Spring Hill High School
Mental Health & Wellbeing Policy

Policy: Mental Health & Wellbeing Policy`
Policy Reference: SHHS-CMc/AW
Version Number: 1.0
Date : September 2020
Review Date: September 2021
Authorised by: Governors and
Updated by: Clare McGrath, SENCo and Amber Weir, Mental Health First Aider

1.0 Policy Statement

1.1 Spring Hill High School promotes the mental and physical health and emotional wellbeing of all its students and staff. For students wellbeing is at the forefront of the School's PSHE programme and promoting good mental health is a priority as the majority of our students have social, emotional and mental health difficulties. Spring Hill High School has a range of interventions available to support mental health and wellbeing, for example, Music Therapy, equine sessions, Mindfulness in Schools Project (MISP), and Talkabout for Teenagers, social skills intervention. Students are supported by a Life Skills Coach. These interventions are tailored for those students that need it, when the time is right. The physical, mental and emotional health benefits of exercise are well documented and the school actively encourages sport for all. The school has identified 10 key qualities that are fundamental to good mental health and wellbeing:

1. Good sleep routine
2. Time for exercise
3. Eating healthily at regular times
4. Time to relax
5. Emotional resilience – accepting being 'good enough'
6. Sense of humour
7. Firm boundaries
8. Random acts of kindness
9. Walking in fresh air
10. A sense of perspective

1.2 Mental health issues can be de-stigmatised by educating students, staff, parents and carers. This is done through tutorials, school council meetings, World Mental Health Day, the delivery of the PSHE curriculum, Pop-up Wellbeing projects and through staff INSET. Positive mental health is also promoted through strong pastoral care and the family social model.

1.3 This policy aims to:

- describe the School's approach to mental health issues
- increase understanding and awareness of mental health issues so as to facilitate the right intervention at the right time
- alert staff to warning signs and risk factors

- provide support and guidance to all staff, including non-teaching staff and governors, dealing with students who suffer from mental health issues
- provide support to students who suffer from mental health issues, their peers and parents/carers.

1.4 This policy has been authorised by the Governors, addressed to all members of Staff, Board of Governors and is available to parents and carers on request. It is also published on the school website. This policy can be made available in large print or other accessible format if required. It applies wherever staff are working with students even where this is away from the School, for example on an educational visit.

2.0 Child Protection Responsibility

2.1 Spring Hill High School is committed to safeguarding and promoting the welfare of children and young people, including their mental health and emotional wellbeing, and expects all staff and Governors to share this commitment. We recognise that children have a fundamental right to be protected from harm and that students 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 students' concerns will be listened to and acted upon. Every student should feel safe, be healthy, enjoy and achieve, make a positive contribution and achieve economic wellbeing (Every Child Matters, 2004, DfES).

2.2 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 instigates a review of the school's safeguarding procedures and reports to the Board annually, making any recommendations for improvements.

2.3 The Headteacher is responsible for ensuring that the procedures outlined in this policy are followed on a day to day basis.

2.4 The School has a senior member of staff with the necessary status and authority (Designated Person – Designated Safeguarding Lead, DSL) to be responsible for matters relating to child protection and welfare. Parents and carers are welcome to approach the DSL if they have any concerns about the welfare of any child or young person in the school, whether these concerns relate to their own child or any other. If preferred, parents and carers may discuss concerns in private with the child's Deputy Headteacher or the Headteacher who will notify the DSL in accordance with these procedures.

2.5 In addition to the child protection measures outlined in the School's Safeguarding (Child Protection) policy, the School has a duty of care to protect and promote a child or young person's mental or emotional wellbeing.

3.0 Background

3.1 One in ten young people between the ages of 5 and 16 will have an identifiable mental health issue at any one time. By the time they reach university this figure is as high as 1 in 6. Around 75% of mental health disorders are diagnosed in adolescence (source: www.youngminds.org.uk). See Appendix VI for further reading. At Spring Hill High School 83% of our students (cohort 2018-2019) has social, emotional and mental health difficulties (SEMH) identified as their primary need, therefore considerably higher than the national averages. The school is a small independent school with a specialist area of SEMH, we play a

fundamental role in helping students turn their lives around and often this is assisting their recovery from often traumatic adverse childhood experiences. With the proper care and nurture, all students have the right to harness their innate capacity to recover from their experiences. Spring Hill High School give them that opportunity.

