organisations.
- In some cases self-harm may raise safeguarding issues, in which case the procedures laid down in the School's Safeguarding Policy must be followed.
- Where a student does not want parents informed, the decision about involving parents/guardians will be taken in consultation with The Safeguarding Team.
- Where the student is judged not to be Gillick competent, is considered to be at severe risk of harming themselves, or where severe self-harm requires medical intervention/A&E, parents/guardians will be informed directly. This will be discussed with the student beforehand. It is always better for the student to share information with parents/guardians so they can be at the centre of their care. Parents and guardians are encouraged to work in partnership with the School to support the student. If any member of staff has any concerns about confidentiality issues they should take advice from the safeguarding lead. Staff must not promise confidentiality, but reassure the student that only those people who need to know will be informed for their safety (See Safeguarding Policy).
- If a member of staff becomes aware of or is alerted to a self-harming issue, or a student discloses self-harm, s/he is advised to treat the matter as a safeguarding issue in the first instance and follow the procedures set

out in the Safeguarding Policy. It is safer to do this, even if the incident eventually turns out to be an isolated one that was not indicative of a serious underlying cause.

- If a student suggests that there is evidence of self-harm beneath his/her clothing, a member of staff should accept such statements and not ask the pupil to remove clothing to reveal wounds/bruises etc.
- Where a student who is self-harming is adversely affecting other students, they may be required to go home temporarily.

The first conversation

The sooner we encourage a young person to disclose their self-harm, the sooner we are able to provide or seek appropriate support to help them break the cycle. We can do so by passing our concerns on to a safeguarding office or by providing a safe space for the young person to talk to us.

The most supportive first conversation is one where:

- The young person is the sole focus of your attention;
- You spend most of your time listening, not talking;
- The young person tells their story, you never guess or assume;
- There is a feeling of acceptance and support, not judgement;
- Self-harm is not dismissed as attention seeking;
- Unrealistic promises are not made about confidentiality;
- This is recognised as the first step on a difficult journey;
- Clear next steps are identified and followed up promptly;
- You recognise how hard this conversation must be for the young person;
- You respond calmly – even if you don't feel calm.

When a young person isn't ready to talk

When a young person is more reluctant to disclose or discuss their self-harm, three important questions to consider are:

1. Who is the best person to have this conversation? You can use your knowledge of the young person, or ask them who they feel comfortable talking to;
2. How can you help the conversation flow? An informal environment or talking whilst carrying out another activity such as walking or drawing can really help;
3. Would another medium work better? Some young people feel happier talking via instant messenger, text or email – be creative and use your knowledge of the child.

If a young person still isn't ready to open up, provide them with details of anonymous sources of support and regularly revisit the situation.

Appendix 5 – other subsets including Conduct Disorders, ADHD, Attachment Disorders, Substance Misuse, Post-Traumatic Stress

Conduct Disorders

Examples of such disorders include defiance, aggression, anti-social behaviour, stealing and fire-setting. Overt behaviour problems often pose the greatest concern for practitioners and parents because of the level of disruption that can be created in the home, school and community. These problems may manifest themselves as verbal or physical aggression, defiance or antisocial behaviour. In the clinical field, depending on the severity and intensity of the behaviours, they may be categorised as Oppositional Defiant Disorder (a pattern of behavioural problems characterised chiefly by tantrums and defiance which are largely confined to family, school and peer group) or Conduct Disorder (a persistent pattern of antisocial behaviour which extends into the community and involves serious violation of rules).

ADHD (disturbance of activity and attention)

Around 4-14% of the child and adolescent population may experience behaviour problems. Many children with attention deficit hyperactivity disorder (ADHD) will also exhibit behaviour problems. Such problems are the most common reason for referral to mental health services for boys and the earlier the problems start, the more serious the outcome. There is, however, evidence to support the effectiveness of early intervention including effective policies and procedures on behaviour in schools. Girls with potential ADHD may present differently to boys in that they may be seen as lazy rather than behaviourally challenged.

Where particular problems have been identified the strongest evidence supports:

- working with the family is preferable, as therapeutic approaches are most effective when they look at the young person in the context of their family structure and work with all family members, even while intervening in the School;
- where this is impossible, individual work focusing on thoughts and behaviour can also be helpful;
- the more social systems engaged in a coordinated fashion by the intervention, the more effective the intervention is likely to be.

