CITY OF LONDON SCHOOL FOR GIRLS

STUDENT MENTAL HEALTH POLICY

This policy was written in June 2014 and will be put for governors' approval in October 2014. To be next reviewed by June 2017.

1. INTRODUCTION

This policy should be read in conjunction with the school's Supporting Students with Long Term and/or Serious Medical Conditions in School Policy.

The purpose of the school's Student Mental Health Policy is to help ensure that the school provides a coherent approach when responding to students with mental health problems. The school will always make its best endeavours to ensure that students with mental health difficulties are supported in school and enabled to continue with their education.

The school has specific legal responsibilities towards students whose mental condition falls within the definition of disability under the law. This requires us to ensure that students with a well-recognised mental illness are not disadvantaged and that reasonable adjustments are put in place to support their learning.

Many personal problems experienced by students can be resolved quickly by talking to a family member or a friend or by seeking help from teachers. It is important not to label as a "mental health" problem what are in reality normal emotional reactions to school and to growing up. However, a small number of students may experience emotional or psychological difficulties which are more persistent and which inhibit their ability to participate fully in education without appropriate professional support. These difficulties may take the form of a long-term mental illness or a temporary, but debilitating, condition or reaction. In addition, some students may arrive at school with a pre-existing problem, either declared or undeclared.

The school aims to provide a supportive environment that will help students with mental health difficulties to realise their full academic potential. It also aims to facilitate and promote positive mental health and well-being by:

- Providing a range of support services, including provision of a school confidential counselling service
- Encouraging students with mental health difficulties to seek support
- Ensuring that the sources of support are clearly communicated to both students and parents
- Promoting understanding and recognition of mental health difficulties through staff training and for students in PHSCE

Whilst the school is committed to providing a supportive environment, it is important to recognise that it is not a mental health facility nor is it a therapeutic community. There are, of necessity, limits to the extent of the support which can be provided and it is not the responsibility of the school to replicate services that already exist in the

community such as those that are available through CAMHS (Children's and Adolescents' Mental Health Service) or local authority Children's Services departments.

2. CONTEXT

It is now widely acknowledged that significant numbers of children and young people experience serious mental health difficulty.

The following statistical information is taken from the website of the charity Young Minds and is derived from the Association for Young People's Health publication *Key Data on Adolescence 2013*.

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is two or three children in every class.
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.
- There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%.
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.
- Nearly 80,000 children and young people suffer from severe depression.
- Over 8,000 children aged under 10 years old suffer from severe depression.
- The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.

Mental health problems can seriously impair academic performance and can lead to confused or disturbed behaviour. Minor problems which interfere with a student's capacity to work result in distress, wasted effort and undermine academic progress. A more seriously disturbed student, as well as needing appropriate professional support, may cause anxiety and concern to fellow students, teachers and other members of staff.

Useful references are two DFE guidance documents:

Behaviour and Discipline in Schools – DFE February 2014

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277894/Behaviour_and_Discipline_in_Schools_-_a_guide_for_headteachers_and_school_staff.pdf

Mental health and behaviour in schools - Departmental advice for school staff DFE June 2014

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317288/Mental_health_and_behaviour_in_schools.pdf

3. PROACTIVE MEASURES FOR PROMOTING STUDENT WELL-BEING AND AWARENESS OF MENTAL HEALTH

The school seeks to foster an atmosphere in which students are encouraged to achieve their full potential in all areas, but not at the expense of their well-being and mental health.

The school aims to help students to become resilient and to avoid perfectionism. We recognise the importance of helping students to accept failure as an inevitable facet of learning and the importance of their developing strategies for dealing with it positively.

We seek to avoid unnecessary and damaging competition between students, for example by using comment only marking as far as possible. Our wide range of co-curricular activities provides students with opportunities for relaxation and pleasure and also for reinforcement and development of self-esteem beyond the classroom.
Our PHSCE programme contains age-appropriate units designed to promote students' understanding of mental health and the pitfalls that confront adolescents. Our pastoral system, based on Form Tutor Groups is designed to ensure that each student feels known and has adults to whom they can address concerns.

