Bishop David Brown School

Mental Health
Policy

UNITY SCHOOLS TRUST

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Policy Statement

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 Bishop David Brown School, we aim to promote positive mental health and wellbeing for every member of our school community. Wellbeing is valued and we actively aim to promote positive mental health and wellbeing for every child, parent/carer and staff. We also recognise the link between physical activity and positive mental health and wellbeing, and we encourage our schools to be 'active schools'.

Scope

This document describes the school's approach to promoting positive mental health and wellbeing. This policy is intended as guidance for all staff including non-teaching staff and governors.

This policy should be read in conjunction with the: E-Safety policy; the 'SEND' policy and, 'Safeguarding' Policy. Schools should also read this policy in conjunction with their anti-bullying and PHSE, BDB 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 other

The Policy Aims to:

Mental health issues can and should be de-stigmatised by educating pupils, staff and parents. This is done through tutorials and PSHE with the pupils, through staff INSET and through parent forum. Positive mental health is also promoted through strong pastoral care, an effective peer support and student voice.

- Promoting positive mental health and wellbeing in all staff and students
- To develop a whole school approach for both the students and staff.
- increase understanding and awareness of mental health issues
- alert staff to warning signs and risk factors
- provide support and guidance to all staff, including non-teaching staff and governors, dealing with pupils who suffer from mental health issues
- provide support to pupils who suffer from mental health issues, their peers and parents/carers.

To effectively communicate a values-based approach and to promote openness and understanding to normalise mental health and its fluctuations throughout life.

Lead Members of Staff

1. Mental Health Lead/Wellbeing Lead
2. Designated Safeguarding Lead (DSL)
3. SENCO
4. Mental health first aiders
5. Head of PSHE

6. 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 their HOY the DSL/ The MHL. 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.

Identifiable mental health issues

1. It is important for staff to be alert to signs that a child might be suffering from mental health issues. Mental health issues come in many forms and manifest themselves in a wide range of ways including:

- Anxiety and Depression
- Eating disorders
- Self-harm
- Suicidal ideation

2. Two important elements enabling the School to identify mental health issues are the effective use of data (i.e. monitoring changes in pupils' patterns of attendance/academic achievement) and an effective pastoral system whereby staff know pupils well and can identify unusual behaviour.

3. 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.

Teaching about Mental Health and Wellbeing

1. 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.

2. 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.

3. We will display relevant sources of support in communal areas such as corridors, The canteen, The 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
   - How to access help
   - Why it is helpful to access help
   - What is likely to happen next

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

Warning Signs

1. School staff may become aware of warning signs which indicate a student or member of staff 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

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

Figure 1

Concerns

ALGEE

Ask, assess, act
Where a young person is distressed, the member of staff should ask them what support they need and want. Assess the risk of harm to self or others and try to reduce any risk that is present.

Listen non-judgementally
Give them time to talk and gain their confidence to take the issue to someone who could help further

Give reassurance and information
Tell them how brave they have been. Gently explain that you would like to help them. Do not promise confidentiality - it could be a child protection matter.

Enable the young person to get help
Work through the avenues of support. Explain that you would like to share their thoughts with someone else so that they can get the best help.
Encourage them to speak to someone - offer to go with them.

Encourage self help strategies

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

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

The DSL/ MHL will decide on the appropriate course of action. This may include:
Contacting parents/carers
Arranging professional assistance e.g. doctor/nurse Arranging an appointment with a counsellor Arranging a referral to CAMHS - with parental consent Giving advice to parents, teachers and other pupils Individual care plan

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

The tutor should pass on the information to the HoY who will instigate the appropriate time period of watchful waiting (up to 4 weeks). The HoY should keep the Assistant Head of school (Character & Culture)

After a period of watchful waiting, a young person deemed to have continuing symptoms should be referred to a medical professional. This might be the School's CAMHS worker or may be a specialist CAMHS or private referral

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 the DSL or The Mental Health and Wellbeing 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 DSL or The Mental Health and Wellbeing Lead 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.

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.

Supporting 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 parent forum
- 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

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

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

Staff Training and CPD

As a minimum, at least two staff will complete the two day Mental Health First Aid course, 'MH First Aiders', staff will receive regular training through Edu Care about recognising and responding to mental health difficulties as part of their regular safeguarding/mental health training in order to enable them to keep themselves and the 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.

Anxiety and Depression

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**. It is estimated that 1 in 6 people will suffer from General Anxiety Disorder at some point in their lives.

