The Ravensbourne School

MENTAL HEALTH POLICY

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Responsibility: Miss A. Jenkins

Advisory Body Signature:

E21C
EDUCATION FOR THE 21ST CENTURY

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Introduction

This policy has been written with the guidance of the Department for Education document 'Mental Health and Behaviour in Schools – Departmental advice for school staff' March 2016 and 'Keeping Children Safe in Education – September 2016.

This document will outline the protocols and interventions that are in place; roles and responsibilities of staff; factors that put students at risk; and outline mental health problems in children and young people, including self-injury/harm (see Appendix 4).

In order to help students to succeed, the Advisory Body and staff of The Ravensbourne School recognise that they have a role to play in supporting them to be resilient and mentally healthy.

Children who are mentally healthy have the ability to develop psychologically, emotionally, intellectually and spiritually. They are able to initiate, develop and sustain mutually satisfying personal relationships. Use and enjoy solitude. Become aware of others and empathise with them. Play and learn. Develop a sense of right and wrong, and finally to resolve and face problems and setbacks and learn from them.

Factors that put students at risk

Certain individuals and groups are more at risk of developing mental health problems than others. These risks can relate to the child themselves, to their family, or to the community or life events. Risk factors are cumulative. Children exposed to multiple risks such as social disadvantage, family adversity and cognitive or attention problems are much more likely to develop behavioural problems and/or mental health issues. However, these issues can affect anyone at any time during a vulnerable period of their lives.

Risk factors can include:

In the Child: Genetic influences; Low IQ and learning difficulties; Specific developmental delay or neuro-diversity; Communication difficulties; Difficult temperament; Physical illness; Academic failure; Low self-esteem.

In the Family: Overt parental - conflict including domestic violence; Family breakdown - including where children are taken into care or adopted; Inconsistent or unclear discipline; Hostile and rejecting relationships; Failure to adapt to a child's changing needs; Physical, sexual, neglect or emotional abuse; Parental psychiatric illness; Parental criminality, alcoholism, drug addiction or personality disorder; Death and loss – including loss of friendship.

In the School: Bullying; Discrimination; Breakdown in or lack of positive friendships; Deviant peer influences; Peer pressure; Poor student to teacher relationships.
In the Community: Socio-economic disadvantages; Homelessness; Disaster, accidents, war or other traumatic events; Discrimination; Other significant life events.

Factors that make children more resilient

Seemingly against all the odds, some children exposed to significant risk factors develop into competent, confident and caring adults. An important key to promoting children's mental health is therefore an understanding of the protective factors that enable children to be resilient when they encounter problems and challenges.

The Ravensbourne School believes that promoting and developing resilience within their students is important, particularly for those children where home life is less supportive. We believe that school should be a safe and affirming place where students can develop a sense of belonging and feel able to trust and talk openly with adults about their problems.

Protective factors are:

In the child: Secure attachment; outgoing temperament as an infant; good communication skills, sociability; being a planner and having a belief in control; humour; problem solving skills and a positive attitude; Experiences of success and achievement; faith or spirituality; capacity to reflect.

In the Family: At least one positive parent (positive attachment figure) child relationship; affection; clear, consistent discipline; support for education; supportive long term relationship or the absence of severe discord.

In the school: clear policies on behaviour and bullying; 'Open door' policy for children to raise problems; a whole school approach to promoting mental health; a sense of belonging; positive peer influences.

In the community: wider supportive network; good housing; high standard of living; high morale school with positive policies for behaviour, attitudes and anti-bullying; opportunities for valued social roles; range of sport/leisure activities.

Difficult events that may have an effect on students

Form tutors and class teachers see their students every day. They are therefore well placed to spot changes in behaviour or mood that may indicate that there is a problem. The balance between risk and protective factors may be disrupted when difficult events happen, such as:

Loss or separation – resulting from death, parental separation, divorce, hospitalisation, loss of friendships (especially in adolescence), family conflict or breakdown that results in the child having to live elsewhere, being taken into care or adoption.
Life changes – such as birth of a sibling, moving house or changing schools or during transition from primary to secondary school, or secondary to sixth form.
Traumatic events – such as abuse, domestic violence, bullying, violence, accidents, injuries or natural disaster.
The Ravensbourne School aims to offer support at such times with early intervention before mental health problems develop.

Promoting positive mental health

The Advisory Body, Headteacher and Senior Leadership Team are committed to the ongoing development of a culture within the school community that values all students; allows them to feel a sense of belonging and ownership; and makes it possible to talk about problems in a non-stigmatising way.

