Emotional Wellbeing and Mental Health Policy

Contents

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 Manor Sandringham/Longbridge, we aim to promote positive mental health for every child and member of our staff. We pursue this aim using workplace practices, universal, whole school approaches and specialised, targeted approaches aimed at vulnerable children. In addition to promoting positive mental health, we aim to recognise and respond to mental ill health.

By developing and implementing a practical, relevant and effective mental health policy and procedures we can promote a safe and stable environment for staff and children affected both directly and indirectly by mental ill health.

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

It should be read in conjunction with our:

- Health and Safety Policy
- Confidentiality Policy
- Safeguarding and Child Protection Policy (where the mental health of a child overlaps with, or is linked to a medical issue)
- Special Needs Policy (where a child has an identified special educational need)

Aim of the Policy

At Manor Sandringham/Longbridge we aim to create an environment that promotes positive mental health in all staff and children by:

- Increasing understanding and awareness of common mental health issues.
- Providing opportunities for staff to look after their mental wellbeing.
- Alerting staff to early warning signs of mental ill health in children.
- Providing support to staff working with children with mental health issues.
- Providing support to children suffering from mental ill health and their peers and parents or carers.

Dissemination

We will share the policy with staff, governors, children and parents/carers via the following methods:

- A copy of the policy will be emailed to all staff.
- Salient points will be added to the PSHE curriculum.
- New staff will receive a copy of this policy during the induction process.
- School website.

Lead Members of Staff

Staff with a specific remit include:

- Designated Safeguarding Lead (DSL) – Mrs Khanom
- Occupational Health and Safety Lead- Mrs Kelly
- PSA – Mrs L Whitehead
- Pastoral Lead- Mrs A Tabrett
- Executive Head Teacher- Mrs A Tabrett
- Head of School Longbridge- Mr N Miller
- Head of School Sandringham - Mrs T McGorrighan
- CPD Lead (for staff training)- Miss F James

Responsibility

Any member of staff who is concerned about the mental health or wellbeing of a child should speak to the DSL in the first instance. If there is a fear that the child is in danger of immediate harm then the normal child protection procedures should be followed. If the child presents a medical emergency then the normal procedures for medical emergencies should be followed, including alerting the School Nurse and contacting the emergency services if necessary.

Where a referral to CAMHS is appropriate, this will be led and managed by the DSL.

All school staff are encouraged to:

- Understand this policy and seek clarification from management where required
- Consider this policy while completing work-related duties and at any time while representing our school
- Support fellow staff in their awareness of this policy
- Support and contribute to Manor Sandringham/Longbridge's aim of providing a mentally healthy and supportive environment for all staff and children.

All school staff have a responsibility to:

- Take reasonable care of their own mental health and wellbeing, including physical health
- Take reasonable care that their actions do not affect the health and safety of other people in the workplace
- Raise concerns with their line manager if they feel there are work issues that are causing them stress and having a negative impact on their well-being

Managers and Senior Leadership have a responsibility to:

- Ensure that all school staff are made aware of this policy.
- Actively support and contribute to the implementation of this policy, including its goals.
- Manage the implementation and review of this policy.
- Champion good management practices such as the establishment of a work ethos which discourages assumptions about long term commitment to working hours of a kind likely to cause stress and which enables staff to maintain a reasonable "work life balance".

- Promote effective communication and ensure that there are procedures in place for consulting and supporting employees on changes in the organisation, to management structures and working arrangements at both a school-wide and departmental level.
- Encourage initiatives and events that promote health and well-being.
- Ensure there are arrangements in place to support individuals experiencing stress, referring them to the school's Occupational Health advisers where appropriate.
- Collate management information which will enable the school to measure its performance in relation to stress management and employee well-being, such as:
    - Sickness absence data.
    - Staff turnover, exit interviews.
    - Number of self-referrals to the counsellor service.
    - Number of referrals to Occupational Health support.
    - Numbers of grievance and harassment cases.
- Seek the views of employees on the effectiveness of the School's Emotional Wellbeing and Mental Health Policy and stress management arrangements using staff surveys and other appropriate questionnaires.

Managing Pupil Disclosures

A child may choose to disclose concerns about themselves or a friend to any member of staff, so all staff need to know how to respond appropriately to a disclosure. If a child chooses to disclose concerns about their own mental health or that of a friend, the member of staff's response should always be calm, supportive and non-judgemental.

Staff should listen, rather than advise and first thoughts should be of the child's emotional and physical safety, rather than of exploring 'Why?' Staff should avoid asking any leading questions.

All disclosures should be recorded in writing and held in the child's confidential file. This should include:

- Date
- Name of member of staff to whom it was disclosed
- Main points from the conversation
- Agreed next steps

This information should be shared with the DSL/PSA, who will store the record appropriately and offer advice about the next step.