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

These 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

Follow the ALGEE principles (see *Figure 1* in main policy)

How to help a pupil having a panic attack

- If you are at all unsure whether the pupil is having a panic attack, a heart attack or an asthma attack, and/or the person is in distress, call the reception immediately. If you are off site, call an ambulance straight away. If you are sure that the pupil is having a panic attack, move them to a quiet safe place if possible.
- Help to calm the pupil 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 pupil 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.
- Assure the pupil that someone will stay with them and keep them safe until the attack stops.

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 depression and long periods of depression can provide symptoms of anxiety. Many young people have a mixture of symptoms of anxiety and depression as a result.

Depression

A clinical depression 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. Depression is a common but serious illness and can be recurrent. In England if affects at least 5% of teenagers, although some estimates are higher. Rates of depression are higher in girls than in boys.

Depression in young people often occurs with other mental 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
- 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 depression 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, misuse of alcohol and other substances, 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 depression
Follow the ALGEE principles shown in *Figure 1* of the main policy

The most important role school staff can play is to familiarise themselves with the risk factors and warning signs outlined above and to make the Assistant Head of school (Character & Culture), The DSL and the MHL aware of any child causing concern.

Following the report, a decision on the appropriate course of action and will record. This may include:

- Contacting parents/carers
- Arranging professional assistance e.g. doctor, nurse
- Arranging an appointment with a counsellor
- Arranging a referral to CAMHS– with parental consent
- Giving advice to parents, teachers and other pupils

Pupils may choose to confide in a member of school staff if they are concerned about their own welfare, or that of a peer. Pupils need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a pupil is at serious risk of causing themselves harm, then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on you to do so.

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.

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 nervosa and bulimia nervosa are the major eating disorders. 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. In contrast, 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).

Risk Factors

The following risk factors, particularly in combination, 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 / perfectionism

Family Factors

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

Social Factors

- Being bullied, teased or ridiculed due to weight or appearance
- Pressure to maintain a high level of fitness/low body weight for e.g. sport or dancing

Warning Signs

School staff may become aware of warning signs which indicate a pupil 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 seek further advice from the Designated Safeguarding Lead or from the medical centre.

Physical Signs

• 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 they are fat when they are not
• Secretive behaviour
• Visits the toilet immediately after meals
• Excessive exercise

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

Staff Roles

The most important role school staff can play is to familiarise themselves with the risk factors and warning signs outlined above and to make the Assistant Head of school (Character & Culture), DSL/MHL aware of any child causing concern.

Following the report, the Assistant Head of school (Character & Culture), DSL/MHL will decide on the appropriate course of action and record it. This may include:
• Contacting parents/carers
• Arranging professional assistance e.g. doctor, nurse
• Arranging an appointment with a counsellor
• Arranging a referral to CAMHS.– with parental consent
• Giving advice to parents, teachers and other pupils

The team will, in a supportive way, establish the student's dietary and exercise habits, assess their physical and psychological condition, explore their personal views of their weight and any precipitants to their current behaviour and family issues.

Pupils may choose to confide in a member of school staff if they are concerned about their own welfare or that of a peer. Pupils need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a pupil is at serious risk of causing themselves harm, then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on you to do so.

Management of eating disorders in school

Exercise and activity – PE and games

Taking part in sports, games and activities is an essential part of school life for all pupils. Excessive exercise, however, can be a behavioural sign of an eating disorder. PE staff will monitor the amount of exercise a student is doing in school. The PE staff can advise parents of a sensible exercise programme for out of school hours.

When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school or is always tired because their eating disorder is disturbing their sleep at night, the form tutor or Head of Year will initially talk to the parents/carers to work out how to help prevent their child from falling behind.

Pupils Undergoing Treatment for/Recovering from Eating Disorders

The decision about how, or if, to proceed with a pupil's schooling while they are suffering from an eating disorder should be made on a case by case basis. Input for this decision should come from discussion with the pupil, their parents, school staff and members of the multi-disciplinary team treating the pupil.

The reintegration of a pupil into school following a period of absence should be handled sensitively and carefully and again, the pupil, their parents, school staff and members of the multi-disciplinary team treating the pupil should be consulted during both the planning and reintegration phase.