4 Identifiable mental health issues

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

- **Neurodevelopmental disorders.** This class covers a wide range of problems that usually begin in infancy or childhood, often before the child begins grade school. Examples include autism spectrum disorder, attention-deficit/hyperactivity disorder (ADHD) and learning disorders.
- **Schizophrenia spectrum and other psychotic disorders.** Psychotic disorders cause detachment from reality — such as delusions, hallucinations, and disorganized thinking and speech. The most notable example is schizophrenia, although other classes of disorders can be associated with detachment from reality at times.
- **Bipolar and related disorders.** This class includes disorders with alternating episodes of mania — periods of excessive activity, energy and excitement — and depression.
- **Depressive disorders.** These include disorders that affect how you feel emotionally, such as the level of sadness and happiness, and they can disrupt your ability to function. Examples include major depressive disorder and premenstrual dysphoric disorder.
- **Anxiety disorders**. Anxiety is an emotion characterized by the anticipation of future danger or misfortune, along with excessive worrying. It can include behavior aimed at avoiding situations that cause anxiety. This class includes generalized anxiety disorder, panic disorder and phobias.
- **Obsessive-compulsive and related disorders.** These disorders involve preoccupations or obsessions and repetitive thoughts and actions. Examples include obsessive-compulsive disorder, hoarding disorder and hair-pulling disorder (trichotillomania).
- **Trauma- and stress-related disorders.** These are adjustment disorders in which a person has trouble coping during or after a stressful life event. Examples include post-traumatic stress disorder (PTSD) and acute stress disorder.
- **Dissociative disorders.** These are disorders in which your sense of self is disrupted, such as with dissociative identity disorder and dissociative amnesia.
- **Somatic symptom and related disorders.** A person with one of these disorders may have physical symptoms that cause major emotional distress and problems functioning. There may or may not be another diagnosed medical condition associated with these symptoms, but the

reaction to the symptoms is not normal. The disorders include somatic symptom disorder, illness anxiety disorder and factitious disorder.

- **Feeding and eating disorders.** These disorders include disturbances related to eating that impact nutrition and health, such as anorexia nervosa and binge-eating disorder.
- **Elimination disorders.** These disorders relate to the inappropriate elimination of urine or stool by accident or on purpose. Bed-wetting (enuresis) is an example.
- **Sleep-wake disorders.** These are disorders of sleep severe enough to require clinical attention, such as insomnia, sleep apnea and restless legs syndrome.
- **Gender dysphoria.** This refers to the distress that accompanies a person's stated desire to be another gender.
- **Disruptive, impulse-control and conduct disorders.** These disorders include problems with emotional and behavioral self-control, such as kleptomania or intermittent explosive disorder.
- **Substance-related and addictive disorders.** These include problems associated with the excessive use of alcohol, caffeine, tobacco and drugs. This class also includes gambling disorder.
- **Neurocognitive disorders.** Neurocognitive disorders affect your ability to think and reason. These acquired (rather than developmental) cognitive problems include delirium, as well as neurocognitive disorders due to conditions or diseases such as traumatic brain injury or Alzheimer's disease.
- **Personality disorders.** A personality disorder involves a lasting pattern of emotional instability and unhealthy behaviour that causes problems in your life and relationships. Examples include borderline, antisocial and narcissistic personality disorders.

Ref: https://www.mayoclinic.org/diseases-conditions/mental-illness/diagnosis-treatment/drc-20374974

NB. Self-harm isn't a mental health problem but it is often linked to mental distress and/or illness.

4.2 Important elements enabling the School to identify mental health difficulties is that the team around the child works in a wholly integrated and holistically-charged manner to provide the best possible outcomes for all involved. School staff have close, effective working relationships with therapists, Forward Thinking and other CAMHs teams, social workers and psychologists, to name a few. The effective use of data (i.e. monitoring changes in pupils' patterns of attendance/academic achievement) and a strong, effective pastoral team whereby staff know students very well and can identify unusual or differing presentational behaviours. Staff then take the necessary steps to help the student as well as ensuring they are free from harm.

5 Signs and symptoms of mental or emotional concerns

5.1 These are outlined in Appendices I, II and III.

6.0 Procedures

6.1 The most important role school staff play is to familiarise themselves with the risk factors and warning signs outlined at Appendices I, II and III. *Figure 1* outlines the procedures that are followed if staff have a concern about a student, if another student raises concerns about one of their peers or, if an individual student speaks to a member of staff specifically about how they are feeling.

