Student Mental Health & Wellbeing Policy

This is a Trust-Wide Schools Policy

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Owner of Policy:	**Director of Teaching School & Partnerships**
Authorised By:	**Executive Management Team**
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Distribution:	**All Staff**

Student Mental Health & Wellbeing Policy

Mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. (World Health Organisation)

At BFET, we aim to promote positive mental health and wellbeing for every member of our school communities. Wellbeing is valued and we actively promote it. We pursue this aim using universal, targeted and specialist approaches aimed at vulnerable students. In addition to promoting positive mental health and wellbeing, we aim to recognise and respond to mental ill health. According to MHFA England and MIND, in an average classroom, three students will be suffering from a diagnosable mental health difficulty. One in ten young people between the ages of 5 and 16 will have an identifiable mental health difficulty at any one time. By the time they reach university this figure is as high as 1 in 6. Around 75% of mental health disorders are diagnosed in adolescence (see Appendix A for more data around mental health and wellbeing). By developing and implementing practical, relevant and effective mental health and wellbeing policies and procedures, we can promote a safe and stable environment for students affected both directly, and indirectly, by mental ill health. We also recognise the link between physical activity and positive mental health and wellbeing, and we encourage our schools to be 'active schools'.

What is this Policy for?

This document describes the trust's approach to promoting positive mental health and wellbeing. The policy is about student mental health but of course staff mental health and wellbeing is inter-related and the two go hand in hand. Positive wellbeing affects schools culture. This policy is intended as guidance for all staff including support staff and governors. This policy should be read in conjunction with the Trust's: E-Safety policy; Supporting students with Medical Conditions policy, in cases where students' mental health difficulties overlap with or are linked to a medical condition; the 'SEND' policy, in cases where a student has an identified special educational need; and, 'Safeguarding' Policy, in cases where there is a specific requirement for this. Schools should also read this policy in conjunction with their Anti Bullying policy, PHSE policy and SCHOOLS CAN MAKE REFRERENCE TO THEIR OWN POLICIES AS APPROPIRATE IN THIS SECTION EG: SELF HARM. BFET is committed to ensuring the wellbeing of staff and students. It is expected that all staff and students are able to contribute to own their own wellbeing as well as contribute to the wellbeing of others.

This policy sets out the framework for a clear and consistent Mental Health and Wellbeing provision by:

- Promoting positive mental health and wellbeing in all staff and students
- Increasing understanding and awareness of common mental health difficulties
- Alerting staff to early warning signs of mental ill health
- Providing support to staff working with young people with mental health difficulties
- Providing support to students suffering mental ill health and their peers and parents/carers
- Promoting physical activity and resilience

Who is this policy for?

All staff and Governors.

1. Policy Standards

1. Lead Members of Staff

1.1 Designated Safeguarding Lead (DSL)
1.2 SENDCo
1.2 Mental Health Lead/Wellbeing Lead
1.3 Mental Health First Aiders
1.4 Head of PSHE

Any member of staff who is concerned about the mental health and/ or wellbeing of a student should speak to the student in the same way they would support students with any kind of concern. If they are willing to share information: it is important to notify the student that this information may need to be passed on to a Pastoral Lead/ Safeguarding Team/ Mental Health First Aider. If there is a fear that the student is in danger of immediate harm then the normal safeguarding procedures should be followed. If the student presents a medical emergency then the normal procedures for medical emergencies should be followed, including alerting the first aid staff and contacting the emergency services if necessary.

2. Supportive documentation

It is helpful to document the support given to students with mental health difficulties. There are a number of documents that could be used depending on the nature of students' mental health difficulties, including:

- Access to Learning Plans (see Appendix B) – Used to summarise students' needs and supportive strategies that can enable their access to the curriculum;
- Risk Assessments – Used to manage any risks associated with students' mental health difficulties, including risks to themselves and others;
- Individual Care Plans – Used to support students with more complex mental health difficulties that overlap with, or are linked to, a diagnosable medical condition that may require medication.

Any supportive documentation should be drawn up involving the student, parents/ carers and relevant health professionals, and should centre on the role that the school can play in supporting students' mental health difficulties.

3. Teaching about Mental Health and Wellbeing

The skills, knowledge and understanding needed by our students to keep themselves and others physically and mentally healthy and safe are included as part of our PSHE curriculum. The specific content of lessons will be determined by the age and specific needs of the cohort being taught but there will always be an emphasis on enabling students to develop the skills, knowledge, understanding, language and confidence to seek help, as needed, for themselves or others.

We will follow the PSHE Association Guidance[1] to and other relevant guidance/ advice (see Appendix C) ensure that we teach students about mental health and wellbeing, and how it can fluctuate between both positive and negative. Where possible we try to embed Mindfulness into curriculum or enrichment time. We also ensure staff understand how important resilience is and provide opportunities to develop this.