Further Considerations

Any meetings with a pupil, their parents or their peers regarding eating disorders should be recorded:
• Dates and times
• A care plan
• Concerns raised
• Details of anyone else who has been informed

Self-Harm

Introduction

Recent research indicates that up to one in ten young people in the UK engage in self-harming behaviours. Girls are thought to be more likely to self-harm than boys. School staff can play an important role in preventing self-harm and also in supporting pupils, peers and parents of pupils currently engaging in self-harm.

Definition of Self-Harm

Self-harm is any behaviour where the intent is to deliberately cause harm to one's own body for example:
• Cutting, scratching, scraping or picking skin
• Swallowing inedible objects
• Taking an overdose of prescription or non-prescription drugs

• Swallowing hazardous materials or substances
• Burning or scalding
• Hair-pulling
• Banging or hitting the head or other parts of the body
• Scouring or scrubbing the body excessively
• Not looking after their needs properly, emotionally or physically
• Eating distress
• Addiction, for example to alcohol or drugs

Self-harm is a common precursor to suicide, and children and young people who deliberately self-harm may kill themselves by accident.

Self-harm may help a person by:

• Providing relief from being emotionally overwhelmed and distressed
• Reducing tension
• Distraction from current difficulties
• Escaping from the situation
• Feeling 'something'
• Feeling in control
• Punishing themselves
• So that they can take care of themselves afterwards

Self-harm is sometimes unhelpfully thought of in terms of 'attention-seeking behaviour'. It needs to be respected as the best way of coping that the student knows about at the time. It is vital that students not be punished for their behaviour but be provided with adequate support. It is not a healthy way of coping, and messages and support must be given to students to prevent others from being encouraged to engage in this behaviour.

Risk Factors

The following risk factors, particularly in combination, may make a young person -particularly vulnerable to self-harm:

Individual Factors:

• Depression/anxiety
• Poor communication skills
• Low self-esteem16
• Poor problem-solving skills
• Hopelessness
• Impulsivity
• Drug or alcohol abuse
• Other mental health issues such as bipolar disorder

Family Factors
• Unreasonable expectations
• Neglect or physical, sexual or emotional abuse
• Poor parental relationships and arguments
• Depression, self-harm or suicide in the family

Social Factors

• Difficulty in making relationships/loneliness
• Being bullied or rejected by peers

Warning Signs

School staff may become aware of warning signs which indicate a pupil is experiencing difficulties that may lead to thoughts of self-harm or suicide. These warning signs should always be taken seriously and

staff observing any of these warning signs should seek further advice from the Assistant Head of school (Character & Culture), DSL or MHL

Possible warning signs include:

• Changes in eating/sleeping habits (e.g. pupil may appear overly tired if not sleeping well)
• Increased isolation from friends or family, becoming socially withdrawn
• Changes in activity and mood e.g. more aggressive or introverted than usual
• 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. always wearing long sleeves, even in very warm weather
• Unwillingness to participate in certain sports activities e.g. swimming

Staff Roles in working with pupils who self-harm

Pupils may choose to confide in a member of school staff if they are concerned about their own welfare or that of a peer. School staff may experience a range of feelings in response to self-harm in a pupil such as anger, sadness, shock, disbelief, guilt, helplessness, disgust and rejection. However, in order to offer the best possible help to pupils it is important to try and maintain a supportive and open attitude – a pupil who has chosen to discuss their concerns with a member of school staff is showing a considerable amount of courage and trust.

Pupils need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a pupil is at serious risk of harming themselves then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on you to do so.

Any member of staff who is aware of a pupil engaging in or suspected to be at risk of engaging in self-harm should consult the Assistant Head of school (Character & Culture).

Following the report, the Assistant Head of school (Character & Culture) will decide on the appropriate course of action.

A risk assessment should be done at the earliest stage. This should include and consider the student's

• Level of planning and intent
• Frequency and nature of thoughts and actions
• Signs or symptoms of a mental health disorder such as depression
• Evidence or disclosure of substance misuse
• Previous history of self-harm or suicide in the wider family or peer group
• Delusional thoughts or behaviour

The level of risk may fluctuate, and a point of contact with a backup should be agreed to allow the young person to make contact if they need to

It is important not to:

• Panic or try quick solutions
• Dismiss what the young person says, their feelings or behaviour
• Believe that the young person who has threatened to harm themselves in the past will not carry it out in the future
• Disempower the young person
• See it as attention seeking or manipulative
• Trust appearances, as many young people learn to cover up their distress

The resulting course of action may include:

• Contacting parents / carers
• Arranging professional assistance e.g. doctor, nurse, social services
• Arranging an appointment with a counsellor
• Arranging a referral to CAMHS
• Immediately removing the pupil from lessons if their remaining in class is likely to cause further distress to themselves or their peers
• **In the case of an acutely distressed pupil, the immediate safety of the pupil is paramount, and an adult should remain with the pupil at all times**

• **If a pupil has self-harmed in school a first aider should be called for immediate help**

Further Considerations

Any meetings with a pupil, their parents or their peers regarding self-harm should be recorded including:
• Dates and times
• Concerns raised
• Details of anyone else who has been informed

It is important to encourage pupils to let staff know if one of their group is in trouble, upset or showing signs of self-harming. Friends can worry about betraying confidences, so they need to know that self-harm can be very dangerous and that by seeking help and advice for a friend they are taking responsible action and being a good friend. They should also be aware that their friend will be treated in a caring and supportive manner.

The peer group of a young person who self-harms may value the opportunity to talk to a member of staff either individually or in a small group. Any member of staff wishing for further advice on this should consult either the Assistant Head of school (Character & Culture) or the DSL/MHL.

When a young person is self-harming it is important to be vigilant in case close contacts with the individual are also self-harming. Occasionally schools discover that a number of pupils in the same peer group are harming themselves.

Suicide Prevention Key definitions

- At risk

A student who is defined as high risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behaviour suggesting the onset or deterioration of a mental health condition. The student may have thought about suicide including potential means of death and may have a plan. In addition, the student may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. The situation would necessitate a referral, as documented in the following procedures.

- Suicide

Death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour. - Suicide attempt a self-injurious behaviour for which there is evidence that the person had at least some intent to kill themselves. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

- Suicidal ideation

Thinking about, considering, or planning for self-injurious behaviour which may result in death. There are two kinds of suicidal ideation: passive and active. In passive suicidal ideation, the individual may be thinking about suicide but has no plans to take their own life. Active suicidal ideation, on the other hand, is not only thinking about it but having the intent to take one's own life; this may include planning how to do it. Suicidal ideation is one of the symptoms of both major depression and the depression found in

bipolar disorder.

A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.

Risk factors

Risk factors for suicide are characteristics or conditions that increase the chance that a person may try to take their life. Suicide risk tends to be highest when someone has several risk factors at the same time. The most frequently cited risk factors for suicide are:

- Major depression (feeling down in a way that impacts your daily life) or bipolar disorder (severe mood swings)
- Substance abuse
- Unusual thoughts and behaviour or confusion about reality
- Personality traits that create a pattern of intense, unstable relationships or trouble with the law
- Impulsivity and aggression, especially along with a mental disorder
- Previous suicide attempt or family history of a suicide attempt or mental disorder
- Serious medical condition and/or pain

It is important to bear in mind that most people with mental disorders or other suicide risk factors do not engage in suicidal behaviour.

Protective factors for suicide

Protective factors for suicide are characteristics or conditions that may help to decrease a person's suicide risk. While these factors do not eliminate the possibility of suicide, especially in someone with risk factors, they may help to reduce that risk.

Protective factors for suicide include:

- Receiving effective mental health care
- Positive connections to family, peers, community
- The skills and ability to solve problems

Note that protective factors do not entirely remove risk, especially when there is a personal or family history of depression or other mental disorders. Certain young people are more vulnerable; some examples are listed below:

- **Young people living with mental and/or substance use disorders**

While most people with mental disorders do not engage in suicidal behaviour, people with mental disorders account for more than 90 percent of deaths by suicide. Mental disorders, in particular depression or bi-polar (manic-depressive) disorder, alcohol or substance abuse, schizophrenia and other psychotic disorders, borderline personality disorder, conduct disorders, and anxiety disorders are important risk factors for suicidal behaviour among young people. Not all people suffering from these mental disorders are engaged in treatment, therefore School staff may play a pivotal role in recognising and referring the student to treatment that may reduce risk.

- Young people who engage in self-harm or have attempted suicide

Suicide risk among those who engage in self-harm is significantly higher than the general population. Whether or not they report suicidal intent, people who engage in self-harm are at elevated risk for dying by suicide within 10 years. Additionally, a previous suicide attempt is a known predictor of suicide death. Many adolescents who have attempted suicide do not receive necessary follow- up care.