Figure 1 - **Procedures following a concern**

Spring Hill High School
Mental Health & Wellbeing Policy

ALGEE

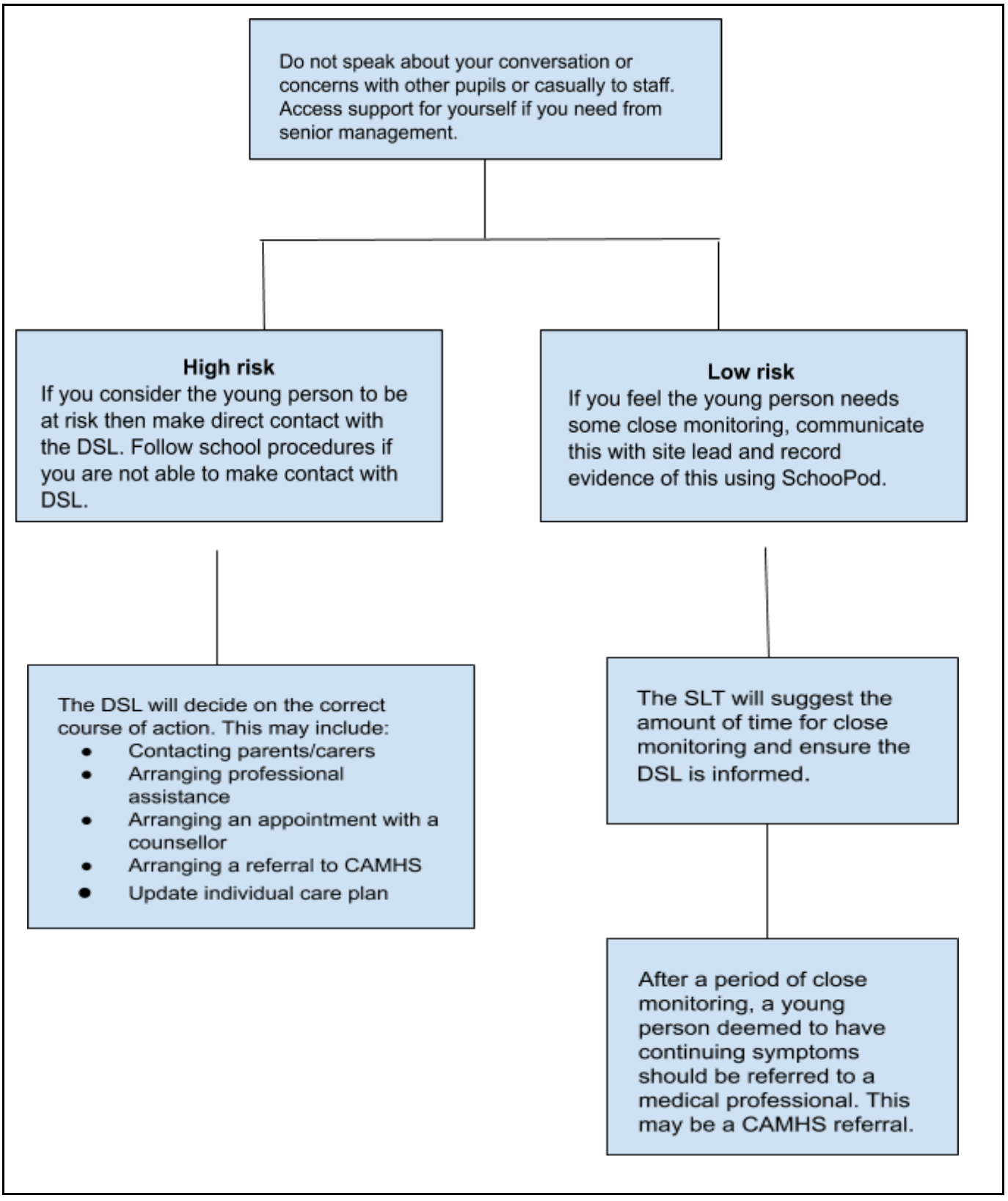
A - Approach, assess, assist.
Open conversation, consider own judgements, be sensitive of personal space, respect privacy unless risk of harm to self or others. Watch for warning signs, self harm? Panic attack? Traumatic event? Psychotic state? Medical emergency? Ensure own personal safety, ensure person is not left alone if immediate crisis, seek help if in doubt, inform external helpers of situation & mental health needs, encourage person to talk, don't give advice, argue or deny their feelings, reassure help is available, stay calm, physical first aid for emergencies.

L - Listen and communicate non-judgmentally
Listen without judging the person. Set aside any judgments you hold, listen without interrupting, ask appropriate questions, reflect back what person has said, silence can be supportive, open body language, comfortable eye contact, personal space, don't be critical, avoid confrontation unless necessary in crisis, remember you can acknowledge emotional experience without agreeing.

G - Give support and information
Give emotional and practical support and information.
Treat person with respect and dignity, do not blame them for their difficulties, have realistic expectations for them, offer consistent emotional support, give hope to recovery (treatments are available), give practical help but don't try to solve all problems, give high quality info relevant to their condition, when risk to self or others, don't keep a secret but try to consult person before sharing details.

E - Encourage appropriate professional help
This can be a difficult step but vital, help person make decision - early intervention aids recovery. Discuss wide range of options: GPs, counsellors, psychologists, psychiatrists, NHS, Community mental health teams, voluntary sector. GP first port of call, 999 for emergency. Medical and psychological treatments both important. If person does not want help, explore reasons why, give support, respect person's right, if very unwell, seek help on their behalf, involve them as much as possible, never threaten with forced treatment.

E - Encourage other supports
Family/friends can play key roles & can help by listening, encouraging & providing practical & emotional support, support groups & informal befriending services can validate experiences, reduce isolation and provide peer learning for self-help, voluntary and community sector support, self-help strategies can help and give people a sense of regaining control and doing something positive, Wellbeing strategies (5 ways to Wellbeing, 10 keys to Happier living), Complementary therapies (mindfulness, massage therapy, yoga, relaxation therapies, nutrition, exercise, creativity), Wellness Recovery Action Planning.