We will ensure that staff, students and parents/carers are aware of sources of support within school and in the local community. What support is available within our school and local community, who it is aimed at and how to access it is outlined in Appendix D.

We will display relevant sources of support in communal areas such as corridors, dining room, assembly hall, Library and toilets, and will regularly highlight sources of support to students within relevant parts of the curriculum. Whenever we highlight sources of support, we will increase the chance of student help-seeking by ensuring students understand:

- What help is available
- Who the help is aimed at

[1] Teacher Guidance: Preparing to teach about mental health and emotional wellbeing

- How to access help
- Why it is helpful to access help
- What is likely to happen next

4. Warning Signs

School staff may become aware of warning signs which indicate a student is experiencing mental health or wellbeing difficulties. These warning signs should **always** be taken seriously and staff observing any of these warning signs should communicate their concerns with the mental health and wellbeing lead, SENDCo and the relevant safeguarding/pastoral staff.

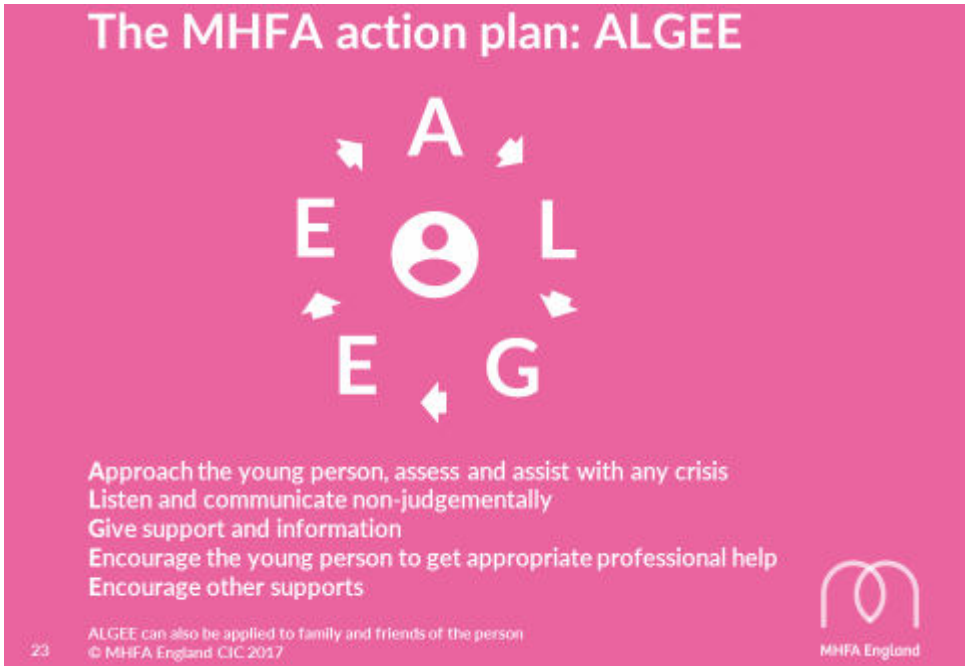
Possible warning signs include:

- Physical signs of harm that are repeated or appear non-accidental
- Changes in eating / sleeping habits
- Increased isolation from friends or family, becoming socially withdrawn
- Changes in activity and mood
- 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 – e.g. long sleeves in warm weather
- Secretive behaviour
- Skipping PE or getting changed secretively
- Lateness to or absence from school
- Repeated physical pain or nausea with no evident cause
- An increase in lateness or absenteeism

Please see Appendix E for Risk Factor Table taken from MHFA England

*A number of these raise safeguarding issues so should always be followed up by the safeguarding route.

5. Concerns



Do not speak about your conversation or concerns with other students / casually to a member of staff.
Access support for yourself if you need it via a senior colleague or your line manager.

Are there any safeguarding concerns? If yes, follow safeguarding policy

High Risk
If you consider the young person to be at risk then you should follow safeguarding procedures and report your concerns directly to the DSL

The DSL/pastoral lead will decide on the appropriate course of action. This may include:
Contacting parents / carers
Arranging professional assistance e.g. doctor/nurse
Referral to SENDCo/ Mental Health First Aider
Arranging an appointment with a counsellor
BFET TaSS Team referral (via SENDCo)
Arranging a referral to CAMHS – with parental consent (see Appendix G for advice)
Giving advice to parents / carers, teachers and other students

Supportive documentation

Low Risk
If you feel that the young person needs a period of 'watchful waiting' communicate this to the tutor/ Class Teacher/ SENDCo