- LGBTQ

Lesbian, gay, bisexual, transgender, or questioning young people are four times more likely, and questioning young people are three times more likely, to attempt suicide as their straight peers. Suicidal

behaviour among LGBTQ young people can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimisation. For those young people with baseline risk for suicide (especially those with a mental disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ which elevate the risk of suicidal behaviour for LGBTQ young people.

- Young people bereaved by suicide

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are at increased risk for suicide themselves.

- **Young people living with medical conditions and disabilities**

Several physical conditions are associated with an elevated risk for suicidal behaviour. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive styles that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behaviour than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

Prevention

- Education

As part of our care for the welfare of our students, the School believes it has a duty to educate and inform young people on mental health issues, including suicidal ideation and suicide. We are committed to developing a programme of age-appropriate, student-centred psycho-education and skills training for pupils. We seek to:

a. Provide accurate information about mental health issues which affect young people
b. Provide opportunities for young people to acquire knowledge and understanding about the consequence of poor or ill mental health
c. Provide opportunities for pupils to be equipped with knowledge, attitudes, protective factors and skills they need to make healthy choices, to promote good self-care and develop coping strategies, to look after others (self-esteem, coping skills, problem-solving skills, decision-making skills and self-disclosure)
d. Enable pupils to identify sources of appropriate personal support
e. Provide opportunities to educate parents
f. Provide opportunities to educate staff

- The Language around suicide
Using sensitive and appropriate language can help build awareness and understanding to increase empathy and support.

Helpful	**Unhelpful**
Ended their life	Commit suicide (suicide is not a crime)
Took their own life	Unsuccessful or failed suicide
Died by suicide	Thinking of doing something silly / stupid
Killed themselves	Attention seeking behaviour
Attempted to take their life	
Attempted suicide	
Engaged in suicide behaviours	

Intervention

If a young person is having thoughts of suicide, they will usually communicate this. However, this is unlikely to be an explicit verbal communication about suicide. Few young people feel that they can be open about suicidal thinking or tell someone when they are struggling with their emotional health and wellbeing. When suicide is part of a young people's thinking, they usually show this in their behaviour, in how they interact and in how they communicate. The only way to check is to ask the young person directly and clearly about suicide.

Behavioural clues	Verbal clues	Situational clues
- Sudden or unexpected changes in behaviour and personality - Quality of academic work declines - Lack of energy - Withdrawal - Prevailing sadness - Loss of interest in activities - Changes in sleep and eating habits - Neglect of personal appearance - Substance abuse - Prized possessions given away - Insufficient problem solving skills	- Preoccupations with talking or writing about death -Talk about taking one's own life - Verbal or written remarks about sense of failure, worthlessness, and/or isolation - Frequent complaints about physical symptoms that are often related to emotions, such as stomach aches, headaches or fatigue	- Loss of a relationship / relationship problems - Death of a close friend of family member - Loss of self-esteem; failure to achieve expectations - Home issues, such as divorce - Family history of psychiatric difficulties - Major life event or chronic stressor - Serious illness, physical or mental - Abuse - Social isolation

Assessment and referral

When a student is identified by a member of staff as potentially suicidal, i.e. verbalises about suicide, presents overt risk-factors such as agitation or intoxication, the act of selfharm occurs, or a student self-refers, the student will be seen by the Assistant Head of school (Character & Culture), DSL or MHL within the same school day to assess risk and facilitate referral. If the DSL is not available, for example if the concern arises on a trip, action should not be delayed

Guidance for young people – how to support a friend

You may feel unsure how to help, but your friend will really appreciate your concern – even if they find it difficult to say this. You can start by letting them know you want to help and can be trusted. The best thing to do is listen and be there for them.

You don't need to have ready answers or solutions. Being there for them and listening to them is often enough.

- If you want to ask how they are, find a space and time when you could talk privately.
- Offer to speak to them again the next day to see how they are.
- Offer to spend more time with them.
- Ask open questions like: "how are you feeling? Or "what makes you say that?"
- Listen to what they say, without judging.
- If they don't feel like talking, let them know you would like to help and are there for them.
- They may go over the story time and time again. That's fine – it's part of the healing process.
- Remember than if they're showing anger, it is because of the pain they're going through, not because of you.
- Give them time to cry when they need too.

Suggest doing things that you know they enjoy. They might not feel ready, but it's important to make them feel included.

- If you think they need it, offer to help them get support by contacting a teacher, GP, school counsellor or a helpline.