Warning Signs

School staff may become aware of warning signs which indicate a child is experiencing mental health or emotional wellbeing issues. These warning signs should always be taken seriously, and communicated to the DSL or DDSLs.

Possible warning signs to look out for in children or their immediate family:

- Physical signs of harm that are repeated or appear non-accidental.
- Changes in eating or sleeping habits.
- Increased isolation from friends of family.

- Becoming socially withdrawn.
- Changes in activity or mood.
- Lowering of academic achievement.
- Talking or joking about self-harm or suicide.
- Abusing drugs or alcohol in the family.
- Expressing feelings of failure, uselessness or loss of hope.
- Changes in clothing e.g. long sleeves in warm weather.
- Secretive behaviour.
- Skipping PE/Games or getting changed secretively.
- Lateness or absence from school.
- Repeated physical pain or nausea with no evident cause.
- Increase in lateness or absenteeism.

Realistic Expectations

Mental health issues can be ongoing for a long time. They can be highly impactful on a child's ability to access school. We need to ensure that all members of staff are realistic in their expectations of affected children, to ensure they are not placed under undue stress which may exacerbate their mental health issues.

Expectations should always be led by what is appropriate for a specific child at a specific point in their recovery journey rather than by what has worked well for others, so some degree of flexibility is essential.

Expectations to consider addressing include:

- Academic achievement.
- Absence and lateness.
- Access to extra-curricular activities including sport.
- Duration and pace of recovery.
- Ability to interact and engage within lessons.

Individual Care Plans

It is helpful to draw up an individual care plan for children causing concern or who receive a diagnosis pertaining to their mental health. This should be drawn up involving the child, the parents/carers and relevant health professionals. This can include:

- Details of a child's condition.
- Special requirements or precautions.
- Medication and any side effects.
- Emergency procedures.
- The role the school can play.

Confidentiality

We should be honest with our children about confidentiality. We should let them know this and discuss with them that it might be necessary to pass the information on and tell them:

- 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 child without letting them know. Ideally, we should receive their consent, though there are certain situations when information must always be shared with another staff member and/or a parent/carer. This would always include children up to the age of 16 who are in danger of harm.

If acting to safeguard a child against harm or look out for their welfare it is imperative to share any information you deem important.

In many cases, the parent/carers should be informed, and the child may choose to tell their parent/carers themselves. If this is the case, depending upon severity and immediacy of risk, 24 hours should be given to share this information before the school contacts the parent/carers. We should always give the child the option of the school informing the parent/carers for them or with them.

If a child gives us reason to believe that there may be underlying child protection issues, parent/carers should not be informed, but the DSL must be notified immediately.

Working with Parents/Carers

Where it is deemed appropriate to inform parent/carers, we need to be sensitive in our approach. It can be shocking and upsetting for parent/carers to learn of their child's issues and many may respond with anger, fear or upset. We should therefore give the parent/carers time to reflect.

We should always highlight further sources of information as parents/carers will often find it hard to take in much of the news that we are sharing. We should always provide clear means of how contact can be made with the school regarding further questions and the school should consider booking in a follow up meeting right away as parents/carers may have many questions as they process the information. We should keep a record on each meeting in the child's confidential record.

In order to support all parent/carers of children at our school, we will:

- Update our school resources to provide information about common mental health issues.
- Ensure all parent/carers know who to talk to if they have any concerns about their own child or a friend of their child.
- Make our mental health policy easily accessible to parent/carers.
- Keep parent/carers informed about the topics their children are learning about in PSHE.

Supporting Peers

When a child is suffering from mental health issues, it can be a difficult time for their friends. 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 might need additional support. It is important to consider:

- What friends should and should not be told.

- How friends can support.
- Things friends should avoid doing or saying.
- Warning signs to look out for.
- How friends can access further support for themselves from the school.
- Healthy ways of coping with the difficult emotions they may be facing.

Training

All staff will receive regular training or guidance about recognising and responding to mental health issues as part of the regular child protection training.

For any staff members who require more in depth knowledge, additional CPD will be suggested and provided. Where the need to provide some becomes apparent, we will host twilight training sessions for all staff to promote learning and understanding about specific issues related to mental health.

Suggestions for individual, group, or whole school CPD should be discussed with the Head teacher.

Signposting

We will ensure that staff, children and parent/carers are aware of sources of support within school and in the local community, who it is aimed at and how to access it is outlined in Appendix B.

We will display relevant sources of support in communal areas such as staff rooms, library and notice boards and will regularly highlight sources of support to children within relevant parts of the curriculum. Whenever we highlight sources of support, we will increase the chance of children seeking help by ensuring children understand:

- What help is available.
- Who it is aimed at.
- How to access it.
- Why to access it.
- What is likely to happen next.

Teaching about Mental Health

The skills, knowledge and understanding needed by our children to keep themselves and others physically and mentally healthy and safe are included as part of the PSHE curriculum.