The teacher should pass on the information to the pastoral lead who will instigate the appropriate time period of watchful waiting (up to 4 weeks). Staff should ensure good communication with any agencies involved

A student with continuing symptoms should be referred to the school counsellor/ Mental Health First Aider/ Pastoral Lead for on-going support. If symptoms persist, refer to CAMHS and or BFET TaSS Team (via SENDCo)

6. Confidentiality

We must be honest with regards to confidentiality. If it is necessary for us to pass our concerns about a student on then we should discuss with the student:

- Who we are going to talk to
- What we are going to tell them
- Why we need to tell them

We should never share information about a student without first telling them. Ideally we would receive their consent, though there are certain situations when information must always be shared with another member of staff and / or a parent/carer, such as students who we believe to be in danger of harm.

It is always advisable to share disclosures with a colleague, usually the Safeguarding / Mental Health Lead as this helps to safeguard our own emotional wellbeing as we are no longer solely responsible for the student, it ensures continuity of care in our absence and it provides an extra source of ideas and support. We should explain this to the student and discuss with them who it would be most appropriate and helpful to share this information with. And, if we believe there are safeguarding concerns, you must follow that referral route.

Parents / carers must always be informed if it is deemed necessary and appropriate by the Principal or Safeguarding Team and students may choose to tell their parents / carers themselves. If this is the case, the student should be given 24 hours to share this information before the school contacts parents / carers. We should always give students the option of us informing parents / carers for them or with them. Of course, we need to consider the level of urgency and if the child is at immediate risk of significant harm.

We should never share information about a student without first telling them. We should always aim to seek the student's consent to share information, however, information must be shared when the student is believed to be in danger of harm. For sharing information about students aged 18 or more please refer to your safeguarding policy.

7. Working with Parents/Carers

Where it is deemed appropriate to inform parents / carers, we need to be sensitive in our approach. Before disclosing to parents / carers we should consider the following questions (on a case by case basis):

- Can the meeting happen face to face? This is preferable.

- Where should the meeting happen? At school, at their home or somewhere neutral?
- Who should be present? Consider parents/carers, the student, other members of staff.
- What are the aims of the meeting?
- We also need to consider staff safety concerns

It can be shocking and upsetting for parents/carers to learn of their child's difficulties and many may respond with anger or fear, or become upset during the first conversation. We should be accepting of this (within reason) and give the parent/carer time to reflect. We will always highlight further sources of information and give them leaflets to take away where possible. Sharing sources of further support aimed specifically at parents/carers can also be helpful too e.g. helplines and forums as listed in Appendix G. We will always provide clear means of contacting us with further questions and consider booking in a follow up meeting or phone call right away as parents/carers often have many questions as they process the information. Each meeting will be finished with agreed next steps and a brief record of the meeting on the student's record will always be kept.

8. Working with All Parents / Carers

Parents/Carers are often very welcoming of support and information from the school about supporting their children's mental health and wellbeing. In order to support parents/carers, we will:

- Highlight sources of information and support about common mental health difficulties on our school website
- Ensure that all parents/carers are aware of who to talk to, and how to get about this, if they have concerns about their own child or a friend of their child
- Make our Mental Health and Wellbeing Policy easily accessible to parents/carers
- Share ideas about how parents/carers can support positive mental health and wellbeing in their children through our regular information evenings
- Keep parents/carers informed about the mental health and wellbeing topics that their children are learning about in PSHE and share ideas for extending and exploring this learning at home

9. Supporting Peers

When a student is experiencing mental health difficulties, it can be a difficult time for their friends. Friends often want to support but do not know how and can take on more of a supportive role than is appropriate. In the case of self-harm or eating disorders, it is possible that friends may learn unhealthy coping mechanisms from each other. In order to keep peers safe, we will consider on a case by case basis which friends may need additional support. Support will be provided either in one to one or group settings and will be guided by conversations by the student experiencing difficulties and their parents/carers.

We will consider:

- What it is helpful for friends to know and what they should not be told
- How friends can offer support
- Boundaries between support from friends and support from adults
- Things friends should avoid doing / saying which may inadvertently cause upset
- Warning signs that their friend help (e.g. signs of relapse)

Additionally, we will want to highlight with peers:

- Where and how to access support for themselves
- Safe sources of further information about their friend's condition
- Healthy ways of coping with the difficult emotions they may be feeling

10. Training

As a minimum, at least two staff will complete the two day Mental Health First Aid course with our Teaching School and be 'MH First Aiders', staff will receive regular training about recognising and responding to mental health difficulties as part of their regular safeguarding training in order to enable them to keep students safe.

Further training opportunities for staff who require more in depth knowledge will be considered as part of our performance management process and additional CPD will be supported throughout the year where it becomes appropriate due to developing situations with one or more students.