7.0 One Page Statements and Risk Assessments

7.1 Following consultation between the relevant members of the staff team, Deputy Headteachers and/or Site Leaders will update individual student risk assessments and inform the SENCo who will also update

individual student One Page Statement. The student and the student's parents/carers will be informed of this alteration/addition. All risk assessments and One Page Statements are available to all the relevant teaching and non-teaching staff in order to provide the appropriate level of support for the student. The context of each student is also included in all half term curriculum plans. The health professionals around the child or young person may provide additional information which may include confidential information.

8 Confidentiality and information sharing

8.1 Students may choose to confide in a member of school staff if they are concerned about their own welfare or that of a peer. Students should be made aware that it may not be possible for staff to offer complete confidentiality. **If a member of staff considers a student 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 student puts pressure on a member of staff to do so.

8.2 Confidentiality will be maintained within the boundaries of safeguarding the student. Staff will pass on information to a member of the senior leadership team, the DSL if necessary, parents and carers and the wider therapeutic team if appropriate to do so. Parents should be involved wherever possible, although the student's wishes should always be taken into account.

8.3 Parents must disclose to the Deputy Headteacher or Site Leader any known mental health problems or any concerns they may have about a student's mental health or emotional wellbeing. This includes any changes in family circumstances that may impact the student's wellbeing.

9 Records and reporting

9.1 Further guidance on procedures for specific mental health concerns is given at Appendices I, II and III.

10 Mental Health First Aid

10.1 In order to ensure adequate mental health first aid provision and awareness it is our policy that:

- There are sufficient numbers of trained personnel to support those pupils who are experiencing mental and/or emotional difficulties.
- A qualified youth mental health first aider (AW) is always available during normal school hours (see section 11.4 for definition of 'qualified youth mental health first aider' and section 12.1 for hours of work).

11 Responsibilities under the policy relating to mental health first aid

11.1 The Designated Safeguarding Lead is responsible for:

- Maintaining accurate records of all safeguarding and child protection issues.

11.2 Qualified youth mental health first aiders (Appendix V) are responsible for:

- Responding promptly to calls for assistance

- Providing first aid support within their level of competence
- Summoning medical help as necessary
- Recording details of support given

11.3 A qualified youth mental health first aider is someone who has undertaken a 12 hour training module approved by MHFA England and holds a valid certificate of competence. Mental Health First Aid is used in over 16 countries worldwide and was introduced into England by the National Institute for Mental Health England (NIMHE) in 2007. MHFA does not prepare people to become therapists. It does, however, enable people to recognise the symptoms of mental ill health, how to provide initial help (first aid) and how to guide a person towards appropriate professional help. The certificate must be issued by an approved organisation and must be renewed every three years. See Appendix V for a list of current youth mental health first aiders.

11.4 All staff have a duty of care towards the students and should respond accordingly when first aid situations arise. New staff are briefed about the student's health concerns and/or diagnoses and how to support the student within school. All staff are reminded regularly about the specific medical and emotional needs of students within the school and they are asked to familiarise themselves with Individual Risk Assessments and One Page Statements detailing those students with medical needs that require specific action to support their mental/emotional wellbeing. The list of qualified Youth Mental Health First Aiders is recorded in this policy and is updated annually.

12.0 Staff roles, environment and procedures

12.1 Students may require the use of low-arousal, calming environment in times of distress, all school sites have designated areas for this to be possible. Use of the medical room on each school is also an option, particularly if there is also a presenting physical concern. Some students may find it more appropriate to use a designated sensory space and have access to sensory items in times of distress.

12.2 The school counsellor/Life Coach and 'in-training' counsellor? is available every day. Students may self-refer to the school counsellor. A member of the Senior Leadership team may feel it necessary to inform Child and Adolescent Mental Health Services (CAMHS). The school music therapist is available in school every Wednesday and Thursday. The school speech and language therapist is available in school every Tuesday and the school speech and language therapist assistant is available every day.

12.3 A record must be kept of all incidents and the first aid treatment/support given, staff involved will complete a detailed significant event log and a copy should be filed in the individual student file, if appropriate to do so. Records are kept for a minimum of eight years in accordance with guidelines for storage of medical information and records.

12.4 If an incident that is linked to a mental health concern is serious, staff should inform the DSL and the staff involved should provide a detailed log.

13.0 Absence from school

13.1 If a student 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 student.

13.2 If the School considers that the presence of a student in school is having a detrimental effect on the wellbeing and safety of other members of the school or that a student's mental health concern cannot be managed effectively and safely within the school, the Headteacher reserves the right to request that parents and carers withdraw their child temporarily until appropriate reassurances have been met.

14.0 Reintegration to school

14.1 Should a student require some time out of school, the School will be fully supportive of this and every step will be taken in order to ensure a smooth reintegration back into school when they are ready.

14.2 The student's Deputy Headteacher will work alongside the Headteacher, SENCo, the Local Authority SEND teams, Virtual School for looked after children, Social Care the student and their parents/carers to draw up an appropriate plan of action. The student should have as much ownership as possible with regards to any decisions made so that they feel they have control over the situation. If a phased return to school is deemed appropriate, this will be agreed with the local authority and the student's parents or carers.

