



MENTAL HEALTH POLICY

Senior School

Introduction

The School recognises the fundamental commitment of all staff to safeguard and promote the welfare of all students. This includes the mental health of all students. We aim to promote positive mental health and wellbeing for our whole school community. We recognise that mental health is a crucial factor in wellbeing and attainment. As a school our role is to ensure that students can manage times of change, be resilient, support each other and are educated about mental health.

This policy has been written with reference to 'Counselling in Schools: A Blueprint for the Future' (DfE February 2016), 'Mental Health and Behaviour in Schools' (DfE Nov 2018), the Equality Act (2010), Mental Health and Wellbeing Provision in schools (DfE October 2018), Supporting Mental Health in schools and colleges (May 2018), Transforming Children and Young People's Mental Health; Green Paper (Dec 2017). State of the Nation 2022: children and young people's wellbeing (DfE February 2022). Keeping Children Safe in Education. Mental Health Act (1983). This policy should be read in conjunction with the following school policies:

- Child Protection and Safeguarding Policy
- Anti-Bullying Policy
- First Aid and Administration of Medicines Policy
- Spiritual, Moral, Social and Cultural Education Policy

Aims of the Mental Health Policy

The School aims to use a whole school approach with regards to mental health, which ensures that all parts of our organisation work to support the mental health of all students. To support this policy, MHSG will ensure that there are robust policies and practices in areas such as behaviour, anti-bullying and diversity, including of prejudice and stigma around mental health. The school will work to train staff and teach pupils about the risk factors to well-being, the importance of early intervention, and the need to base responses on a sound understanding of a child's needs and development.

Definition of Mental Health

Students who are mentally healthy have the ability to:

- develop psychologically, emotionally, intellectually and spiritually
- 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
- resolve (face) problems and setbacks and learn from them

Mental health is defined here as “a state of wellbeing in which every individual realises his or her abilities, can cope with the normal stresses of life, work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, August 2019). Some students, however, experience a range of emotional and behavioural problems that are outside the normal range for their age or gender. These students could be described as experiencing mental health problems or disorders. Mental health problems start early in life. Half of all mental health problems have been established by the age of 14, rising to 75% by the age of 24.

Mental health professionals have defined mental health problems as:

- Adverse Childhood Experiences (ACE); stressful events which occur in childhood
- 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 autism and those with pervasive developmental disorders
- 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 manic depressive disorder

Many of these problems will be experienced as mild and transitory challenges for the student and their family, whereas others will have serious and longer lasting effects. Sometimes such problems may occur as a result of students’ expectations of themselves, which are sometimes unrealistic and due to a lack of personal resilience.

When a problem is particularly severe or persistent over time, or when a number of these difficulties are experienced at the same time, children are often described as having mental health disorders. According to [Healthy Young Minds](#), one in six children aged five to 16 were identified as having a probable mental health problem in July 2021. In March [2022](#), 90,789 young people were referred to Child and Adolescent Mental Health services, the highest figure since the data first began being collected.

Further information on specific mental health disorders can be found in the appendices at the end of this policy document.

Promoting Positive Mental Health

As a school, we have a vital role to play in supporting girls to be resilient and mentally healthy. This can be done in an environment in which positive, pro-active approaches to pastoral care are encouraged. These include:

- A committed team of staff who encourage a sense of belonging.
- A structured pastoral system where each student has a form tutor, Head of Year and Head of Section. The School also benefits from School Nurses full time, and a Deputy Head Mistress who oversees the pastoral work of the School and who is also the Designated Safeguarding Lead.
- Staff encourage students to talk about any problems they may be having in a non-stigmatising way.
- An ethos of high expectations but with consistently applied support in terms of peer mentoring and academic intervention.
- Positive and clear lines of communication with parents/guardians.
- Training for staff on issues relating to mental health.

