Egerton Rothesay School
Mental Health Policy
October 2015

1. Introduction

The Annual Report of the Chief Medical Officer 2012 recognises that one in ten children and young people aged 5 to 16 have a clinically diagnosed mental health disorder and around one in seven has less severe problems.

This policy is designed to show how ERS promotes positive mental health in pupils and identifies and addresses mental health problems, helps to build pupil resilience and makes appropriate referrals to specialist agencies such as Child and Adolescent Mental Health Services (CAHMS) where necessary.

At ERS, we recognise that indentifying and tackling mental health issues is the responsibility of all staff, regardless of position.

2. Aims

The aims of this policy are:

- To support pupils to be resilient and mentally healthy.
- To identify when a pupil needs specific support and how to gain additional support from outside the school when appropriate, including from medical professionals working in specialist Child and Adolescent Mental Health Services (CAMHS) and pupils' GPs.
- To provide pupils and their families with information and support and to enable them to participate as fully as possible in decisions regarding the pupil's mental health.

3. How ERS promotes Pupils' Mental Health

ERS promotes pupils' mental health through:

- To provide pupils and their families with information and support and to enable them to participate as fully as possible in decisions regarding the pupil's mental health.
- **A Designated Person for Mental Health of Pupils (DPMH)** is appointed by the Headteacher. At ERS this is the Designated Senior Person (DSP) for Safeguarding. The DPMH is responsible for overseeing the implementation of this policy and the roles within it. The DPMH is responsible to the Headteacher and reports regularly to the Senior Management Team.
- **The Senior Management Team** which sets a culture within the school that values all pupils; allows them to feel a sense of belonging; and makes it possible to talk about problems in a non-stigmatising way.
- **The Relational Youth Worker** who is available to listen to pupils on an informal basis and to support them appropriately and as required.
- **The school's ethos** which seeks to provide an environment where learning can flourish, enabled by excellent teaching and care; where each child can achieve their individual highest potential and is valued for who they are and where each child learns to fully respect and be respected by others. The school has clear policies on behaviour and bullying which set out the responsibilities of everyone in the school and which are understood clearly by all and are consistently applied by staff.
- **The school's Special Educational Needs Policy**, overseen by the Head of Special Needs (HSEN), through which all adults working in the school understand their responsibilities to children with special educational needs and disabilities (SEND),

including pupils whose persistent mental health difficulties mean they need special educational provision.

- **Working with parents and carers as well as with the pupils themselves**, ensuring their opinions and wishes are taken into account and that they are kept fully informed so they can participate in decisions taken about them.
- **Continuous professional development for staff** that makes it clear that promoting good mental health is the responsibility of all members of school staff and community, informs them about the early signs of mental health problems, what is and isn't a cause for concern, and what to do if they think they have spotted a developing problem.
- **Clear systems and processes** to help staff who identify children and young people with possible mental health problems, provide routes to escalate issues with clear referral and accountability systems.
- **Promoting the health and wellbeing of all pupils in the school** through the implementation of the school's PSHE Scheme of Work
- **Recognising the importance of Safeguarding** and protecting the welfare of its pupils as set out in the Safeguarding Policy.
- **Referring to and working with local health partners when required**, for example, Child and Adolescent Mental Health Services (CAMHS) and/ or a pupil's GP.

4. Identification of children with possible mental health problems

Some groups of children are more vulnerable to mental health difficulties than others. These include, but are not limited to, looked after children, children with learning difficulties and children from disadvantaged backgrounds.

Only medical professionals should make a formal diagnosis of a mental health condition. In addition, behavioural difficulties do not necessarily mean that a child or young person has a possible mental health problem or a special educational need. However, consistently disruptive or withdrawn behaviours can be an indication of an underlying problem.

At ERS the high adult: pupil ratio means that staff are well-placed to identify at an early stage any changes to a pupils' patterns of attainment, attendance or behaviour which in turn may suggest that they are suffering from a mental health problem or be at risk of developing one. A member of staff who becomes concerned about a pupil will inform the child's Base Leader, who will then be responsible for determining a course of action. This may include escalating the issue.

For a number of reasons, a prospective pupil may arrive at ERS with an existing mental health issue. As part of the admissions process, through the compilation of an 'Entry Profile', the school seeks to identify any such issue prior to admitting the pupil, so that supporting arrangements can be put in place on their arrival.

5. Risk Factors and Protective Factors

Certain individuals and groups are more at risk of developing mental health problems than others. These risks can relate to the child themselves, to their family, or to their community or life events. The risk factors are listed in Appendix 1. Risk factors are cumulative, for example, children exposed to multiple risks such as social disadvantage, family adversity and cognitive or attention problems are much more likely to develop behavioural problems.

Many children exposed to significant risk factors develop into competent, confident and caring adults. An important key to promoting children's mental health is therefore an understanding of

the protective factors that enable children to be resilient when they encounter problems and challenges.