14.3 If a significant period of time has elapsed where a pupil's return to school might not be considered to be in their best interests, the Headteacher will liaise with the pupil's parents, in consultation with the SENCo and the Local Authority on a case by case basis, to support an application to another educational establishment.

Appendix I

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 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 it 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 DSL aware of any child causing concern.

Following the report, the DSL will decide on the appropriate course of action and will 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 or private referral – with parental consent
- Giving advice to parents, teachers and other students

Students may choose to confide in a member of school staff if they are concerned about their own welfare, or that of a peer. Students 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 student puts pressure on you to do so.

Appendix II

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 student 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 DSL or from a medical professional.

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 DSL aware of any child causing concern. Following the report, the DSL 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, EDU or private referral – with parental consent
- Giving advice to parents, teachers and other pupils
- Inform the student's Deputy Headteacher so that the student's risk assessment is updated and shared with all staff.

The DSL will recommend that the students be referred to a medical professional to weigh the student and to monitor their weight on a regular, individual basis. This is so that the medical professional will 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. If there is further weight loss or other cause for concern, especially where the parent/carer do not seem to be taking the matter seriously the DSL will raise a safeguarding concern through to MASH.

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 students. Excessive exercise, however, can be a behavioural sign of an eating disorder. If the DSL deem it appropriate they may liaise with PE staff to monitor the amount of exercise a student is doing in school. They may also request that the PE staff advise parents/carers of a sensible exercise programme for out of school hours. All PE teachers at the School will be made aware of which students have a known eating disorder. The School will not discriminate against students 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. Students may be asked to stop until they are deemed healthy enough to resume activity.

When a pupil is falling behind in lessons
If a student is missing a lot of time at school or is always tired because their eating disorder is disturbing their sleep at night, the Deputy Headteacher in consultation with the DSL will initially talk to the parents/carers to work out how to help prevent their child from falling behind. The SENCo may be involved in this process. If applicable, the Deputy Heasdteacher will consult with the professional treating the student. This information will be shared with the relevant pastoral/ teaching staff on a need to know basis.

Pupils Undergoing Treatment for/Recovering from Eating Disorders
The decision about how, or if, to proceed with a student'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 student, their parents/carers, school staff and members of the multi-disciplinary team treating the student. The reintegration of a student into school following a period of absence should be handled sensitively and carefully and again, the student, their parents/carers, school staff and members of the multi-disciplinary team treating the student should be consulted during both the planning and reintegration phase.

Further Considerations
Any meetings with a student, their parents or their peers regarding eating disorders should be recorded:

- Dates and times
- An action /care plan
- Concerns raised
- Details of anyone else who has been informed

Appendix III

Self-Harm

Spring Hill High School
Mental Health & Wellbeing Policy

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-esteem
- 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 student 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
- 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 students who self-harm

Students 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 student such as anger, sadness, shock, disbelief, guilt, helplessness, disgust and rejection. However, in order to offer the best possible help to students it is important to try and maintain a supportive and open attitude – a student who has chosen to discuss their concerns with a member of school staff is showing a considerable amount of courage and trust.

Students need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a student 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 student puts pressure on you to do so.

Any member of staff who is aware of a student engaging in or suspected to be at risk of engaging in self-harm should consult with the DSL.

Following the report, the DSL will decide on the appropriate course of action.

The student's risk assessment should be updated at the earliest stage, agreed by parents/carers and shared with all staff. The risks of self harm may 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 the risk assessment will be updated accordingly.

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 or private referral – with parental consent
- Immediately removing the student 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 student, the immediate safety of the student is paramount, and an adult should remain with them at all times**
- **If a student has self-harmed in school a first aider should be called for immediate help**

Further Considerations

Any meetings with a student, their parents / carers or their peers regarding self-harm should be recorded:

- Dates and times
- Action /care plan
- Concerns raised
- Details of anyone else who has been informed

It is important to encourage students 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 with the DSL.

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 students in the same peer group are harming themselves.

Appendix IV

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 staff
To have bereavement support training and cascade learning to other staff
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 Headteacher, and the family's wishes in communicating with others.
- Deputy Headteacher will meet with the bereaved student and offer support; counselling will be offered.
- Staff should be informed before students and be prepared to share information in age-appropriate ways, as agreed for each individual circumstance.
- Where appropriate, students should be informed, preferably in small groups, by their f=Deputy Headteacher. 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 students need to be informed.
- In the situation of the death of a parent / carer or sibling of a student, the deceased's family may decide that the school contact their childs' friends' parents.
- The school should be aware that the school timetable may need a degree of flexibility to accommodate the needs and wellbeing of students 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 student through their school life, so information should be recorded and shared with relevant people, particularly at transition points. Staff members should be aware of anniversaries where possible.
- The Deputy Headteacher 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

Appendix V

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

NB 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 Took their own life Died by suicide Killed themselves Attempted to take their own life Attempted suicide Engaged in suicidal behaviours	Commit suicide (suicide is not a crime) Unsuccessful or failed suicide Thinking of doing something silly / stupid

Spring Hill High School
Mental Health & Wellbeing Policy

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 person'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 DSL 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:
See the counsellor/Life Coach; book yourself an appointment via a teacher
Call Childline or Samaritans
Speak to a teacher, Gary, DSL or Sheraine, DSL

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.