You don't have to take everything on your shoulders. If you are helping a friend, make sure you have support for yourself. It is hard knowing that a friend is hurting, and you may find yourself struggling to cope:

- Call Childline or Samaritans
- Speak to the Assistant Head of school (Character & Culture), DSL or MHL
- Speak to a teacher

Apps to support your wellbeing

Stay Alive

Stay alive is a free suicide prevention app that helps its users to stay safe from acting on their thoughts of suicide. Downloading this app means that the help and information someone may need when managing thoughts of suicide is easily accessible, helping them to stay safe.

Self-Help Anxiety Management This app is helpful for helping the user manage their anxiety. The anxiety tracker can help the user better understand things that make them feel anxious, whilst the self-help toolkit allows them to learn new skills around anxiety management.

Moodometer

This NHS app allows the user to track and understand influence behind their mood. Acting like a mood diary, this app can be helpful in identifying triggers that can impact on low mood and suggest ways to lift your mood.

Calm Harm

This app can be used to help the user manage urges to self-harm. It's a private app and can be password protected. The help and advice provide suggestions of 5-15-minute categorised activities that can help the user 'ride the wave' of an urge to self-harm.

Talk life

Talk Life is a free online peer-to-peer support network for those battling with mental health issues.

Guidance for staff and parents - How to ask about suicide ?

“Are you thinking about suicide?”. By using the word suicide, the member of staff supporting the young person will be signaling that it is OK to talk openly about their thoughts of suicide.

Conversation starters:

- It sounds like you’re thinking about suicide. Is that right?
- It sounds like life feels too hard for you right now, and you want to kill yourself. Is that right?
- Are you telling me you want to kill yourself / end your life / die / die by suicide?
- Sometimes, when people are feeling the way you are, they think about suicide. Is that what you are thinking about?
- When you say you don’t want to be here anymore, do you mean you would rather be dead?

If the young person is not having thoughts of suicide, they will tell you so. If you are still concerned, keep exploring why your concerns remain until you are clear that suicide is not part of their thinking. If they are not having thoughts of suicide, nothing is lost by having the conversation: you will have developed suicide-safety for and with that young person now and for the future.

Below are some ways to continue a conversation about suicide in a reassuring, safe way:

- It’s hard and scary to talk about suicide but take your time, and I will listen
- Can you tell me more about why you want to die?
- Things must be so painful for you to feel like there is no way out. I want to listen and help.
- It’s not uncommon to have thoughts of suicide. With help and support many people can work through these thoughts and stay safe.
- It sounds as though things are really hard at the moment… Can you tell me a bit more?
- There are organisations that offer support. I can give you their contact details.
- There is hope. There is help available and we can find it together.
- Take your time and tell me what’s happening for you at the moment.
- I am so sorry you’re feeling this way. Can you tell me more about how you are feeling?
- You’ve shown a lot of strength in telling me this. I want to help you find support.

If a young person indicates that they have been thinking about suicide, listen and allow them to express their feelings. They will likely feel a huge sense of relief that someone is willing to hear their darkest thoughts without judgment. Reassure them that they are not alone, and you can look for support together.

