# HERRIES PREPARATORY SCHOOL

# 7a – MENTAL HEALTH POLICY

**Reviewed September 2020 as standalone policy**
**Created November 2018 as part of Safeguarding & Child Protection Policy**

**Rationale:** The Department of Health has said: 'there is no health without mental health (2012) but possibly a more practical way of expressing this is to say: 'mental health is not just the absence of mental illness but rather the presence of emotional wellbeing'.

Figures show 10% of children aged 5 – 16 have been diagnosed with a mental health problem. The British Child and Adolescent Mental Health Surveys from 1999 and 2004 found that 1 in 10 children and young people under the age of 16 had a diagnosable mental health disorder. A further breakdown by age shows that among 5 to 10 year olds, 10% of boys and 5% of girls had a mental health problem while among the 11 to 16 year olds, the prevalence was 13% for boys and 10% for girls. At Herries we are committed to promoting a culture of greater awareness of wellbeing. Wellbeing is at the forefront of our Personal Development programme which is evidenced through homework diary pages and our toolbox, as well as our robust pastoral approach involving nurture groups. Promoting good mental health is a priority.

The purpose of the policy is to underline the importance of promoting good mental health and emotional wellbeing and to facilitate early recognition of mental health issues in our pupils, thereby preventing the escalation of problems by early intervention. It serves to assist staff in their actions so that appropriate help and support can be accessed when problems persist.

The policy aims to:

- Describe the school's approach to mental health issues
- Increase understanding and awareness of mental health issues so as to facilitate early intervention of mental health problems
- Alert staff to warning signs and risk factors
- Provide support and guidance to all staff, including non-teaching staff and governors
- Provide support to those who suffer from mental health issues, their peers and parents/carers

This policy has been authorised by the Governors, is addressed to all members of staff and volunteers, is available to parents on request and is published on the

schools website. It applies wherever staff or volunteers are working with pupils even where this is away from the school, for example on an educational visit.

**Child Protection Responsibilities**

Herries is committed to safeguarding and promoting the welfare of children, including their mental health and emotional wellbeing and expects all staff and volunteers to share this commitment. We recognise that children have a fundamental right to be protected from harm and that pupils cannot learn effectively unless they feel secure. We therefore aim to provide a school environment which promotes self-confidence, a feeling of self-worth and the knowledge that concerns will be listened to and acted upon. Every pupil should feel safe, be healthy, enjoy and achieve, make a positive contribution and achieve economic wellbeing (Every Child Matters, 2004, DfES).

The Board of Governors takes seriously its responsibility to uphold the aims of the school and its duty in promoting an environment in which children can feel secure and safe from harm. A nominated Governor monitors the school's safeguarding procedures and through the Headteacher, reports to the Board, making any recommendations for improvements.

The Headteacher is responsible for ensuring that the procedures outlined in this policy are followed on a day to day basis. The DSL and DDSL are responsible for matters relating to child protection and welfare. In addition to the measures outlined in this Safeguarding Policy, the school has a duty of care to protect and promote mental or emotional wellbeing.

**Promotion of good mental health**

Herries promotes emotional wellbeing; it is a growing part of the culture of the school, reflected in and beyond the classroom where good mental health is explored through encouraging resilience, mind-set and mindfulness practice involving PSHEE lessons, values in assembly, the Herries toolbox and the personal development pages in the homework diary. Time, effort and these resources are directed to making 'good' mental health a priority. Through our values, there is also a collective responsibility within the Herries Community for an individual to be empathic towards another's need for help and support. At this level there is much that many people can offer by way of practical support and suggestions using, for example:

- Do something caring for another person
- Getting perspective
- Walking in the fresh air
- Spending time with friends
- Random acts of kindness
- Eating healthily
- Practising mindfulness
- Sport and exercise

**Key People to speak to**

Within the Herries community there are many people who may be concerned about emotional wellbeing and who are ideally placed to act on their concern, for example teaching staff, ELSA trained staff, nurture group staff and friends. Initial intervention that is offered will vary depending on who is involved and what the cause is for concern.