Clear Fear
An Award-Winning **App** Designed To Help Anxiety Using Cognitive Behaviour Techniques.

<u>Guidance for staff and parents - How to ask about suicide ?</u>

"Are you thinking about suicide?". By using the word suicide, the member of staff supporting the young person will be signalling 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 help immediately 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.

<u>In all events, inform the DSL.</u>

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:

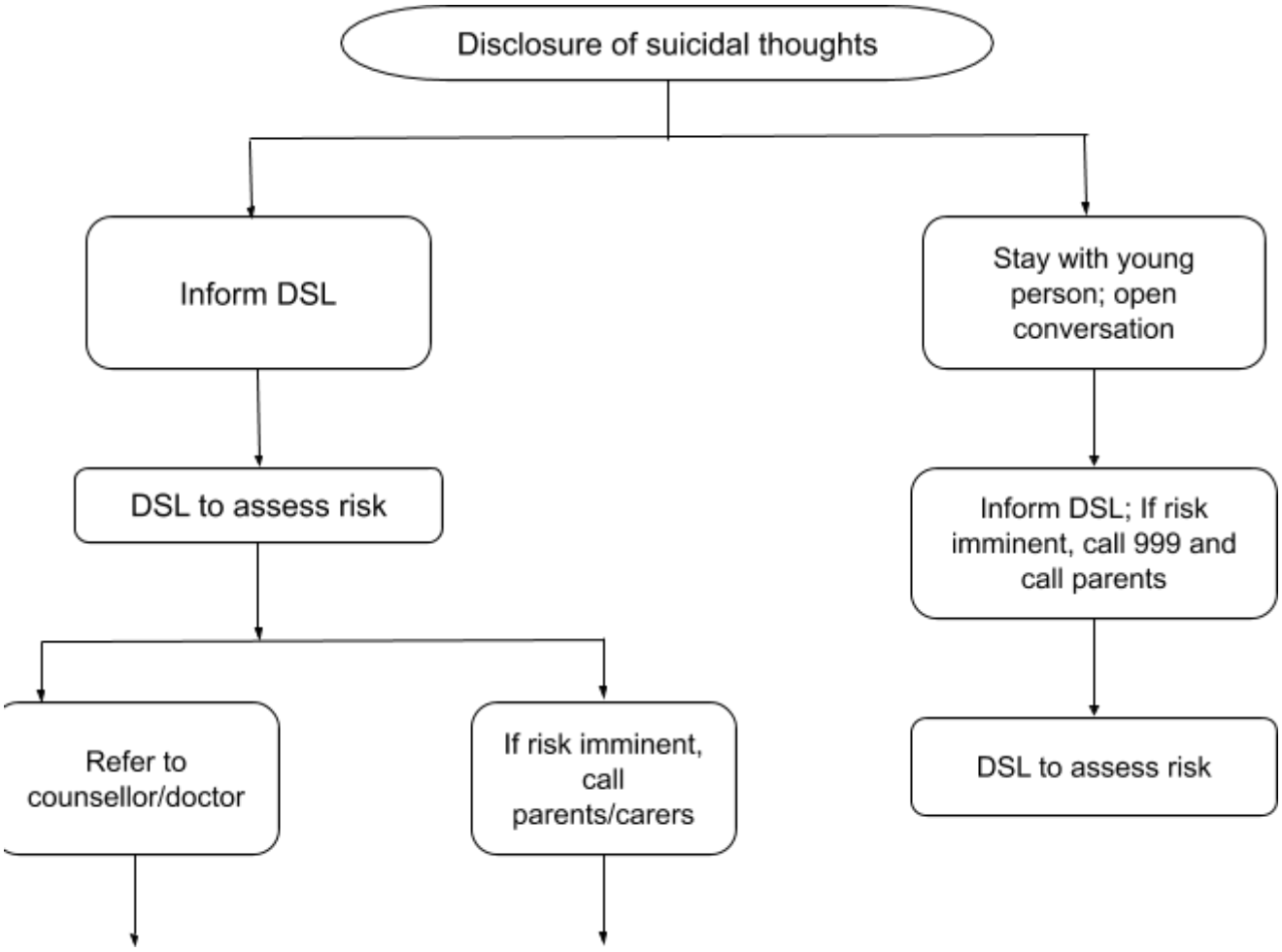
- Reflective practice: it supports us to value and build on prior learning and experience, and allows

for a better understanding of how to work safely and effectively with young people