The school has high expectations for all students and offers appropriate support where necessary. There are clear policies which outline the responsibilities of everyone in the school. The expectation is that all members of the school community are aware of these policies and that they are applied consistently.

The Special Educational Needs Co-ordinator (SENCO) advises and supports staff in understanding their responsibilities to students with special educational needs and disabilities (SEND), and liaises with external SEND professionals when necessary.

The school has a culture of working with parents and carers as well as with students to ensure that their opinions and wishes are taken into account, so that they remain fully informed and can participate in decisions taken about them.

Continuous professional development is promoted amongst all staff with INSET programmes that focus on mental health, informing of the early warning signs, understanding different mental health issues and what to do if they believe there is a developing problem.

There is an established process for escalating issues when staff identify students with possible mental health issues, referring to the Safeguarding Team and the school's Lead Counsellor/Psychotherapist. When necessary the school works with external professionals and services to provide the best support for the student.

The school endeavours to work with others to provide interventions for students with mental health problems via assessment, planning and regular reviews.

Identifying children with possible mental health problems

Behavioural difficulties do not necessarily mean that a child or young person has a possible mental health problem or SEND. Staff are well placed to observe consistent disruptive behaviour or withdrawn behaviour, which can be an indication of an underlying problem.

There are two key elements that are used to identify children at risk of mental health problems:

Effective use of data - noticing changes in attendance, patterns of attainment and changes in behaviour.
Pastoral system – a team for each key stage which knows the students well and can spot any changes.

When concerns arise referrals are made by staff and assessment is carried out by the Designated Safeguarding Lead, Deputy Designated Safeguarding Lead, SENCO and Lead Counsellor/Psychotherapist to establish if there are any causal factors and underlying issues. Where necessary referral to external agencies and professionals are made for formal diagnosis. If it is believed that a student is at immediate risk from mental health issues, then parents are informed to take their child to A&E or the GP. Concerns are also to be logged in the 'My Concern' programme on the school computer system.

All staff are alert to emerging difficulties and respond at the earliest opportunity. They are mindful that parents and carers know the young person best, and therefore are open to listening and understanding their concerns, as well as holding in mind any concerns that the young person them self may have.

Staff are aware of the particular vulnerability of certain groups of children, such as children on the autistic spectrum, looked after children, children with learning difficulties and those from disadvantaged backgrounds. This list is not exhaustive.
Appendix 1 has the main types of mental health needs as defined by the DfE Mental Health and Behaviour in Schools Advice 2016.

Special Educational Needs (SEN)

When considering persistent mental health problems it may lead to students having significantly greater difficulty in learning than others the same age. If this is the case the school will draw upon the SEND Code of Practice: 0-25years for guidance in considering whether a special educational provision needs to be made.

There are a wide range of mental health problems that might require special provision. These include mood issues (anxiety or depression), problems of conduct (oppositional problems and severe conduct problems including aggression), self-harming, substance abuse, eating disorders or other physical symptoms that are medically unexplained. There are also recognised disorders such as attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), pervasive developmental disorder (PDD), attachment disorder, anxiety disorder, a disruptive disorder, and rarely schizophrenia or bi-polar disorder.

Where a student has been identified as needing specialist educational provision then the appropriate support mechanisms will be put in place and regularly reviewed.

Roles & responsibilities of all staff

The Ravensbourne School will, where appropriate, make a referral to the appropriate professional services and external agencies where it has concerns regarding a child's well-being/mental health.

- All staff are made aware of, and understand the Mental Health Policy
- All staff must report their concerns to the DSL, DDSL, SENCO and or the Lead Counsellor/Psychotherapist and log this in 'My Concern'
- All staff should follow safeguarding procedures (see Safeguarding Policy)
- Avoid dismissing a student's reasons for distress as invalid
- Remain calm and non-judgemental
- Encourage students to be open and reassure them that they can get the help they need if they are willing to talk
- Do not make promises that cannot be kept regarding confidentiality
- If a student discloses self-harm this needs to be reported to the DSL and DDSL

Roles and responsibilities of Designated & Deputy Safeguarding Persons

Designated Safeguarding Lead	Mark O'Shaughnessy (Deputy Head)
Deputy Designated Safeguarding Lead KS3	Emma Campbell (Assistant Head KS3)
Deputy Designated Safeguarding Lead KS4/5	Lisa Moriarty (Pastoral Director KS5)
Safeguarding Administrator	Nancy Eames (Office Manager)
Associated Members of Safeguarding Team	Emily Codling (Deputy Head)
	Alison Jenkins (Lead Counsellor/Psychotherapist)