Suggestions for individual, group or whole school CPD should be discussed with the school CPD Lead and the Director of Teaching School and Partnerships who can also highlight sources of relevant training and support for individuals as needed.

Appendix A: Data Sources

- Children and young people's mental health and wellbeing profiling tool collates and analyses a wide range of publically available data on risk, prevalence and detail (including cost data) on those services that support children with, or vulnerable to, mental illness. It enables benchmarking of data between areas
- ChiMat school health hub provides access to resources relating to the commissioning and delivery of health services for school children and young people and its associated good practice, including the new service offer for school nursing
- Health behaviour of school age children is an international cross-sectional study that takes place in 43 countries and is concerned with the determinants of young people's health and wellbeing.

Pen Portrait

Name	Class/Form	Data	Data	Data
DOB	Area of Need	Data	Data	Data

Additional Need

Things that help me (classroom strategies)

photo

Interventions and additional provision

Desired Outcomes	How will this be measured?	
		Term 1
		Term 2
		Term 3

Appendix C: Guidance and advice documents

- PSHE Association : Preparing to Teach about Mental Health and Emotional Wellbeing – PSHE Association teacher guidance funded by the Department for Education (March 2015)
- Mental health and behaviour in schools - departmental advice for school staff. Department for Education (2014)
- Counselling in schools: a blueprint for the future - departmental advice for school staff and counsellors. Department for Education (2015)
- Teacher Guidance: Preparing to teach about mental health and emotional wellbeing (2015). PSHE Association. Funded by the Department for Education (2015)
- Keeping children safe in education - statutory guidance for schools and colleges. Department for Education (2014)
- Supporting pupils at school with medical conditions - statutory guidance for governing bodies of maintained schools and proprietors of academies in England. Department for Education (2014)
- Healthy child programme from 5 to 19 years old is a recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. Department of Health (2009)
- Future in mind – promoting, protecting and improving our children and young people's mental health and wellbeing - a report produced by the Children and Young People's Mental Health and Wellbeing Taskforce to examine how to improve mental health services for children and young people. Department of Health (2015)
- NICE guidance on social and emotional wellbeing in primary education
- NICE guidance on social and emotional wellbeing in secondary education
- What works in promoting social and emotional wellbeing and responding to mental health problems in schools? Advice for schools and framework document written by Professor Katherine Weare. National Children's Bureau (2015)
- CAMHS - Self-harm in children and young people handbook (National Workforce Programme) - designed to provide basic knowledge and awareness of the facts and difficulties behind self-harm in children and young people, with advice about ways staff in children's services can respond.
- How to Thrive – Specialists in practical resilience training in schools
- Academic Resilience Resources and Auditing Tool – Young Minds