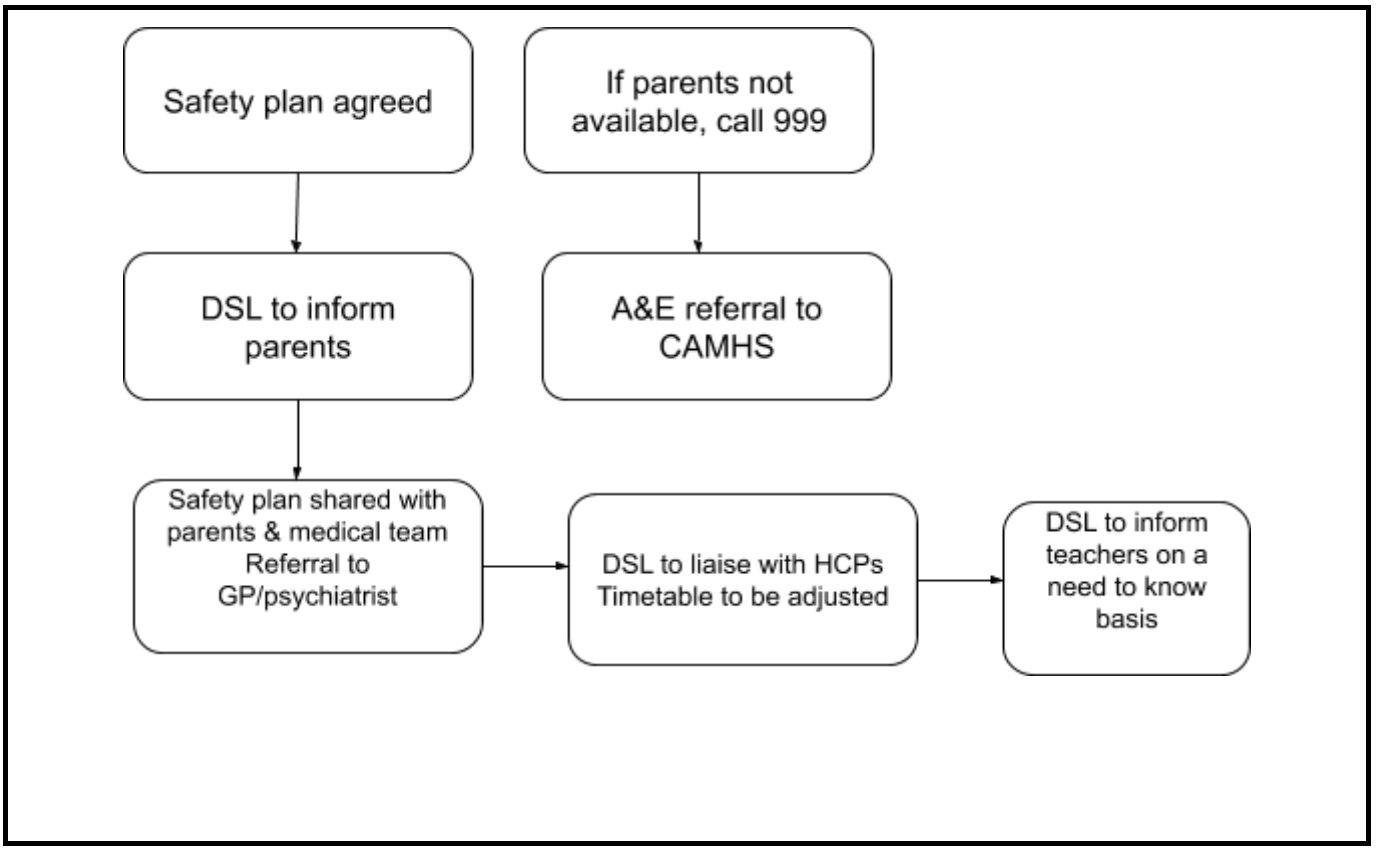
- Training: consider whether you need to seek additional training to improve your skills, knowledge and confidence in helping young people who experience suicidal feelings.
- Be honest about your limits: if supporting the young person becomes too much of a burden, it may affect your relationship with them.

Talk to the DSL, the Chair of Governors or utilise our staff 24 hour counselling support line (Health Assured).

Suicidal Thoughts Pathway



Spring Hill High School
Mental Health & Wellbeing Policy



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

- ❏ Staff members will be alerted to the presenting risk on a need-to-know basis
- ❏ The DSL in consultation with the Deputy Headteacher will offer the young person a chance to talk to their trusted adult in school or our school Life Coach/counsellor at the earliest opportunity
- ❏ This member of staff will further assess the risk and discuss a safety plan with the young person, which will then be shared with the parents / carers, when appropriate, and maybe the SENCo who will inform CAMHs if the student is known to them.
- ❏ The students parents / carers will be asked to take their child to a medical professional who may carry out a screening for depression, mental health or other contributing factors.
- ❏ If the student is not known by CAMHs then either the Deputy Headteacher or DSL will assist the family with urgent referral.
- ❏ Where high risk has been identified and the parents cannot be reached, the DSL may call the emergency services or bring the student to the nearest A&E and bring along relevant documents, e.g. student risk assessment.