Although many children are inattentive, easily distracted or impulsive, in some these behaviours are exaggerated and persistent, compared with other children of a similar age and stage of development. When these behaviours interfere with a child's family and social functioning and with progress at school, they become a matter for professional concern.

Attention Deficit Hyperactivity Disorder (ADHD) is a diagnosis used by clinicians. It involves three characteristic types of behaviour:

- Inattention;

- Hyperactivity;
- Impulsivity.

Some children show signs of all three types of behaviour (this is called 'combined type' ADHD), other children diagnosed show signs only of inattention or hyperactivity / impulsiveness. ADD (attention deficit disorder) is more often seen in girls who do not demonstrate hyperactivity. The core symptoms must have been present before the age of seven and must be evident in two or more settings, in order for diagnoses to be made.

The strongest evidence supports:

Parent Education Programmes

- Use of medication where ADHD is diagnosed and other reasons for the behaviour have been excluded. These treatments have few side-effects (but if present can have detrimental effects on growth) and are effective in 75% of cases when there is no low mood or anxiety accompanying the ADHD. High doses can be avoided if behavioural treatments accompany the medication.
- Behavioural interventions, especially if anxiety is also present.

For children also presenting with conduct difficulties, Tourette's syndrome, and social communication disorders, appropriate psychosocial treatments may also be considered by medical professionals.

Attachment Disorders

Positive Attachment is the bond children have with special people in their lives that leads them to feel pleasure when they interact with them and be comforted by their nearness during times of stress. Researchers generally agree that there are four main factors that influence attachment security:

- An opportunity to establish a close relationship with a primary caregiver;
- The quality of caregiving;
- The child's characteristics;
- The family context.

Secure attachment is an important protective factor for mental health later in childhood, while attachment insecurity is widely recognised as a risk factor for the development of behavioural and other mental health problems.

Substance Misuse

Substance misuse can result in physical or emotional harm. It can lead to problems in relationships, at home and at work. In the clinical field, a distinction is made between substance misuse (where use leads to personal harm) and substance dependence (where there is a compulsive pattern of use that takes precedence over other activities).

It is important to distinguish between young people who are experimenting with substances and fall into problems, and young people who are at high risk of long-term dependency. This first group will benefit from a brief, recovery-oriented programme focusing on cognitions and behaviour to prevent them moving into more serious use. The second group will require ongoing support and assessment, with careful consideration of other concurrent mental health issues.

The strongest evidence supports:

- Therapeutic approaches which involve the family rather than just the individual; this assists communication, problem-solving, becoming drug-free and planning for relapse prevention. These approaches are especially helpful with low-level substance users, and when combined with cognitive-behavioural therapy or treatments focusing on motivation.

Evidence also supports:

- The introduction of programmes delivered in schools and which focus on developing skills that enhance resilience as a preventative measure, as substance abuse is connected to other problems that can be addressed within these settings.

Post-traumatic stress

If a child experiences or witnesses something deeply shocking or disturbing, they may have a traumatic stress reaction. This is a normal way of dealing with shocking events and it may affect the way the child thinks, feels and behaves. If these symptoms and behaviours persist, and the child is unable to come to terms with what has happened, then clinicians may make a diagnosis of post-traumatic stress disorder (PTSD).

The strongest evidence supports:

- Therapeutic support which is focused on the trauma and which addresses cognition and behaviour, especially regarding sexual trauma, and some can be delivered in schools such as *Trauma and grief component therapy* and *Cognitive Behavioural Intervention for Trauma in Schools* (CBITS). Trauma focused CBT should be adapted appropriately to suit age, circumstances and level of development.

The evidence specifically does <u>not</u> support:

- Prescription of drug treatments for children and young people with PTSD;
- The routine practice of 'debriefing' immediately following a trauma.