Appendix D: Sources or support at school and in the local community

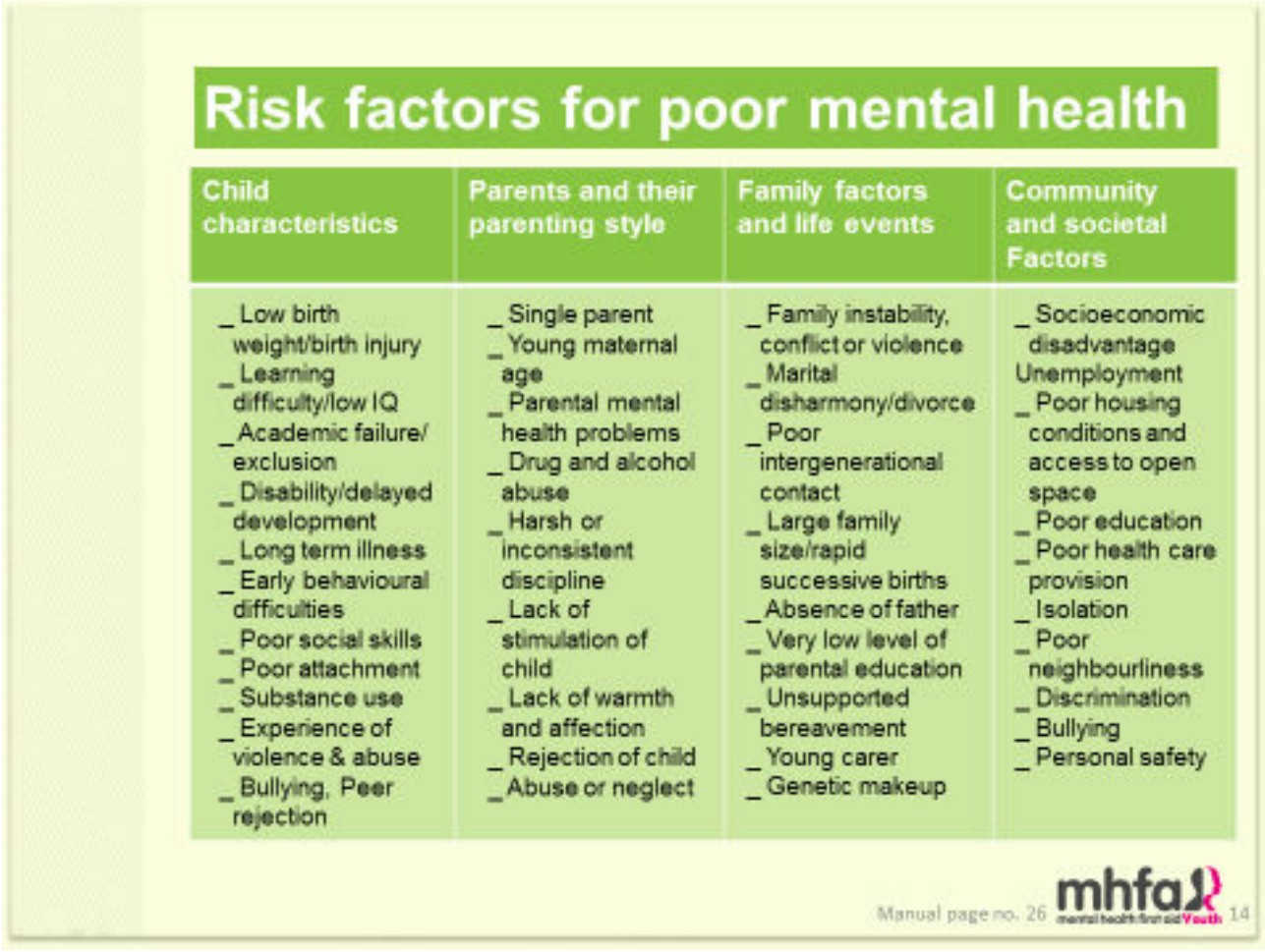
School Based Support

EACH SCHOOL TO FILL THIS BIT IN AS IT IS BESPOKE-SUGGESTIONS BELOW

- School Website area?

- BFET TaSS Team
- School Health Team – School Nurse, Providing support for those who need it most via confidential drop-in sessions:
- Keeping Healthy/Immunisations
- Emotional Health
- Weight Management
- Sexual Health
- Drugs, Alcohol & Substance Misuse support
- Smoking support

Appendix E: Mental Health Risk Factors



Risk factors for poor mental health

Child characteristics	Parents and their parenting style	Family factors and life events	Community and societal Factors
_ Low birth weight/birth injury _ Learning difficulty/low IQ _ Academic failure/ exclusion _ Disability/delayed development _ Long term illness _ Early behavioural difficulties _ Poor social skills _ Poor attachment _ Substance use _ Experience of violence & abuse _ Bullying, Peer rejection	_ Single parent _ Young maternal age _ Parental mental health problems _ Drug and alcohol abuse _ Harsh or inconsistent discipline _ Lack of stimulation of child _ Lack of warmth and affection _ Rejection of child _ Abuse or neglect	_ Family instability, conflict or violence _ Marital disharmony/divorce _ Poor intergenerational contact _ Large family size/rapid successive births _ Absence of father _ Very low level of parental education _ Unsupported bereavement _ Young carer _ Genetic makeup	_ Socioeconomic disadvantage Unemployment _ Poor housing conditions and access to open space _ Poor education _ Poor health care provision _ Isolation _ Poor neighbourliness _ Discrimination _ Bullying _ Personal safety

Manual page no. 26 mhfa Youth 14

Appendix F: Talking to students when they disclose mental health difficulties

The advice below is from students themselves, in their own words, together with some additional ideas to help you in initial conversations with students when they disclose mental health difficulties. This advice should be considered alongside relevant school policies on pastoral care and child protection and discussed with relevant colleagues as appropriate.

Focus on listening

> *"She listened, and I mean REALLY listened. She didn't interrupt me or ask me to explain myself or anything, she just let me talk and talk and talk. I had been unsure about talking to anyone but I knew quite quickly that I'd chosen the right person to talk to and that it would be a turning point."*

If a student has come to you, it's because they trust you and feel a need to share their difficulties with someone. Let them talk. Ask occasional open questions if you need to in order to encourage them to keep exploring their feelings and opening up to you. Just letting them pour out what they're thinking will make a huge difference and marks a huge first step in recovery. Up until now they may not have admitted even to themselves that there is a problem.