The school runs regular information evenings and discussion forums for parents, sometimes in conjunction with the Friends organisation, which cover the difficulties faced by young people, including mental health difficulties.

4. STAFF RESPONSIBILITIES

All members of staff should respond to students with mental health difficulties in a non-discriminatory, non-stigmatising and positive manner. They should be vigilant about the well-being of the students in their care and alert to the possibility that a student may be experiencing mental health difficulties. They should always report concerns about individual students to their pupil's Form Tutor and/or Assistant Head of Section or Head of Section.

Most teachers are not trained counsellors and they are certainly not mental health professionals. They cannot be expected to provide support beyond the level of normal pastoral care and should be aware of the limitations of their expertise and of the time available to support individual students with complex difficulties. Members of staff should be conscious of their own well-being as well as that of their students, and should retain an appropriate professional detachment from their pupils' difficulties.

Members of staff should encourage students to access the help available from the school nurse, the school doctor or the school counsellors. Details of the school's confidential counselling scheme are published in a number of different school publications and are attached to this policy as an annex for ease of reference. It should be noted that support services available in school are limited and in severe cases or where prolonged help is indicated the school will encourage students or their parents to see referral to external agencies.

5. CONFIDENTIALITY

The confidence of students who disclose mental health concerns about themselves or about a friend is closely guarded, but it is never possible to give a guarantee of total confidentiality and students have to be aware that it may be necessary for safety reasons for information to be shared on a strictly "need to know" basis.

CONFIDENTIALITY AND THE WORK OF THE SCHOOL NURSE:
As a qualified medical professional the school nurse operates at a level of confidentiality informed by the legal principles of Gillick Competence and the Fraser Guidelines. These concepts arise from the judgements in the case of Gillick v West Norfolk and Wisbech Area Health Authority and another (1985). In summary, key principles are:
If the health-care professional cannot persuade the young person to inform her parents or to allow the health-care professional to inform her parents that she is seeking advice or treatment, it can be provided to a child under 16 without parental consent or knowledge provided that the health-care professional is satisfied the young person has the emotional and intellectual maturity to understand the proposed treatment and its implications. Although the Gillick case was concerned with contraceptive advice and treatment for girls under 16, the principle that a child under 16 can consent to treatment on their own behalf has been extended to treatment and advice other than for contraception.

6. ATTENDANCE AT SCHOOL

The school will always aim to make reasonable adjustments to enable a student who is suffering from mental health difficulties to attend school, but sometimes this may not be possible, for example if the young person is seen as presenting an unacceptably high risk to herself or as likely to cause undue distress to other students.

Similarly, whilst all reasonable efforts will be made to make educational visits accessible to all students, it sometimes may not be appropriate for a student who is suffering from mental health difficulties to attend a school educational visit, even if she is well enough to attend lessons in school.

Where a student has had a prolonged absence because of a mental health difficulty, the school may require assurance from a relevant professional person that she is fit to return to school before she is readmitted.

7. REFERRAL TO OUTSIDE AGENCIES

The usual route for referral of a student to an outside agency for support will be via their GP and thence to CAMHS or a private sector equivalent.

8. USEFUL INFORMATION AND CONTACTS

Students and parents can obtain information and advice about mental health issues from a variety of sources including:

- Their GP
- The Children's Services Department of their home area Local authority
- Young Minds www.youngminds.org.uk
- The Association for Young People's Health www.youngpeopleshealth.org.uk
- Public Health England – Child and Maternal Health Intelligence Network www.chimat.org.uk/camhs/schools/tools
- Childline www.childline.org.uk
- The Samaritans www.smaritans.org

9. RELATED CLSG POLICIES

- Parental Terms and Conditions
- The School and City of London Equal Opportunities Statements
- The School Health and Safety Policy
- The School SEND Policy
- The School Disability Policy
- The School Accessibility Plan
- School Nurse Guide Lines and Protocols
- The School Policy on Discipline, Pastoral Care and Exclusions
- The School Educational Visits Policy
- The School's Policies on the Curriculum and Assessment
- Supporting Students with Long Term and/or Serious Medical Conditions in School Policy

STUDENT MENTAL HEALTH POLICY

ANNEX 1 - Common Mental Disorders

1. Anxiety and Phobic Disorders

1.1 Generalised Anxiety Disorder occurs when an individual feels anxious all the time and when there's no obvious reason for concern. Anxiety in certain situations is quite normal and the feeling passes. With Generalised Anxiety Disorder, the individual is left debilitated by the anxiety, and normal functioning is severely restricted.