Levels of risk and intervention

Risk Level	**Presentation**	**Initial Actions**	**SHHS Options**
Low	Self-harm as coping mechanism; Fleeting thoughts of	Acknowledge distress, identify options to address underlying difficulties and agree a	School counsellor/Life Coach; Self-help resources and

	suicide but no intent or plan; Protective factors evident including support network, hope of recovery seeking help.	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.	online information; In-school monitoring (DSL – weekly)
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; Reluctance to share with support network or withdrawal from peers and/or family.	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; Clarify confidentiality and inform parents. Think about phrasing again	In-school counselling; In-school medical team; Self-help resources and online information; Referral to GP; Consider professional consultation with CAMHS; In-school monitoring (DSL – weekly)
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;	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;	GP; CAMHS; Increased support from existing network; Increased monitoring and review (Deputy headteacher/Site Leader in conjunction with DSL – daily)

	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.	Clarify confidentiality and inform parents and GP	

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

Useful contacts

Papyrus – HOPEline UK	**HOPELineUK** offers support and advice: To children and young people under the age of 35 having thoughts of suicide To anyone who is concerned about a child or young person Call: 0800 068 41 41 Text: 07786 209 697 Email: pat@papyrus-uk.org Monday – Friday 10am – 10pm Weekends 2pm – 10pm Bank Holidays 2pm – 5pm
National Suicide Prevention Alliance	http://nspa.org.uk www.prevent-suicide.org.uk
Support after Suicide Partnership	https://supportaftersuicide.org.uk/

Spring Hill High School
Mental Health & Wellbeing Policy

Child Bereavement UK	Child Bereavement UK provides support to families grieving the loss of a child, and advice for professionals working with bereaved families Phone: 01494 568 900 www.childbereavement.org.uk/
Crisis / Mental Health Crisis	**West London Mental Health Trust 24-hour phone line: 0300 1234 244**
Childline	Phone: 0800 11 11 Counselling chat **https://www.childline.org.uk/get-support/1-2-1-counsellor-chat/** **Email: https://www.childline.org.uk/get-support/**
Samaritans	Phone: 116 123 Email: jo@samaritans.org
Young Minds	**Young Minds** offers advice and support to parents worried about their children's emotional or mental wellbeing Phone: 0808 802 5544 https://youngminds.org.uk/
Emergency Services	999
Child and Adolescent Mental Health Clinics	**Birmingham Forward Thinking** **https://www.forwardthinkingbirmingham.org.uk/** **Parkview Clinic** 60 Queensbridge Road, Moseley, Birmingham, B13 8QE Tel: 0121 333 9955 **Oaklands Centre** Raddlebarn Road, Selly Oak, Birmingham, B29 6JB Tel: 0121 333 8342 **Blakesley Centre** 102 Blakesley Road, Yardley, Birmingham, B25 8RN Tel: 0121 333 8396 **Birmingham Road** 21-23 Birmingham Road, Sutton Coldfield, Birmingham, B72 1QA Tel: 0121 333 8085 **Pause** 21 Digbeth, Birmingham, B5 6BJ **Finch Road** 1st Floor, Finch Road Primary Care Centre, 2 Finch Road, Lozells, Birmingham, B19 1HS

	Tel: 0121 255 0110 **Tamworth, South Staffs** Argyle Street, Glascote , Tamworth, B77 3EW Tel: 0300 790 7000 **Telford & Wrekin** Langley School, Duce Drive, Dawley, Telford, TF4 3JS Tel: 0300 124 0093 **Solihull** 1 Downing Cl, Knowle, Solihull B93 0QA Tel: 01564 732860 **Wolverhampton** Gem Centre, Neachells Ln, Wolverhampton WV11 3PG Tel: 01902 444021 **Sandwell** 48 Lodge Rd, West Bromwich B70 8NY Tel: 0121 612 6620
Other resources	https://www.verywellmind.com/ https://www.mind.org.uk/information-support/types-of-mental-health-problems/suicidal-feelings#.XcvpfFf7TIU https://www.samaritans.org/how-we-can-help/schools/step-step/ https://www.annafreud.org/

Spring Hill High School
Mental Health & Wellbeing Policy

Appendix VI

YOUTH MENTAL HEALTH FIRST AIDERS

Name	Location	Telephone Number
Amber Weir	**Spring Hill High School**	**07527977600**

If a member of staff is unavailable on their site or mobile number, please try Celia on 0121 240 0992 and she will be able to locate this staff member.

Appendix VII

Further Reading and Useful Links

HM Government (2011), *No Health Without Mental Health*, Department of Health

Websites

b-eat: https://www.beateatingdisorders.org.uk/

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

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

NHS: https://www.nhs.uk/conditions/stress-anxiety-depression/

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

Stem4: https://stem4.org.uk/

Royal College of Psychiatrists: https://www.rcpsych.ac.uk/mental-health/parents-and-young-people

Disorders Support: http://www.eatingdisorderssupport.co.uk/help/links-resources

Anna Freud - self-harm: https://soundcloud.com/anna-freud-centre/why-do-some-people-self-harm

Harmless: http://www.harmless.org.uk/

Young Minds: https://youngminds.org.uk/find-help/for-parents/parents-helpline/

National Self Harm Network: http://www.nshn.co.uk/

Youth wellbeing directory: https://www.annafreud.org/on-my-mind/youth-wellbeing/