- Records of mental health issues and incidents of self-harm are to be kept up to date
- DSL and DDSL are to keep the Head Teacher up to date on a regular basis of all incidents and developments
- Be aware of when it is essential for other professional services/bodies are to be informed and/or referred to, including Child & Adolescent Mental Health Service (CAMHS) Tier 2, Bromley Well-Being, GP
- Inform the students' parents and liaise with them as to what support mechanisms will be put in place and whether referral to external services are necessary

Roles and responsibilities of the Advisory Body

- To support and offer guidance to staff in maintaining standards set out in the policy
- To continue to support the importance of promoting mental health within the school setting
- To challenge the staff to deliver World-Day Mental Health education

Supporting Mental Health at The Ravensbourne School – Interventions in place

The Ravensbourne School recognise that poor mental health undermines educational attainment. The following interventions are currently in place:

- Full time school based counselling service (developed under DfE and BACP Guidelines)
- Referrals to Bromley Well-Being and/or CAMHS
- Weekly meeting of the Safeguarding Team to discuss vulnerable students and identify support strategies for students
- Early intervention
- Continuous professional development for all staff
- Peer Mentoring
- Big Brother Big Sister Support (targeted at bullying, but for all vulnerable students)
- Clear policies for bullying and behaviour
- Promoting Mental Health within Personal, Social Health Education (PSHE), school assemblies, Spiritual, Social, Moral & Cultural (SSMC)days and Your Choice Your Voice Days
- A culture within the school that values all students, allows them a sense of belonging and makes it possible for them to talk about their problems in a non-stigmatising way
- Working in collaboration with outside agencies when supporting a student with mental health problems
- A whole school approach to promoting mental health and well-being

Sources of Support and Information

WHO	WHAT THEY DO	WEBSITE/TELEPHONE NUMBER
ChildLine	A confidential service, provided by the NSPCC	www.childline.or.uk 0800 1111
Samaritans	Available 24 hrs a day to provide confidential emotional support for people who experience feelings of distress, despair or suicidal thoughts	www.samaritans.org 116 123
MindEd	Provides free e-learning for adults to understand children and young people with mental health issues	www.minded.org.uk
HeadMeds	Website developed by the charity Young Minds providing mental health advice	www.headmeds.org.uk
Mental health and bullying	A guide for teachers and any other children's workforce staff	http://www.anti-bullyingalliance.org.uk/media/5436/Mental-health-and-bullying-module-FINAL.pdf
National Institute for Health Care and Excellence (NICE)	To improve outcomes for people using the NHS	https://www.nice.org.uk
PSHE Teacher Guidance	PSHE Association provide guidance to schools on teaching about mental health and emotional well-being	www.pshe-association.org.uk
Relate	Offers advice and relationship counselling	www.relate.org.uk
School Nursing Public Health Service	Supporting students at school with medical conditions – statutory advice for schools	www.gov.uk
Women's Aid	National Domestic Violence Charity	www.womensaid.org.uk
Young Minds	Charity to improve emotional well-being and mental health up to the age of 25yrs	www.youngminds.org.uk
Mental Health and Behaviour in School	DfE guidance for school	www.gov.uk

Appendix 3 – Mental Health Problems in Children and Young People (As detailed in the Mental Health and Behaviour in Schools March 2016. Please refer here for further details)

Some children experience a range of emotional and behavioural problems that are outside the normal range for their age or gender. Mental Health Professionals have defined these as:

- Emotional disorders, e.g. phobias, anxiety states and depression
- Conduct Disorders, e.g. stealing, defiance, fire-setting, aggression and anti-social behaviour
- Hyperkinetic Disorders, e.g. disturbance of activity and attention
- Developmental Disorders, e.g. delay in acquiring certain skills such as speech, social ability or bladder control, primarily affecting children with ASD and those with PDD
- Attachment Disorders, e.g. children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major care givers
- Other mental health problems include eating disorders, habit disorders, post-traumatic stress syndromes, somatic disorders and psychotic disorders, e.g. schizophrenia and bi-polar disorder

Conduct Disorders:

Overt behaviour problems often pose the greatest concern for practitioners and parents/carers, because of the level of disruption that can be created in the home, school and community. These problems may manifest themselves as verbal or physical aggression, defiance or anti-social behaviour. Depending on the severity and intensity of the behaviours they may be categorised as Oppositional Defiant Disorder (a pattern of behaviour problems characterised chiefly by tantrums and defiance which are largely confined to family, school and peer group) or Conduct Disorder (a persistent pattern of anti-social behaviour which extends into the community and involves serious violation of rules). Many children with ADHD will also exhibit behaviour problems.