Don't talk too much

> *"Sometimes it's hard to explain what's going on in my head – it doesn't make a lot of sense and I've kind of gotten used to keeping myself to myself. But just 'cos I'm struggling to find the right words doesn't mean you should help me. Just keep quiet, I'll get there in the end."*

The student should be talking at least three quarters of the time. If that's not the case then you need to redress the balance. You are here to listen, not to talk. Sometimes the conversation may lapse into silence. Try not to give in to the urge to fill the gap, but rather wait until the student does so. This can often lead to them exploring their feelings more deeply. Of course, you should interject occasionally, perhaps with questions to the student to explore certain topics they've touched on more deeply, or to show that you understand and are supportive. Don't feel an urge to over-analyse the situation or try to offer answers. This all comes later. For now your role is simply one of supportive listener. So make sure you're listening!

Don't pretend to understand

> *"I think that all teachers got taught on some course somewhere to say 'I understand how that must feel' the moment you open up. YOU DON'T – don't even pretend to, it's not helpful, it's insulting."*

The concept of a mental health difficulty such as an eating disorder or obsessive compulsive disorder (OCD) can seem completely alien if you've never experienced these difficulties first hand. You may find yourself wondering why on earth someone would do these things to themselves, but don't explore those feelings with the sufferer. Instead listen hard to what they're saying and encourage them to talk and you'll slowly start to understand what steps they might be ready to take in order to start making some changes.

Don't be afraid to make eye contact

> *"She was so disgusted by what I told her that she couldn't bear to look at me."*

It's important to try to maintain a natural level of eye contact (even if you have to think very hard about doing so and it doesn't feel natural to you at all). If you make too much eye contact, the student may interpret this as you staring at them. They may think that you are horrified about what they are saying or think they are a 'freak'. On the other hand, if you don't make eye contact at all then a student may interpret this as you being disgusted by them – to the extent that you can't bring yourself to look at them. Making an effort to maintain natural eye contact will convey a very positive message to the student.

Offer support

> *"I was worried how she'd react, but my Mum just listened then said 'How can I support you?' – no one had asked me that before and it made me realise that she cared. Between us we thought of some really practical things she could do to help me stop self-harming."*

Never leave this kind of conversation without agreeing next steps. These will be informed by your conversations with appropriate colleagues and the schools' policies on such difficulties. Whatever happens, you should have some form of next steps to carry out after the conversation because this will help the student to realise that you're working with them to move things forward.

Acknowledge how hard it is to discuss these difficulties

> *"Talking about my bingeing for the first time was the hardest thing I ever did. When I was done talking, my teacher looked me in the eye and said 'That must*

have been really tough' – he was right, it was, but it meant so much that he realised what a big deal it was for me."

It can take a young person weeks or even months to admit they have a problem to themselves, let alone share that with anyone else. If a student chooses to confide in you, you should feel proud and privileged that they have such a high level of trust in you. Acknowledging both how brave they have been, and how glad you are they chose to speak to you, conveys positive messages of support to the student.

Don't assume that an apparently negative response is actually a negative response

"The anorexic voice in my head was telling me to push help away so I was saying no. But there was a tiny part of me that wanted to get better. I just couldn't say it out loud or else I'd have to punish myself."

Despite the fact that a student has confided in you, and may even have expressed a desire to get on top of their illness, that doesn't mean they'll readily accept help. The illness may ensure they resist any form of help for as long as they possibly can. Don't be offended or upset if your offers of help are met with anger, indifference or insolence, it's the illness talking, not the student.

Never break your promises

"Whatever you say you'll do you have to do or else the trust we've built in you will be smashed to smithereens. And never lie. Just be honest. If you're going to tell someone just be upfront about it, we can handle that, what we can't handle is having our trust broken."

Above all else, a student wants to know they can trust you. That means if they want you to keep their information confidential and you can't then you must be honest. Explain that, whilst you can't keep it a secret, you can ensure that it is handled within the school's policy of confidentiality and that only those who need to know about it in order to help will know about the situation. You can also be honest about the fact you don't have all the answers or aren't exactly sure what will happen next. Follow our policies.

Appendix G: What makes a good CAMHS/Mental Health referral?[2]

Schools in different areas have different referral processes and refer to different places eg: Place 2 Be / Place 2 Talk, but this general advice should be useful.

General considerations

- Have you met with the parent(s) / carer(s) and the referred child / children?
- Has the referral to CAMHS been discussed with a parent / carer and the referred student?
- Has the student given consent for the referral?
- Has a parent / carer given consent for the referral?
- What are the parent / carer / student attitudes to the referral?
- Is Educational Psychology involvement required in order for the CAMHS referral to be accepted?
- Is the SENDCo involved? (N.B.: Social and emotional wellbeing, and mental health difficulties is a category of need within the SEND Code of Practice)

Basic information

- Is there a child protection plan in place?
- Is the child looked after?
- Name and date of birth of referred child / children
- Address and telephone number
- Who has parental responsibility?
- Surnames if different to child's
- GP details
- What is the ethnicity of the student / family?
- Will an interpreter be needed?
- Are there other agencies involved?