1.2 Panic Disorder is an anxiety disorder characterised mostly by panic attacks. A panic attack is a frightening experience of feeling totally out of control, and is often accompanied by unpleasant physical symptoms. It can be linked to depression or substance misuse, and can lead to phobias.

1.3 A Phobia is a marked and persistent fear that is caused by the presence of an object or a situation. Phobias are irrational in that the fear caused by them is not associated with a real danger. A person who has a phobia is overwhelmed by anxiety and avoids the feared object or situation, as well as people and events associated with the source of fear.

There are three categories of phobias: agoraphobia, specific phobias, and social phobias.

(1) Agoraphobia is a fear of being alone in any place or situation from which the person thinks that escape is impossible or difficult. An extreme example is the person is afraid to leave their home.

(2) Specific phobias are those directed at specific objects or situations, such as dogs or spiders, open spaces, flying, injections, or heights.

(3) Social phobia is the fear of being in a situation where others are watching the individual, with the result being embarrassment or humiliation. This can make socialising, taking part in seminars, interviews, etc. very difficult.

2. Depression and Bipolar Disorders

2.1 Depression is a widely misused self-diagnosis. It is more than a temporary feeling of sadness, being fed up, feeling negative about relationships or job prospects, and it is more than the feelings we all get after a bereavement, or a personal disaster. A major depressive disorder often exists without any obvious reason or stress, or it can be triggered by life events, and it often lasts for long periods and becomes pervasive, affecting every aspect of individual functioning. The individual is left feeling unmotivated, sad, listless, and emotionally drained, and unable to gain pleasure from the usual things such as

entertainment, holidays, personal relationships, hobbies, etc. It can interfere with work, play, eating, sleeping, and most social interaction.

2.2 Bipolar Disorder (manic depression) is characterised by periods of depression alternating with high levels of elation, excitability, extreme physical activity, and grandiose ideas. It is probably caused by a major imbalance in the neurochemistry of the brain, and has a possible genetic link. The imbalance can be exacerbated by stressful life events.

3. Obsessive-Compulsive Disorder (O.C.D.)

A condition characterised by intrusive and unwanted thoughts-obsessions, and repetitive behaviour-compulsions. The anxiety created by the obsession is usually relieved through acting out the compulsive behaviour, creating a cycle of behaviour that can totally disrupt everyday functioning. The patient knows that the thoughts are not normal, but cannot control them, and is often too embarrassed to seek help, or may keep it secret and learn to live with it.

4. Post-traumatic Stress Disorder

Post-traumatic stress disorder is an anxiety disorder, wherein the sufferer relives the traumatic experience, as flashbacks, nightmares, or intrusive thoughts; or finds the trauma dominating their thoughts, behaviour and actions. Any event that involves actual or threatened physical harm, and leaves the individual feeling frightened and helpless, can trigger the disorder. The event can be natural (flood, earthquake), manmade (train crash, terrorist attack), or personal (physical or sexual assault).

5. Eating Disorders

5.1 Anorexia Nervosa

Anorexia is characterised by such a severe reduction in food intake over a long period that the individual's health and life are threatened. It is different from dieting, or deliberate starvation, in that the sufferer usually thinks their diet is adequate, and often has a very distorted image of what they look like, i.e. their body weight falls to a level where their ribcage and pelvic bones are visible through their skin, but still they believe they are fat.

Causes include: low self-esteem, a need to maintain some control over one's life, body, perfectionism, a fear of growing up, society's obsession with weight, poor female role models in the entertainment and fashion industry, and childhood sexual or emotional trauma. As with all eating disorders, there is thought to be some genetic link.