- A Well Being curriculum that teaches students about mental health issues and how to build resilience.
- An Anonymous referral system via the SHARP system.
- 'Thought for the Week' published around the School to encourage girls to consider moral and uplifting messages.
- Campaigns and assemblies to raise awareness of mental health.
- Monitoring/nurture groups for specific students.
- Displays and information which helps meet the needs of students
- Time out passes for individual students.
- The sharing of information about students with staff in a weekly briefing/via email e.g. following a bereavement.
- Students' achievements (academic and non-academic) are celebrated by the School community.
- Focus on mindfulness during the Well Being programme and reflection activities.
- Theme Weeks, which provide students with the opportunity to develop resilience and consider the importance of personal achievement and how to respond to failure.
- Students have the opportunity to participate in decision making, for example through the School Council and leadership opportunities.
- Effective anti-bullying policy and E-Safety procedures so that all students feel safe in school.
- A SENCO and Learning Support Co-ordinator who regularly monitor the wellbeing of those girls on the Inclusion register within school.
- Access to a School Counsellor.
- A Pastoral Record system (CPOMS) which enables the swift but secure sharing of relevant information.

Identifying Students with Mental Health Problems

All staff are committed to the safeguarding of students at the School. This includes referring any concerns they have about the mental health of a student to a member of the pastoral team such as the Head of Year, Heads of Section, Deputy Head (Pastoral) or the School Nurse. The following list provides an indication that a student's mental health is deteriorating:

- Change in behaviour; too disruptive or withdrawn.
- Significant changes in attainment and approach to learning.
- Disrupted attendance and/or punctuality.
- Disclosure of concerns to a member of staff.
- Failure to keep appointments.
- Distancing from others.
- Changes to eating/sleeping habits.
- Changes in activity and mood.
- Talking or joking about self-harm and suicide.
- Expressing feelings of failure, uselessness, or loss of hope.
- Repeated physical pain or nausea with no evident cause.

It is also acknowledged that students exposed to adversity may be more prone to developing mental health problems in the future. Adverse Childhood Experiences (ACE) are traumatic events occurring before the age of 18. ACEs include all types of abuse and neglect as well as parental mental illness, substance abuse, divorce, incarceration, and domestic abuse.

Reactive Support

Despite proactive measures employed by the School to help prevent mental health issues arising, it is inevitable that some students will suffer from a mental health disorder. Sometimes, the School will

be informed by parents or external agencies of the diagnosis or concern. On other occasions, the School is able to identify a concern and seek further support. Indeed, where severe problems occur, we expect the student to receive external support as well as ongoing help and support from pastoral staff.

Reactive measures to support those with potential or identified mental health problems are vital in ensuring appropriate support.

- Although teaching and support staff are often the first to identify mental health concerns, it is important that they do not manage support in isolation, without informing pastoral staff. These include the Head of Year, Head of Section, School Nurse and Deputy Head Mistress (Pastoral) who is the Designated Safeguarding Lead (DSL). If there is a suspected safeguarding issue, the DSL should be informed immediately in line with the School's Child Protection and Safeguarding Policy.
- A mental health assessment can be offered (informally) by the School Nurse.
- The School Nurse liaises with the student's GP and parents (as appropriate). The School Nurse always encourages full family involvement with a student's mental health care. However, the School does acknowledge that those aged 16 or over are entitled to consent for their own treatment and students under 16 can consent if it is thought that they have sufficient competence to understand what is involved in potential treatments. Therefore, whether parents will be informed about mental health concerns will be made on a case-by-case basis.
- If there are any risks identifiable which may be contributing to the student's mental health issues (e.g. home trauma, witnessing domestic violence) the DSL is informed who will liaise with external services as appropriate.
- The DSL and School Nurses make referrals to CAMHS (Child and Adolescent Mental Health Services) / Emerge and then liaises with these services to ensure that the student is receiving follow-up support depending on need.
- The School Nurse, Pastoral staff and DSL will, as appropriate, meet regularly with both student and parents to review the support in place and to identify future need. This may be through the CAF (Common Assessment Framework) process.
- Pastoral staff, including the School Nurse and, on occasion, form tutors and individual teaching staff, provide an ongoing 'listening ear' to support those in need. This may include identifying trigger points and liaising with teaching staff as appropriate.
- The SENCO and Learning Support Co-ordinator may put in place extra measures to coach teachers how they might best manage a student who suffers from mental health problems as a part of their learning need.
- If a student is considered at risk to herself and/or others, the DSL will produce a risk assessment and distribute it to all relevant teaching staff and to the Senior Leadership Team in order to ensure the safety of all students within the School.
- A student may be referred to the School Counsellor for extra support.