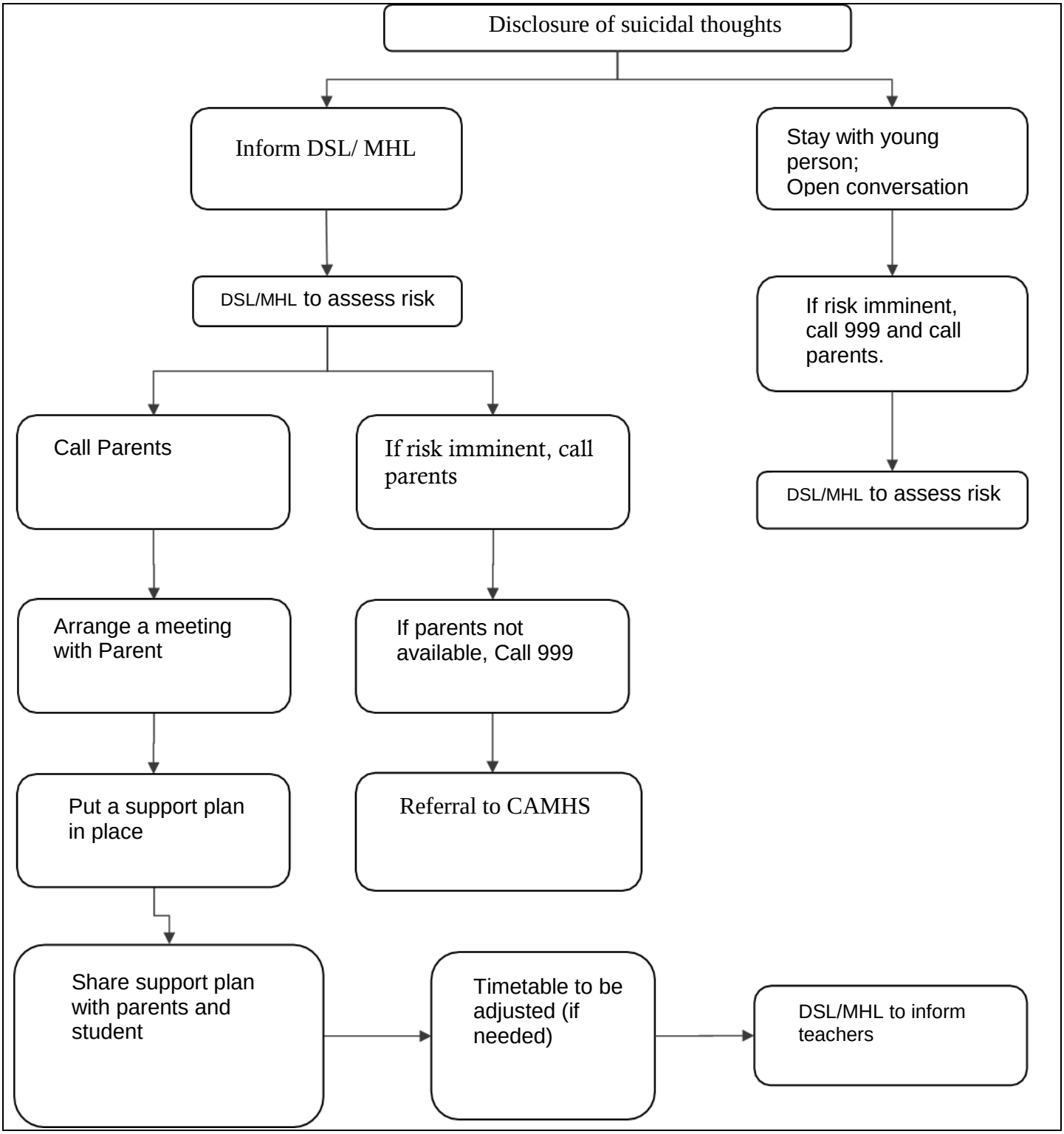
In situations where you feel there is imminent risk of death or harm, call for professional help and stay with the young person. The young person may not want to talk, but you can let them know that you will remain with them in supportive silence.

If the behaviour in question is historical, then the focus will be on what the young person has learned from this behaviour and using that learning to keep the young person safe.
In all events, inform the Director of Pastoral Care / DSL. Looking after yourself
Talking to young people who have suicidal thoughts is challenging and can provoke uncomfortable feelings in ourselves, such as anxiety, fear, confusion, sadness, frustration and powerlessness. You will need to consider how to look after yourself so that you are in the best position to help:

- Reflective practice: it supports us to value and build on prior learning and experience, and allows for a better understanding of how to work safely and effectively with young people
- Training: consider whether you need to seek additional training to improve your skills, knowledge and confidence in helping young people who experience suicidal feelings.

- Be honest about your limits: if supporting the young person becomes too much of a burden, it may affect your relationship with them.

Talk to the Assistant Head of school (Character & Culture), DSL or MHL


Disclosure of suicidal thoughts
Inform DSL/ MHL
Stay with young person;
Open conversation
DSL/MHL to assess risk
If risk imminent, call 999 and call parents.
Call Parents
If risk imminent, call parents
DSL/MHL to assess risk
Arrange a meeting with Parent
If parents not available, Call 999
Put a support plan in place
Referral to CAMHS
Share support plan with parents and student
Timetable to be adjusted (if needed)
DSL/MHL to inform teachers

For young people at risk, the following procedure will be followed at School

- Their teachers will be alerted to the presenting risk on a need-to-know basis
- The Designated Safeguarding Lead or the Mental Health Will contact the Parents as soon as possible and assist the family with urgent referral
- Where high risk has been identified and the parents cannot be reached, the DSL/MHL may call the emergency services or bring the student to the nearest A&E