Posters help pupils know whom they can access for help when they feel under emotional stress but it is important for all staff to be available to the children. The worry box adds another layer of pastoral support for each child.

**Identifiable mental health issues**

- Anxiety and Depression
- Eating disorders
- Self-harm

**Signs and symptoms on mental or emotional concerns**

These are outlined in Appendices I, II and III

**Procedures**

The most important role school staff play is to familiarise themselves with the risk factors and warning signs outline at Appendices I, II and III. If staff have a concern about a pupil, or another pupil raises concerns about one of their friends or if an individual pupil speaks to a member of staff specifically about how they are feeling, the DDSL is notified during the pastoral meeting which takes place weekly or in private if it is sensitive.

**Individual Care Plans (ICPs)**

Following consultation between the relevant members of the pastoral team an ICP would be agreed between the pastoral team, the pupil and the pupil's parents (see appendix IV). This would be available to the relevant teaching staff in order to provide the appropriate level of support for the pupil.

**Confidentiality and information sharing**

Pupils may choose to confide in a member of staff if they are concerned about their own welfare or that of a peer. Pupils should be made aware that it may not be possible for staff to offer complete confidentiality. If a member of staff considers a pupil to be at any 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 a member of staff to do so. We will always explain to the child that if and when we break confidentially, it is so that we can support the child promoting trust and engagement with the child.

**Responsibilities and procedures under the policy relating to mental health first aid**

The school medical officer is responsible for maintaining accurate records of all mental health first aid given in the sick room.

**The DSL is responsible for:**

- Maintaining accurate records of all safeguarding and child protection issues
- To signpost children and families to the appropriate level of external support
- To support staff in dealing with pupils who have mental health issue

A record must be kept of all incidents and the first aid treatment/support given. A copy is kept by the school medical officer and a copy is kept in the Pastoral File. Records should be kept securely in our archive until the child has reached 18. If an incident that is linked to a mental health concern is serious, an incident report should be completed.

**Absence from school**

If a pupil is absent from school for any length of time then appropriate arrangements will be made to send work home. This may be in discussion with any medical professionals who may be treating a pupil.

If the school considers that the presence of a pupil in a school is having a detrimental effect on the wellbeing and safety of other members of the community or that pupils mental health concern cannot be managed effectively and safely within the school, the Headteacher reserves the right to request that parents withdraw their child temporarily until appropriate reassurance have been met. It might be that permanent specific classroom support will need to be arranged through the family and provided. Reintegration to school: should a pupil require some time out of school, the school will be fully supportive of this and every step will be taken in order to ensure smooth reintegration back into school when they are ready.

The Assistant Head Pastoral will work alongside the Medical officer, DSL, the pupil and the parents to draw up an appropriate care plan (see Appendix IV). The pupil should have as much ownership as possible with regards to the ICP so that they feel they have some control over the situation. If a phased return to school is deemed appropriate, this will be agreed with the parents.

**ALGEE**

**Ask, assess, act**

Where a child is distressed, the member of staff should ask them what support they need, 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 child 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** and speak to the Assistant Head Pastoral quickly.

**High Risk**
If you consider the child to be at risk then you should follow Child Protection procedures and report your concerns directly to the DSL (Headteacher) who 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 (ICP)

**Low Risk: The child needs a period of 'watchful waiting'**
The Assistant Head Pastoral will instigate the appropriate time period of watchful waiting (up to 4 weeks).
After a period of watchful waiting, a child deemed to have continuing symptoms should be referred to a medical professional. This might be a specialist CAMHS or private referral.

**APPENDIX I Anxiety disorders**

Anxiety 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 children 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, some 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 learning or relationships.

**Anxiety disorders include:**

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

**Symptoms of an anxiety disorder**
**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 or 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)

**Depression**
A clinical depression is one that lasts for at least 2 weeks, affects behaviour and has physical, emotional and cognitive effects. Depression is a common but serious illness and can be recurrent. Rates of depression are higher in girls than in boys. Depression in children 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.