The School Counsellor

There are occasions when the School Nurse, Head of Section or the Deputy Head Mistress (Pastoral) may feel it necessary to refer a student to the School Counsellor. Counselling is a mental health intervention that students can voluntarily enter into if they wish to explore, understand and overcome issues in their lives which may be causing them difficulty, distress and/or confusion. (Counselling is **never** compulsory or required as part of a sanction). The aims of counselling are to assist the student to achieve a greater understanding of themselves and their relationship to their world, to create a greater awareness and utilisation of their personal resources, to build their resilience and to support their ability to address problems and pursue personally meaningful goals. Counselling within secondary schools has been shown to bring about significant reductions in psychological distress in the short term, and help young people move closer towards their professional goals. Such referrals may take place because:

- the student has issues and concerns that cannot be addressed by other forms of school pastoral support. In this way, counselling can be an early intervention measure and the counsellor can work with the student to help her address her problem(s) and reduce psychological distress
- the student is waiting for CAMHS / emergency support
- the student needs school support which works in conjunction with external support offered, for example, by CAMHS. Sometimes, resource constraints can mean that specialist mental health service appointments are not as frequent as the service and/or the student and parents would like. Here the counsellor can support the student in between specialist mental health service appointments.
- a tapering or step down of intervention is needed when a case is closed by specialist mental health services. Sometimes, when a specialist mental health service intervention is completed, a student may attend school counselling as a further support which consolidates the work of the specialist mental health service.

The School Counsellor is employed by the School and offers a range of psychological therapies to help and support the students. There is no fixed programme offered by the School Counsellor but she organises the number of sessions, depending on the individual need. She will also liaise with external services via the School Nurse (e.g. CAMHS) as appropriate in order to ensure that there is no conflict with the support being offered in school.

The School Counsellor documents all sessions. Precise details of individual sessions remain confidential although she consults with the School Nurse and Deputy Head (Pastoral) if there are issues that need to be monitored in between counselling sessions. She will also liaise immediately if she has any safeguarding concerns.

In the majority of situations, the School Nurse or DSL will consult with parents about a referral having been made to the School Counsellor. If, however, a student feels strongly that her parents should not be informed, a decision will be made about the referral depending on the age and competency of the student in line with the principle of Gillick competency (a term used in Medical Law to decide if a child under the age of 16 can give consent to medical treatment).

Roles and Responsibilities

Teaching Staff / Form Tutors

- Maintain a close eye on students to identify changes in behaviour, attendance or appearance.
- If appropriate (for instance, if a student approaches the member of teaching staff for support), be prepared to listen to the student but act in accordance with the Child Protection and Safeguarding Policy and do not promise confidentiality.
- Recognise that not being truthful, actively seeking attention or manipulative behaviour are possible signs of poor mental health.
- In any conversation with a student, remain calm and non-judgemental and do not dismiss a student's reasons for distress as invalid or trivial.
- Pass on any concerns to pastoral staff / DSL.
- Continue to support student if this is agreed with the pastoral team.
- Ensure that one's own personal welfare is considered and do not offer support when this is unmanageable.
- Actively support theme weeks and strategies to improve resilience among the student body
- Celebrate achievement through the consistent use of the House Point/Commendation systems.

Heads of Section/Heads of Year/Head of Well Being

- Liaise with teaching staff / School Nurse / Deputy Head Mistress (Pastoral) about students with mental health concerns.
- Support individual students on the advice of the School Nurse / Deputy Head Mistress (Pastoral).
- Develop Well Being resources and lessons which encourage a pro-active approach to mental health.
- Ensure friendship issues / potential or actual bullying issues are dealt with swiftly in line with school policies and procedures.
- Actively support theme weeks and strategies to improve resilience among the student body.
- Track the academic progress of all students in the year and intervene as and when appropriate to ensure ongoing support.
- Recognise the link between poor behaviour and mental health.
- Liaise with parents, actively, to ensure students are supported in school.

SENCO and Learning Support Co-ordinator

- Liaise with educational psychologists / parents as appropriate to identify any mental health need for students on the Inclusion Register.
- Advise teaching staff and the pastoral team associated with an SEN student about how the student can be best supported in and outside of the classroom.
- Regularly review the SEN student's Individual Student Plan (ISP) to ensure that support is assessed for effectiveness and changes are made as appropriate.