Appendix 6 – Risk Assessment Exemplar

For a pupil with anger management issues

Risk category	Detail	Actions to reduce risk	Consequences
To themselves in school	Self-harm and low self-esteem	The pupil must see someone appropriate in The Safeguarding Team.	Safety plan written and action points followed. Review date set.
	Underachievement in academic work and co-curricular	Increase in one to one help either from within the house or from teachers	Formal support offered in school. Teachers are emailed with broad details of the issue and, if required, one to one support put in place
	Flight - May choose to leave the School without permission or knowledge	Pupil must be encouraged to let someone know where they are	All teachers informed Safety plan agreed with student and parents
To others in school	Physical or emotional harm to others	The pupil must see someone appropriate in The Safeguarding Team.	Safety plan written and action points followed. Review date set.
	Age and physical size to be considered	Ensure appropriate supervision is offered until the safety plan is complete	Formal time: teachers are made aware and safe place arrangements are agreed Informal time: appropriate supervision put in place such as around the school
		Offer safe place for the student where they find personal space	Communication from the student to adults is agreed e.g. if using the safe place the student will email relevant staff to inform them
		Seek the view of others within the peer group.	This will be built into the safety plan and action points agreed

For a Pupil with suicidal thoughts

Risk category	Detail	Actions to reduce risk	Consequences
To themselves in school	Self-harm and low self-esteem	The pupil must see someone appropriate in The Safeguarding Team. If appropriate, mental health nurse to liaise with CAMHS	Safety plan written and action points followed. Review date set. Care plan put in place which could include counsellors, CAHMS Parents informed
	Underachievement in academic work and co-curricular	Increase in one to one help from teachers	Formal support offered in school. Teachers are emailed with broad details of the issue and, if required, one to one support put in place
	Flight - May choose to leave the School without permission or knowledge	Protective factors: discussion with student and people they trust to consider the protective factors which will support them	All teachers informed Safety plan agreed with student and parents Communication strategy agreed between the pupil and the School i.e. who they would talk to if they are worried about putting themselves at risk Written into the safety plan
To others in school	Physical or emotional harm to others	The pupil must see someone appropriate in The Safeguarding Team. Ensure appropriate supervision is offered until the safety plan is complete Offer safe place for the student where they find personal space Other students who may be affected by the behaviour are given support	Safety plan written and action points followed. Review date set. Formal time: teachers are made aware and safe place arrangements are agreed Informal time: appropriate supervision put in place around school. Communication from the student to adults is agreed e.g. if using the safe place the student will email relevant staff to inform them This will be built into the safety plan and action points agreed

Appendix 7 – Counselling at St John's School

The way for a student to see a counsellor:

To get a referral, staff or pupils must go through The Safeguarding Team.

If The Safeguarding Team concludes counselling is appropriate they will liaise directly with parents and the counsellor who will invite the student in for an appointment.

Periodically a member of the Safeguarding Team will meet with the counsellor to help review how the counselling sessions are progressing and, if appropriate, act as a communication hub between counsellor and other pastoral leads. This will also allow them to have an overview of the current capacity and demand of the counsellor's time.

The focus within counselling is to empower and build personal resilience in young people in the hope that a number of sessions (perhaps 5-6 sessions) will then enable the student to return to other support systems at school and at home.

If a student needs more than 5-6 sessions then the counsellor will talk this through with The Safeguarding Team in their meetings: the review process is a critical part of this whole process.

Appendix 8 – Mental Health Questions to use with a student

A useful set of questions for a member of staff to use

Are you feeling anxious or worried?
Are you feeling sad?
How is your sleep/how is your energy?
Do you prefer to stay in rather than going out and doing new things?
Are you feeling guilt-ridden?
Are you feeling irritable and intolerant of others?
Do you have no motivation or interest in things?
Are you finding it difficult to make decisions?
Are you having or have you thought about harming yourself?
Are you having difficulties in your home and family life?
What would you like to happen?
OK, what out of that list do you have the power to change?
Who can help with that?
How much time are you spending thinking about that?
What is the worst that can happen?
Now, crucially, what is the best that can happen?
What advice would you give to a friend who came to you with this dilemma?
In the past two weeks, how often have you felt down or low mood?

If you have concerns that the pupil is at risk of significant harm – for example, serious self-harm – then the member of staff should follow safeguarding protocols and ensure they are assessed by a trained practitioner.