**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 family relationship

**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.
- 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.

## APPENDIX II EATING DISORDERS

### Definition of Eating Disorders

Anyone can get an eating disorder. People with eating disorders are preoccupied with food and/or their weight and body shape, and are usually highly dissatisfied with their appearance. They will strive to maintain a low body weight. 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, by restricting what they eat and sometimes compulsively over-exercising. In contrast, people with bulimia have episodes of binge-eating, characterised by a loss of control, and usually in secret. This is then often followed by feelings of guilt or disgust, triggering compensatory behaviours to prevent weight gain.

### Risk Factors

### Individual Factors

• Difficulty expressing emotions – coping with significant changes in body shape or weight around puberty, in both boys and girls
• A tendency to comply with other's demands – following the crowd
• Very high expectations of achievement, perfectionism and low self-esteem

### Family Factors

• A home environment where food, weight or appearance have disproportionate significance or an over-protective home environment
• Poor parental relationships and arguments

• 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

**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 should always be taken seriously and staff observing any of these warning signs should seek further advice from one of the designated teachers for safeguarding children or from the medical officer.

**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 or following a diet/ excluding food groups, e.g. carbohydrates
• Skipping meals
• Scheduling activities during lunch
• Strange behaviour around food
• Excessive drinking of water

• Increased conscientiousness
• Increasing isolation / loss of friends
• Belief they are overweight
• Secretive behaviour
• Visiting the toilet immediately after meals

**Psychological Signs**
• Preoccupation with food and sensitivity about eating
• Denial of hunger despite lack of food
• Feeling distressed or guilty after eating
• Self-dislike – particularly of body shape and 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 DSL aware of any child causing concern. Following the report, the DSL will decide on the appropriate course of action. This may include:
• Contacting parents/carers
• Arranging professional assistance e.g. doctor, nurse, counsellor
• Arranging a referral to CAMHS – with parental consent
• Giving advice to parents, teachers and other pupils

**Management of eating disorders in school**
The school will not discriminate against pupils with an eating disorder and will enable them whenever appropriate, to be involved in sports. Advice will be taken from medical professionals, however, and the amount and type of exercise will be closely monitored.

**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 Assistant Head Pastoral, form tutor and medical officer will initially talk to the parents/carers to work out how to prevent their child from falling behind. This information will be shared with the relevant pastoral/ teaching staff on a need to know basis and to inform the ICP.

**Pupils Undergoing Treatment for/Recovering from Eating Disorders**

The decision about how, or if, to attend school while they are suffering from an eating disorder should be made on a case by case basis. This decision should come from discussion with the pupil, their parents and members of the team supporting the pupil. The reintegration of a pupil into school following a period of absence should be handled sensitively.

**Further Considerations**

Any meetings regarding eating disorders should be recorded in writing including:
• Dates and times
• An action plan

• Concerns raised
• Details of anyone else who has been informed
This information should be stored in the Pastoral File held by the DSL

**Appendix III 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
• Hair-pulling
• Banging or hitting the head or other parts of the body
• Scrubbing the body excessively

**Risk Factors**
The following risk factors may make a child particularly vulnerable:

**Individual Factors:**
• Depression/anxiety
• Poor communication skills
• Low self-esteem
• Poor problem-solving skills
• Hopelessness
• Impulsivity

**Family Factors**
• Unreasonable expectations
• 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 DSL.

**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 and lowering of academic achievement
• Talking or joking about self-harm or suicide
• Expressing feelings of uselessness

• Unwillingness to participate in certain sports activities e.g. swimming

**Staff Roles in working with 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. School staff may experience a range of feelings 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 high risk behaviour should consult the DSL. Following the report, the DSL will decide on the appropriate course of action. Meetings should be dated, recorded and kept securely in the Pastoral file.

**Further Reading and Useful Links**
HM Government (2011), No Health Without Mental Health, Department of Health
Websites

Young Minds: http://www.youngminds.org.uk/for_parents

b-eat: http://www.b-eat.co.uk/

Childline: http://www.childline.org.uk

Mind: http://www.mind.org.uk/

NHS: http://www.nhs.uk/livewell/mentalhealth/Pages/Mentalhealthhome.aspx

Mental Health Foundation: http://www.mentalhealth.org.uk/