Reason for referral

- What are the specific difficulties that you want CAMHS to address?
- How long has this been a problem and why is the family seeking help now?
- Is the problem situation-specific or more generalised?
- Your understanding of the problem/difficulties involved.

Further helpful information

- Who else is living at home and details of separated parents / carers if appropriate?
- Name of school
- Who else has been or is professionally involved and in what capacity?
- Has there been any previous contact with our department?
- Has there been any previous contact with social services?
- Details of any known protective factors
- Any relevant history i.e. family, life events and / or developmental factors
- Are there any recent changes in the student's or family's life?
- Are there any known risks, to self, to others or to professionals?
- Is there a history of developmental delay e.g. speech and language delay?
- Are there any symptoms of ADHD / ASD and if so have you talked to the Educational psychologist?

The screening tool on the following page will help to guide whether or not a CAMHS referral is appropriate.

Screening Tool

	INVOLVEMENT WITH CAMHS
	Current CAMHS involvement
	Previous history of CAMHS involvement
	Previous history of medication for mental health issues
	Any current medication for mental health issues
	Developmental issues e.g. ADHD, ASD, LD

	DURATION OF DIFFICULTIES
	1-2 weeks
	Less than a month
	1-3 months
	More than 3 months
	More than 6 months

*** Ask for consent to telephone CAMHS clinic for discussion with clinician involved in young person's care**

Tick the appropriate boxes to obtain a score for the young person's mental health needs.

		MENTAL HEALTH SYMPTOMS
	1	Panic attacks (overwhelming fear, heart pounding, breathing fast etc.)
	1	Mood disturbance (low mood – sad, apathetic; high mood – exaggerated / unrealistic elation)
	2	Depressive symptoms (e.g. tearful, irritable, sad)
	1	Sleep disturbance (difficulty getting to sleep or staying asleep)
	1	Eating issues (change in weight / eating habits, negative body image, purging or binging)
	1	Difficulties following traumatic experiences (e.g. flashbacks, powerful memories, avoidance)
	2	Psychotic symptoms (hearing and / or appearing to respond to voices, overly suspicious)
	2	Delusional thoughts (grandiose thoughts, thinking they are someone else)
	1	Hyperactivity (levels of overactivity & impulsivity above what would be expected; in all settings)
	2	Obsessive thoughts and/or compulsive behaviours (e.g. hand-washing, cleaning, checking)

Impact of above symptoms on functioning - circle the relevant score and add to the total

Little or none	Score = 0	Some	Score = 1	Moderate	Score = 2	Severe	Score = 3

		HARMING BEHAVIOURS
	1	History of self harm (cutting, burning etc)
	1	History of thoughts about suicide
	2	History of suicidal attempts (e.g. deep cuts to wrists, overdose, attempting to hang self)
	2	Current self harm behaviours
	2	Anger outbursts or aggressive behaviour towards children or adults
	5	Verbalised suicidal thoughts* (e.g. talking about wanting to kill self / how they might do this)
	5	Thoughts of harming others* or actual harming / violent behaviours towards others

*** If yes – call CAMHS team to discuss an urgent referral and immediate risk management strategies**

	Social setting - for these situations you may also need to inform other agencies (e.g. Child Protection)			
	Family mental health issues			Physical health issues
	History of bereavement/loss/trauma			Identified drug / alcohol use
	Problems in family relationships			Living in care

	Problems with peer relationships		Involved in criminal activity
	Not attending/functioning in school		History of social services involvement
	Excluded from school (FTE, permanent)		Current Child Protection concerns

How many social setting boxes have you ticked? Circle the relevant score and add to the total

0 or 1	Score = 0	2 or 3	Score = 1	4 or 5	Score = 2	6 or more	Score = 3

Add up all the scores for the young person and enter into Scoring table:

Score 0-4	Score 5-7	Score 8+
Give information/advice to the young person	Seek advice about the young person from CAMHS Primary Mental Health Team	Refer to CAMHS clinic

***** If the young person does not consent to you making a referral, you can speak to the appropriate CAMHS service anonymously for advice *****

Appendix H: Further information and sources of support about common mental health difficulties

Prevalence of Mental Health difficulties[3]

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class.
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.
- There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%.
- More than half of all adults with mental health difficulties were diagnosed in childhood. Less than half received appropriate treatment at the time.
- Nearly 80,000 children and young people suffer from severe depression.
- The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.
- Over 8,000 children aged under 10 years old suffer from severe depression.
- 3.3% or about 290,000 children and young people have an anxiety disorder.
- 72% of children in care have behavioural or emotional problems - these are some of the most vulnerable people in our society.