Anxiety:

Anxiety problems can significantly affect a child's ability to develop, learn or to maintain and sustain friendships.

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

There are a number of diagnostic categories:

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

Depression:

Feeling low or sad is a common feeling for children and adults and a normal reaction to experiences that are upsetting or stressful. When these feelings dominate and interfere with a person's life, it can become an illness. According the Royal College of Psychiatrists, depression effects 2% of children under 12 years old and 5% of teenagers. Depression can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships. There is some degree of overlap between depression and other problems. For example, 10% to 17% of children who are depressed are also likely to develop behaviour problems.

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

Hyperkinetic Disorders:

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

ADHD involves three characteristic types of behaviour – inattention, hyperactivity and impulsivity. Whereas some children show signs of all three types of behaviour, other children diagnosed show signs of only inattention or hyperactivity/impulsiveness.

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

Attachment Disorders:

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

Eating Disorders:

The most common eating disorders are anorexia nervosa and bulimia nervosa. Eating disorders can emerge when worries about weight begin to dominate a person's life. Someone with anorexia nervosa worries persistently about being fat and eats very little. They lose a lot of weight and if female, their periods may stop. Someone with bulimia nervosa also worries persistently about weight. They alternate between eating very little, and then binging. They vomit or take laxatives to control their weight. Both these eating disorders affect boys and girls but are more common in girls.

Substance Misuse:

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

Post-traumatic Stress:

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

Appendix 4: Self-Injury/Harm

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

Self-harm/injury only provides temporary relief and does not deal with the underlying issues. It can become a natural response for a person to the stresses of daily life and can escalate in frequency and severity. It is often habitual, chronic and repetitive and may affect someone for months and years.

Those who self-harm/injure tend to hide their injuries and scars, and are often uncomfortable about discussing their emotional inner or physical outer pain. It is difficult for young people to seek help from those in positions of authority due to the stigma associated with seeking help for mental health issues. Self-harm/injury is usually private and personal, sometimes ritualistic and is often hidden from friends and family. People who do show their scars may do so as a reaction to the incredible secrecy, and one should not assume that they are 'inflicting' their scars on others to seek attention, although attention may well be needed.

Risk factors include, but are not limited to:

- Low self-esteem
- Perfectionism
- Bullying
- Mental health issues such as depression and anxiety
- The onset of more complicated mental illness such as schizophrenia, bi-polar disorder or a personality disorder
- Problems at home or school
- Physical, emotional, neglectful abuse

It is important to recognise that none of these risk factors may appear to be present. Sometimes it is the outwardly happy, high-achieving person with a stable background who is suffering internally and hurting themselves in order to cope.
There may be no warning sign, but be aware of the following, as they may indicate that a student is suffering internally which may lead to self-harm/injury:

- Drug and/or alcohol misuse or risk taking behaviour
- Negativity and lack of self-esteem
- Out of character behaviour
- Bullying other students
- A sudden change in friends or withdrawal from a group

- Physical signs that self-harm/injury may be occurring
- Obvious cuts, scratches or burns that do not appear to be of an accidental nature
- Frequent 'accidents' that cause physical injury
- Regularly bandaged arms and/or wrists
- Reluctance to take part in physical exercise or other activities that require a change of clothes
- Wearing long sleeves and trousers during hot weather

Like any behaviour, self-harm/injury may be used to attract attention, but this is not usually the focus of chronic, repetitive self-harm/injury. If self-harm/injury is being used in order to gain attention, one must look to find reasons as to why someone is in such dire need of attention that they need to resort to hurting themselves. They may feel that no-one is listening or hearing to them with regard to problems at home or bullying. Self-harm/injury is not about 'seeking attention'. A way of fitting in or a response to music, films or emo or gothic culture. Prejudices and perceptions may lead people to believe they 'know' that self-harm/injury is linked to a certain demographic or background, but each person is unique and will have found self-harm/injury by their own route, and rely on it at times of stress due to the release and relief it offers them.

If a member of staff is suspicious of or has been informed that a student is self-harming/injuring then they must inform the DSL, DDSL in the first instance. The DSL and DDSL will then inform parents of this matter and the appropriate referrals will be made to either the schools counselling services or external agencies.