Levels of risk and intervention

Risk level	Presentation	Initial Actions	Service Options
Low	Self-harm as coping mechanism; Fleeting thoughts of suicide but no intent or plan; Protective factors evident including support network, hope of recovery seeking help.	Acknowledge distress, identify options to address underlying difficulties and agree a plan with the young person; Clarify confidentiality and issues of consent Encourage young person to tell parents; Parents to be informed within a reasonable timeframe if risk remains.	Eikon, Self-help resources and online information; ELSA School Nurse
Medium	Suicidal thoughts frequently but no specific plan or immediate intent; Evidence of persistent symptoms of mental ill health in particular depression, anxiety, or psychosis; Significant alcohol and/or substance abuse; Previous suicide attempts; Current self-harm;	Acknowledge distress, identify options to address underlying difficulties and agree a plan with the young person, including clear plan for follow-up; Plan must include actions to be taken if distress increases or suicidal thoughts become more persistent of difficult to resist i.e. a safety plan;	school Nurse Self-help resources and online information; Referral to GP; Consider professional consultation with CAMHS;

	Reluctance to share with support network or withdrawal from peers and/or family.	Clarify confidentiality and inform parents. Think about phrasing again	In-school monitoring
High	Frequent suicidal thoughts with increased intensity which are difficult to ignore; Some planning / intent or ambivalence; Research of potential lethal means; Access to means; Previous suicide attempts; Significant alcohol and/or substance use; Withdrawal from support network; Evidence of persistent symptoms of mental ill health, especially depression, anxiety or psychosis; Family history of, or peer suicide.	Acknowledge distress, identify options to address underlying difficulties and agree a plan with young person to include a clear plan for follow up – this will include immediate actions to be taken i.e. GP appointment, urgent referral to CAMHS, A&E; Clarify confidentiality and inform parents	GP; CAMHS; Increased support from existing network; Increased monitoring and review (DSL/MHL daily)

Suicide-Safety plan

A good suicide-safety plan always includes the following:

- Why do I want to stay safe?
- Making my environment safe
- Helpline numbers that are available and appropriate, including 24-hour helplines.
- Safety contacts: people and organisations that the young person can contact when they feel they cannot keep themselves safe, including a safety contact for when they are at school
- Professional support from a counsellor or therapist

Below is an example from Papyrus

https://papyrus-uk.org/wp-content/uploads/2018/10/Suicide-Safety-Plan-Template-1.pdf

Bereavement

Every 22 minutes in the UK, a parent of dependent children dies, leaving about 41,000 bereaved children each year. Many more are bereaved of a grandparent, sibling, friend or a significant other, and, sadly, around 12,000 children die in the UK each year.

The role of the pastoral staff

- To have bereavement support training.
- To establish and co-ordinate links with external agencies where necessary
- To support the bereaved student

Procedures

- Contact with the deceased's family should be established by the Assistant Head of school (Character & Culture), DSL or MHL , and the family's wishes in communicating with others.
- Head of Year the Assistant Head of school (Character & Culture) will meet with the bereaved student and offer support; counselling will be offered.
- Staff should be informed before pupils and be prepared to share information in age- appropriate ways, as agreed for each individual circumstance.
- Where appropriate, pupils should be informed, preferably in small groups, by their form tutor. A decision should be made as to whether this information should be given as part of a whole-school approach or if only certain groups of pupils need to be informed.
- In the situation of the death of the parent or sibling of a student, the deceased's family may decide that the school contact their son/ daughters' friends' parents.
- The school should be aware that the school timetable may need a degree of flexibility to accommodate the needs and wellbeing of children affected by the situation. However, minimal disruption to the timetable also offers a sense of security and familiarity.
- In consultation with the bereaved family, arrangements for funeral attendance may be clarified.
- School should be aware that the impact of bereavement follows a child through their school life, so information should be recorded and shared with relevant people, particularly at transition points. The pastoral team should be aware of anniversaries where possible.
- The form tutor / Head of Year should have regular contact with the bereaved student; conversations need not always focus on grief.

Helpful resources:

- Griefcast: funny people talking about death and grief. Hosted by Cariad Lloyd.
- Child Bereavement UK
- Rainbows for all Children
- Cruse Bereavement Care
- Samaritans 116 123
- Childline 0800 1111
- The Mix 0808 808 4994
- 10 ways to support a bereaved friend
- Help2makesense
- R. Abrams (1995) When Parents Die. Routledge: London