Below is sign-posted information and guidance about the mental health difficulties most commonly seen in school-aged children. The links will take you through to the most relevant page of the listed website. Some pages are aimed primarily at parents / carers but they are listed here because they are useful for school staff too.

Support and information related to all these difficulties can be accessed via Young Minds (www.youngminds.org.uk), Mind (www.mind.org.uk) and (for e-learning opportunities) Minded (www.minded.org.uk).

Self-harm

Self-harm describes any behaviour where a young person causes harm to themselves in order to cope with thoughts, feelings or experiences they are not able to manage in any other way. It most frequently takes the form of cutting, burning or non-lethal overdoses in adolescents, while younger children and young people with special needs are more likely to pick or scratch at wounds, pull out their hair or bang or bruise themselves.

Online support

- SelfHarm.co.uk: www.selfharm.co.uk
- National Self-Harm Network: www.nshn.co.uk

[3] Source: Young Minds

Books

- Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers
- Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers
- Carol Fitzpatrick (2012) *A Short Introduction to Understanding and Supporting Children and Young People Who Self-Harm*. London: Jessica Kingsley Publishers

Depression

Ups and downs are a normal part of life for all of us, but for someone who is suffering from depression these ups and downs may be more extreme. Feelings of failure, hopelessness, numbness or sadness may invade their day-to-day life over an extended period of weeks or months, and have a significant impact on their behaviour and ability and motivation to engage in day-to-day activities.

Online support

- Depression Alliance: www.depressionalliance.org/information/what-depression

Books

- Christopher Dowrick and Susan Martin (2015) *Can I Tell you about Depression?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Anxiety, panic attacks and phobias

Anxiety can take many forms in children and young people, and it is something that each of us experiences at low levels as part of normal life. When thoughts of anxiety, fear or panic are repeatedly present over several weeks or months and/or they are beginning to impact on a young person's ability to access or enjoy day-to-day life, intervention is needed.

Online support

- Anxiety UK: www.anxietyuk.org.uk

Books

- Lucy Willetts and Polly Waite (2014) *Can I Tell you about Anxiety?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers
- Carol Fitzpatrick (2015) *A Short Introduction to Helping Young People Manage Anxiety*. London: Jessica Kingsley Publishers

Obsessions and compulsions

Obsessions describe intrusive thoughts or feelings that enter our minds which are disturbing or upsetting; compulsions are the behaviours we carry out in order to manage those thoughts or feelings. For example, a young person may be constantly worried that their house will burn down if they don't turn off all switches before leaving the house. They may respond to these thoughts by repeatedly checking switches, perhaps returning home several times to do so. Obsessive compulsive disorder (OCD) can take many forms – it is not just about cleaning and checking.

Online support

- OCD UK: www.ocduk.org/ocd

Books

- Amita Jassi and Sarah Hull (2013) *Can I Tell you about OCD?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers
- Susan Conners (2011) *The Tourette Syndrome & OCD Checklist: A practical reference for parents / carers and teachers*. San Francisco: Jossey-Bass

Suicidal feelings

Young people may experience complicated thoughts and feelings about wanting to end their own lives. Some young people never act on these feelings though they may openly discuss and explore them, while other young people die suddenly from suicide apparently out of the blue.

Online support

- Prevention of young suicide UK – PAPYRUS: www.papyrus-uk.org
- On the edge: ChildLine spotlight report on suicide: www.nspcc.org.uk/preventing-abuse/research-and-resources/on-the-edge-childline-spotlight/

Books

- Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers
- Terri A.Erbacher, Jonathan B. Singer and Scott Poland (2015) *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention*. New York: Routledge

Eating Disorders

Food, weight and shape may be used as a way of coping with, or communicating about, difficult thoughts, feelings and behaviours that a young person experiences day to day. Some young

people develop eating disorders such as anorexia (where food intake is restricted), binge eating disorder and bulimia nervosa (a cycle of bingeing and purging). Other young people, particularly those of primary or preschool age, may develop problematic behaviours around food including refusing to eat in certain situations or with certain people. This can be a way of communicating messages the child does not have the words to convey.

Online support

- Beat – the eating disorders charity: www.b-eat.co.uk/about-eating-disorders
- Eating Difficulties in Younger Children and when to worry: www.inourhands.com/eating-difficulties-in-younger-children

Books

- Bryan Lask and Lucy Watson (2014) *Can I tell you about Eating Disorders?: A Guide for Friends, Family and Professionals*. London: Jessica Kingsley Publishers
- Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers
- Pooky Knightsmith (2012) *Eating Disorders Pocketbook*. Teachers' Pocketbooks