The School Nurse

- Follow up any concerns referred by a member of staff relating to a student.
- As appropriate, advise pastoral staff on what support is needed for the ongoing mental health of the student.
- Contact and liaise with GP / CAMHS / External Agencies as appropriate.
- Liaise with parents as appropriate / encourage the student to discuss concerns with parents. (Parents will generally be informed of such concerns unless a student is deemed sufficiently competent to make the decision that she does not want this or when it is deemed in the best of the student for the parents not to be made aware of an issue).
- Review at regular intervals and assess whether the situation needs escalating or de-escalating
- Liaise with the DSL so that she can be alerted to the potential for safeguarding risks. Discuss these cases on a monthly basis with the DSL to consider whether further action is needed.
- Observe other students / friends that may be affected and ensure that adequate support is given to them.
- Make referrals to the School Counsellor.

The Deputy Head Mistress (Pastoral) / Designated Safeguarding Lead

- Liaise with the School Nurse and Heads of Section in deciding upon the potential safeguarding implications of any students with significant mental health issues.
- Produce risk assessments for those students who may pose a risk to themselves and/or to others in school and liaise with teaching staff as appropriate.
- Liaise with children's services / parents as appropriate (See Child Protection and Safeguarding Policy).
- Manage the 'Thought for the Week'.
- Manage and lead on theme weeks which encourage resilience among the student body.
- Make referrals to the School Counsellor in conjunction with the School Nurse and Heads of Section.
- Keep staff up to date with regards to training and changes in policy.

Head Mistress

- Oversee the implementation of the School policy.

Governors

- Ensure that appropriate systems are in place to ensure that the policy can be implemented.
- The Safeguarding Governor meets at least termly with the Deputy Head (Pastoral) to discuss and evaluate any mental health trends and assess what strategies could be put in place to proactively address these.

Amended by Deputy Head Mistress, Pastoral – April 2023

Approved by Head Mistress – April 2023

Appendix A - Anxiety

Anxiety problems can significantly affect a child's ability to develop, to 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.

Clinical professionals make reference to a number of diagnostic categories:

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

While the majority of referrals to specialist services are made for difficulties and behaviours which are more immediately apparent and more disruptive (externalising difficulties), there are increasing levels of concern about the problems facing more withdrawn and anxious children, given the likelihood of poor outcomes in later life.

The strongest evidence supports prevention/early intervention approaches that include a focus on:

- regular targeted work with small groups of children exhibiting early signs of anxiety, to develop problem-solving and other skills associated with a cognitive behavioural approach.
- additional work with parents/carers to help them support their children and reinforce small group work. Such work is likely to be especially effective when the parents/carers are themselves anxious and the children are younger.

Where particular problems have been identified the strongest evidence supports:

- therapeutic approaches focusing on cognition and behaviour for children with specific phobias, generalised anxiety and obsessive compulsive disorder (in some cases doctors may consider using medicines alongside therapy if therapy alone is not working but this does not include anxiety related to traumatic experiences). This should include parents/carers where the child is under 11 or where there is high parental anxiety
- specific individual child-focused programmes which show recovery in 50-60% of C&YP include *Coping Cat* and *FRIENDS*. On the other hand, group-based interventions are likely to be almost as effective. The programmes have been shown to be effective when delivered by different professionals, including teachers
- education support, training in social skills and some behaviour-focused interventions are highly effective for social phobia (e.g. *Social Effectiveness Therapy*)

- for obsessive compulsive disorders, professionally administered *Exposure and Response Prevention (ERP)* and cognition-focused interventions are most effective
- trauma-related problems require special adaptations of therapy (e.g. *Trauma - focused CBT*) including sexual trauma. Trauma and grief component therapy is effective for trauma and can be delivered in school (e.g. *Cognitive Behavioral Intervention for Trauma in Schools*).

There is also evidence to support:

- for anxiety, the use of play-based approaches to develop more positive child/parent relationships or to enable the child to express themselves
- psychoanalytic family psychotherapy (focusing on the 'internal' world of family members and their unconscious processes) has reported some positive outcomes especially when trauma is involved.

Appendix B - Depression

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

Depression can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships. There is some degree of overlap between depression and other problems. For example, around 10% to 17% of children who are depressed are also likely to exhibit behaviour problems.