5.2 Bulimia Nervosa

Bulimia is characterised by periods of uncontrolled, and usually secretive, binge eating, followed by purging-self induced vomiting, or the use of laxatives or diuretics. Bulimia affects the same group of Symptoms people as anorexia, i.e. young women. The causes are much the same, but the symptoms are different. Also, because the sufferer often looks quite healthy, it is easier to deny, and can be kept secret. Bulimia is ten times more common than anorexia, and can occur in middle aged women.

6. Schizophrenia

Schizophrenia is the most disabling of all the major mental disorders. It affects the individual's ability to think clearly, distinguish reality from fantasy, react in an emotionally appropriate way, and interact with others. It affects about 1% of the population, with onset for men usually between 18 to 24 years, and for women between 24 and 28 years. This means that the sufferer is less likely to complete higher education or job training and social and interpersonal skills suffer.

Stress factors include unrealistic role expectations, major life events which require considerable adjustment, unhappy personal relationships, inappropriate career choices and triggers such as substance misuse.

Symptoms

Delusions: Ideas and personal beliefs that are unrelated to reality, e.g. a person believes he is being persecuted by a dead rock singer, or that he has supernatural powers, or he is the reincarnation of someone famous.

Hallucinations: Hearing and seeing people and things that are not there, and sometimes responding to the hallucinations by obeying commands, or talking to the "voices".

Disorganised thinking and speech. Unable to hold a coherent conversation, and appearing to be struggling with a flood of ideas and thoughts.

Inappropriate emotional expression such as laughing uncontrollably while talking about someone's death.

Lacking energy and motivation, flat emotions, poor self-care, and little interest in everyday things.

Some patients will be able to control the symptoms by taking medication, while others, even though they are taking medication, will relapse. All medication has side effects, and patients often see little point in taking it when they are feeling well, and so stop and then start to relapse again.

7. Personality Disorder

A personality disorder exists when a personality characteristic significantly impedes social, educational, or occupational functioning and distresses the sufferer. Many of the symptoms are present in all of us but these are temporary, and not extreme, and just part of our personality. With a personality disorder, the symptoms are extreme, and significantly disrupt everyday life. Many of the characteristics are also present in other illnesses, e.g. in one study 40% of bulimia sufferers also had a diagnosis of personality disorder. Many sufferers will get through life without engaging in therapy or treatment, and will just be regarded as odd, difficult, antisocial, obsessional, or inadequate, or if they are rich or powerful, they may just be seen as eccentric. They are also as likely to end up in prison.

8. Deliberate Self-Harm

Deliberate self-harm includes taking overdoses of medication and drugs; cutting; jumping from high places, or in front of cars and trains; burning with cigarettes; shooting; and drowning. Some people will intend to kill themselves, but many will not. The distinction between suicide and deliberate self-harm is not absolute. Some people who take overdoses with the intention of drawing attention to their problems, and getting help, will die from the effects, while others who take overdoses, intending to kill themselves, will be revived.

8.1 Drug Overdoses

In the U.K. 90% of self-harm cases admitted to hospital involve a drug overdose. The most commonly used drugs are aspirin and paracetamol.

8.2 Self-Laceration

Self-laceration, or cutting, can be the means of suicide, or an indication of serious suicidal intent, but the majority of cases result in superficial wounds that do not endanger life.

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ANNEX 2 – Confidential Counselling Service

CONFIDENTIAL COUNSELLING SERVICE

- The school provides a confidential counselling service for pupils. Suitably qualified counsellors come into school three times a week during term time.

- Pupils may arrange to see the counsellor on their own initiative in confidence. Where a pupil arranges an appointment with the counsellor directly, staff and parents are not informed of the appointment and parental permission is not sought.

- Members of staff may suggest that a pupil might benefit from seeing the counsellor. Parents may also request that their daughter sees the counsellor. Where this is the case, the counsellor will offer the pupil an appointment, but the pupil will be under no compulsion to accept it. Once an appointment has been arranged under these circumstances, all matters discussed between the pupil and the counsellor will be confidential.

- No confidential counselling service can offer young people a guarantee of unlimited confidentiality. Where Child Protection issues are concerned or where a pupil appears to be otherwise at risk, the counsellor may have to inform appropriate individuals or agencies. The counsellor will only inform another person of anything that a pupil tells her with the pupil's prior knowledge that she has to do so.