Research suggests that there is a complex interplay between risk factors in children's lives and promoting their resilience. As social disadvantage and the number of stressful life events accumulate for children or young people, more factors that are protective are needed to act as a counterbalance. The key protective factors, which build resilience to mental health problems, are shown alongside the risk factors in Appendix 1.

The role that schools play in promoting the resilience of their pupils is important, particularly so for some children where their home life is less supportive. School should be a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems.

6. Events that may have an effect on pupils

Form tutors, class teachers and teaching assistants see their pupils day in, day out. They know them well and are well placed to spot changes in behaviour that might indicate a problem. The balance between the risk and protective factors set out above is most likely to be disrupted when difficult events happen in pupils' lives. These include, but are not limited to:

- **loss or separation** – resulting from death, parental separation, divorce, hospitalisation, loss of friendships (especially in adolescence), family conflict or breakdown that results in the child having to live elsewhere, being taken into care or adopted
- **life changes** – such as the birth of a sibling, moving house or changing schools or during transition from primary to secondary school, or secondary school to sixth form
- **traumatic events** such as abuse, domestic violence, bullying, violence, accidents, injuries or natural disaster.

Schools will often be able to support children at such times, intervening well before mental health problems develop.

7. Referring a Concern

A summary of the main types of mental health conditions is contained in Appendix 2. A member of staff who becomes concerned that a child may be developing a mental health issue should inform the DPMH of the concern at the earliest opportunity. This may be done informally and either verbally or through a written message. Following this contact, the member of staff may be asked to record their concern more formally in writing. As the DPMH is also the DSP, the decision that a concern should be taken as a safeguarding issue can be made concurrently and addressed according to the school's Safeguarding Policy.

On being informed of a mental health concern, the DPMH becomes responsible for managing the consequential outcome. Examples of actions that may be taken include, but are not limited to:

- the monitoring of a situation
- arranging for the pupil to meet with the school's youth worker
- consultation with appropriate other member(s) of staff leading to an agreed course of action
- (for serious cases) referral to an outside agency.

8. Referral to an Outside Agency

On deciding that a concern should lead to referral to an outside agency, the DPMH will be responsible for ensuring that the referral is made. In order that this can be done effectively, the DPMH will have in place:

- A clear method for identifying a child in need of support. This may be through the use of a 'Strengths and Difficulties Questionnaire' (SDQ)
- Sufficient written evidence of the symptoms displayed by the child
- A means by which the pupil and their parents are encouraged to speak to their GP
- Access to relevant forms as required by CAMHS and/ or other relevant agencies
- An established working relationship with CAMHS and/ or other relevant agencies which enables a referral to reach the right person effectively and promotes cooperation between the agency and the school to enable effective and continuing support for the child.

9. Responsibilities and review

All staff within the school are expected to understand and to work consistently and in accordance with this policy.

The Headteacher and the DPMH have a joint responsibility in ensuring that this policy is implemented and that it is reviewed every three years.

Policy approved by: John Bowcock
(on behalf of Governing Body)
Date: October 2015

Next Review (latest):September 2018

Appendix 1: Risk and Protective Factors for Child and Adolescent Mental Health

	Risk factors	Protective factors
In the child	• Genetic influences • Low IQ and learning disabilities • Specific development delay or neuro-diversity • Communication difficulties • Difficult temperament • Physical illness • Academic failure • Low self-esteem	• Being female (in younger children) • Secure attachment experience • Outgoing temperament as an infant • Good communication skills, sociability • Being a planner and having a belief in control • Humour • Problem solving skills and a positive attitude • Experiences of success and achievement • Faith or spirituality • Capacity to reflect
In the family	• Overt parental conflict including Domestic Violence • Family breakdown (including where children are taken into care or adopted) • Inconsistent or unclear discipline • Hostile or rejecting relationships • Failure to adapt to a child's changing needs • Physical, sexual or emotional abuse • Parental psychiatric illness • Parental criminality, alcoholism or personality disorder • Death and loss – including loss of friendship	• At least one good parent-child relationship (or one supportive adult) • Affection • Clear, consistent discipline • Support for education • Supportive long term relationship or the absence of severe discord
In the school	• Bullying • Discrimination • Breakdown in or lack of positive friendships • Deviant peer influences • Peer pressure • Poor pupil to teacher relationships	• Clear policies on behaviour and bullying • 'Open-door' policy for children to raise problems • A whole-school approach to promoting good mental health • Positive classroom management • A sense of belonging • Positive peer influences
In the community	• Socio-economic disadvantage • Homelessness • Disaster, accidents, war or other overwhelming events • Discrimination • Other significant life events	• Wider supportive network • Good housing • High standard of living • High morale school with positive policies for behaviour, attitudes and anti-bullying • Opportunities for valued social roles • Range of sport/leisure activities

Appendix 2: Summary of main types of Mental Health Conditions

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

Around 4-14% of the child and adolescent population may experience behaviour problems. Many children with attention deficit hyperactivity disorder (ADHD) will also exhibit behaviour problems. Such problems are the most common reason for referral to mental health services for boys, and the earlier the problems start, the more serious the outcome. There is, however, evidence to support the effectiveness of early intervention.