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

The strongest evidence supports prevention/early intervention approaches that include a focus on regular work with small groups of children focusing on cognition and behaviour – for example changing thinking patterns and developing problem-solving skills – to relieve and prevent depressive symptoms.

Where particular problems have been identified the strongest evidence supports:

- therapeutic approaches focusing on cognition and behaviour, family therapy or inter-personal therapy lasting for up to three months (in severe cases these interventions are more effective when combined with medication)
- psychoanalytic child psychotherapy may also be helpful for children whose depression is associated with anxiety
- family therapy for children whose depression is associated with behavioural problems or suicidal ideation
- for mild depression, non-directive supportive counselling.

Appendix C - Eating disorders

Eating Disorders describe illnesses that are characterised by irregular eating habits and severe distress or concern about body weight or shape.

Eating disturbances may include inadequate or excessive food intake which can ultimately damage an individual's well-being. The most common forms of eating disorders include Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder and affect both females and males.

Individuals with anorexia and bulimia tend to be quite competitive and driven to succeed. They tend to compare their appearance and accomplishments against unrealistic standards and typically find themselves lacking. Regardless of what set of standards they judge themselves against, such perfectionist always strive to meet the highest standards of performance possible.

The strongest evidence supports:

- early contact with the authority Eating Disorder Service
- the primary aim of intervention is restoration of weight
- for young people with anorexia nervosa, therapeutic work with the family, taking either a structural systemic or behavioural approach may be helpful even when there is family conflict
- for young people with bulimia nervosa, individual therapeutic work focusing on cognition and behaviour, for example to change thinking patterns and responses.

Evidence also supports:

- early intervention because of the significant risk of ill-health and even death among sufferers of anorexia
- school-based peer support groups as a preventative measure (i.e. before any disordered eating patterns become evident) may help improve body esteem and self-esteem
- when family interventions are impracticable, cognitive-behavioural therapy may be effective

What to look for:

- Preoccupation with food and weight
- Not sitting with friends at lunch
- Peer relationship issues
- Excessive interest in or complete avoidance of P.E
- Concerns raised by parents or friend.
- Changes in weight or appearance.
- Increase absence from school or lessons

Appendix D - Deliberate self-harm

Self-harm is when somebody intentionally damages or injures their body. It is usually a way of coping with or expressing overwhelming emotional distress. The intention of people who self-harm is to punish themselves, express distress or relieve unbearable tension. Sometime it is a mixture of all three. Self-harm can be a cry for help.

The strongest evidence supports:

- assessment by a care team with a treatment plan
- intervention by a therapist to discuss thoughts and feelings and how these affect behaviour and wellbeing
- brief interventions engaging the child and involving the family, following a suicide attempt by a child or young person
- assessment of the child for psychological disturbance or mental health problems which, if present, should be treated as appropriate. At times, brief hospitalisation may be necessary
- some individual psychodynamic therapies (*Mentalisation Based Treatment*) and behavioural treatments (*Dialectic Behaviour Therapy*).

Appendix E - Post-traumatic stress

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

The strongest evidence supports:

therapeutic support focused on the trauma and which addresses cognition and behaviour especially regarding sexual trauma and some can be delivered in schools such as *Trauma and grief component therapy* and *Cognitive Behavioural Intervention for Trauma in Schools (CBITS)*. Trauma focused CBT should be adapted appropriately to suit age, circumstances and level of development.

The evidence specifically does not support:

- prescription of drug treatments for children and young people with PTSD; or
- the routine practice of 'debriefing' immediately following a trauma.

Appendix F: Adverse Childhood Experiences (ACE)

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years).

Examples of ACE:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with:

Such as:

- substance misuse
- mental health problems
- instability due to parental separation or household members being in jail or prison

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities. However, ACEs can be prevented.

ACEs can have lasting, negative effects on health, well-being, and opportunity. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide.

ACEs and associated conditions, such as living in under-resourced or racially segregated neighborhoods, frequently moving, and experiencing food insecurity, can cause toxic stress (extended or prolonged stress). Toxic stress from ACEs can change brain development and affect such things as attention, decision-making, learning, and response to stress.

Children growing up with **toxic stress** may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, jobs, and depression throughout life. These effects can also be passed on to their own children. Some children may face further exposure to toxic stress from historical and ongoing traumas due to systemic racism or the impacts of poverty resulting from limited educational and economic opportunities.