The specific content of lessons will be determined by the specific needs of the cohort being taught but there will always be an emphasis on enabling children to develop the skills, knowledge, understanding, language and confidence to seek help, as needed, for themselves or others.

We will follow the PSHE Association's Guidance[1] to ensure that we teach mental health and emotional wellbeing issues in a safe and sensitive manner which helps rather than harms.

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

Policy Review

This policy will be reviewed every two years as a minimum.

Effectiveness of the policy will be assessed through:

- feedback from staff, children and parents
- review of the policy by SLT and governors to determine if objectives have been met and to identify barriers and enablers to ongoing policy implementation.

The policy is next due for review in September 2024.

Signed: _____

Date: _____

Appendix A: Further information and sources of support about common mental health issues

Prevalence of Mental Health and Emotional Wellbeing Issues[2]

- 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 problems were diagnosed in childhood. Less than half were treated appropriately 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.

Support on many mental health issues 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).

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 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

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

Eating problems

[2] Source: Young Minds

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

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

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

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/

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

School Based Support

- **Referral to CAMHS (Child and Mental Health Service).** Suitable for all children in primary and secondary schools. Access is via a referral from the school with permission and consent from the parents. The HT/DHT/SENCO is able to make a referral and discuss the process with the child and parents. Meetings and support can be organised in school time, having access to a room and review meetings planned as appropriate. This is suitable for a range of family experiences and can include family therapy and play therapy together with counselling support.
- **Discussion with the School Nurse.** HT/DHT/SENCO talk together and discuss concerns with school nurse. With consent from the parents, the child is able to speak with the school nurse with/without parents present – depending on the needs of the child and request of the parents. This is suitable for dealing with any health issues and managing emotions of the child and family.
- **Referral to the Early Help Team.** A Referral form is completed. This can be carried out by the HT, DHT or SENCO in consultation and with parental consent. Meetings can take place on the school site with parents fully involved. Several meetings take place with a review session to discuss the next steps. This is available to children in primary schools and can include support on Transition, managing change and issues around anxiety associated with bereavement and separation.
- **In school, members of the Senior Leadership Team are available to support children experiencing short term issues.** However, SLT are not trained counsellors and may need to sign post to other agencies for more, long term support. Staff can support with managing behaviour and developing behaviour that fully supports learning. With more challenging behaviour, the school can refer to the Inclusion officers at the Behaviour, Emotional and Social Difficulties Team with regards to behaviour issues or the Educational Psychologist if relating to lack of progress with learning.

Appendix C: Talking to pupils/students when they make mental health disclosures

The advice below is from children/students themselves, in their own words, together with some additional ideas to help you in initial conversations with children/ students when they disclose mental health concerns. 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 child/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 child/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 pupil/ 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 pupil/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 pupil/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 pupil/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 child.

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 issues. Whatever happens, you should have some form of next steps to carry out after the conversation because this will help the child to realise that you're working with them to move things forward.

Acknowledge how hard it is to discuss these issues

> *"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 child 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 child.

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 child 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 child.

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 child wants to know they can trust you. That means if they want you to keep their issues 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. Consider yourself the child's ally rather than their saviour and think about which next steps you can take together, always ensuring you follow relevant policies and consult appropriate colleagues.

Appendix D: Making a CAMHS referral.[3]

If the referral is urgent it should be initiated by phone so that CAMHS can advise of best next steps

Before making the referral, have a clear outcome in mind, what do you want CAMHS to do? You might be looking for advice, strategies, support or a diagnosis for instance.

You must also be able to provide evidence to CAMHS about what intervention and support has been offered to the pupil by the school and the impact of this. CAMHS will always ask 'What have you tried?' so be prepared to supply relevant evidence, reports and records.

General considerations

- Have you met with the parent(s)/carer(s) and the referred child/children?
- Has the referral to CMHS been discussed with a parent / carer and the referred child?
- Has the child given consent for the referral?
- Has a parent / carer given consent for the referral?
- What are the parent/carer child's attitudes to the referral?

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 parent/carer responsibility?
- Surnames if different to child's.
- GP details.
- What is the ethnicity of the child/ family.
- Will an interpreter be needed?
- Are there other agencies involved?

Below are some bullet points West London Mental Health Trust CAMHS Team send to GP's where the referral information is poor:

- Emotional and mental wellbeing state/presentation – e.g. current presentation's impact upon: emotional wellbeing, socialising, behaviour, academia and general functioning.
- How long the worry/concern has been present and when was it first noticed.
- Child's current mental state; mood, appetite, sleep and concentration.
- Interventions and support already tried or in place already (e.g. school pastoral support to include behavioural support, other agencies/services involved to include Children's Services and Early Help)
- Detailed risks to self or others

Reason for referral

- What are the specific difficulties that you want CAMHS to address?

[3] Adapted from Surrey and Border NHS Trust

- 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/issues involved.

Further helpful information

- Who else is living at home and details of separated parents 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 pupil'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?