Anxiety
Anxiety problems can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but they tend not to impact on their environment.

Children and young people may feel anxious for a number of reasons – for example because of worries about things that are happening at home or school, or because of a traumatic event. Symptoms of anxiety include feeling fearful or panicky, breathless, tense, fidgety, sick, irritable, tearful or having difficulty sleeping. If they become persistent or exaggerated, then specialist help and support will be required.

Clinical professionals make reference to a number of diagnostic categories:

- generalised anxiety disorder (GAD) – a long-term condition which causes people to feel anxious about a wide range of situations and issues, rather than one specific event
- panic disorder – a condition in which people have recurring and regular panic attacks, often for no obvious reason
- obsessive-compulsive disorder (OCD) – a mental health condition where a person has obsessive thoughts (unwanted, unpleasant thoughts, images or urges that repeatedly enter their mind, causing them anxiety) and compulsions (repetitive behaviour or mental acts that they feel they must carry out to try to prevent an obsession coming true)
- specific phobias – the excessive fear of an object or a situation, to the extent that it causes an anxious response, such as panic attack (e.g. school phobia)
- separation anxiety disorder (SAD) – worry about being away from home or about being far away from parents, at a level that is much more than normal for the child's age
- social phobia – intense fear of social or performance situations
- agoraphobia – a fear of being in situations where escape might be difficult, or help wouldn't be available if things go wrong

While the majority of referrals to specialist services are made for difficulties and behaviours which are more immediately apparent and more disruptive (externalising difficulties), there

are increasing levels of concern about the problems facing more withdrawn and anxious children, given the likelihood of poor outcomes in later life.

Depression

Feeling low or sad is a common feeling for children and adults, and a normal reaction to experiences that are stressful or upsetting. When these feelings dominate and interfere with a person's life, it can become an illness. According to the Royal College of Psychiatrists, depression affects 2% of children under 12 years old, and 5% of teenagers.

Depression can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but tends not to impact on their environment. There is some degree of overlap between depression and other problems. For example, around 10% to 17% of children who are depressed are also likely to exhibit behaviour problems.

Clinicians making a diagnosis of depression will generally use the categories major depressive disorder (MDD – where the person will show a number of depressive symptoms to the extent that they impair work, social or personal functioning) or dysthymic disorder (DD – less severe than MDD but characterised by a daily depressed mood for at least two years).

Hyperkinetic disorders
(eg disturbance of activity and attention)

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

Attention Deficit Hyperactivity Disorder (ADHD) is a diagnosis used by clinicians. It involves three characteristic types of behaviour – inattention, hyperactivity and impulsivity. Whereas some children show signs of all three types of behaviour (this is called 'combined type' ADHD), other children diagnosed show signs only of inattention or hyperactivity/ impulsiveness.

Hyperkinetic disorder is another diagnosis used by clinicians. It is a more restrictive diagnosis but is broadly similar to severe combined type ADHD, in that signs of inattention, hyperactivity and impulsiveness must all be present. These core symptoms must also have been present before the age of seven, and must be evident in two or more settings.

Attachment disorders

Attachment is the affectionate bond children have with special people in their lives that lead them to feel pleasure when they interact with them and be comforted by their nearness during times of stress. Researchers generally agree that there are four main factors that influence attachment security: opportunity to establish a close relationship with a primary caregiver; the quality of caregiving; the child's characteristics and the family context. Secure attachment is an important protective factor for mental health later in childhood, while attachment insecurity is widely recognised as a risk factor for the development of behaviour problems.

Eating disorders

The most common eating disorders are anorexia nervosa and bulimia nervosa. Eating disorders can emerge when worries about weight begin to dominate a person's life. Someone with anorexia nervosa worries persistently about being fat and eats very little. They lose a lot of weight and if female, their periods may stop. Someone with bulimia nervosa also worries

persistently about weight. They alternate between eating very little, and then binging. They vomit or take laxatives to control their weight. Both of these eating disorders affect girls and boys but are more common in girls.

Substance misuse
Substance misuse can result in physical or emotional harm. It can lead to problems in relationships, at home and at work. In the clinical field, a distinction is made between substance abuse (where use leads to personal harm) and substance dependence (where there is a compulsive pattern of use that takes precedence over other activities). It is important to distinguish between young people who are experimenting with substance and fall into problems, and young people who are at high risk of long-term dependency. This first group will benefit from a brief, recovery oriented programme focusing in cognitions and behaviour to prevent them to move into more serious use. The second group will require ongoing support and assessment, with careful consideration of other concurrent mental health issues.

Deliberate self-harm
Common examples of deliberate self-harm include 'overdosing' (self-poisoning), hitting, cutting or burning oneself, pulling hair or picking skin, or self-strangulation. The clinical definition includes attempted suicide, though some argue that self-harm only includes actions, which are not intended to be fatal. It can also include taking illegal drugs and excessive amounts of alcohol. It can be a coping mechanism, a way of inflicting punishment on oneself and a way of validating the self or influencing others.

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