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**Life Lodge Alternative Education Positive Social, Emotional and Mental Health (SEMH) and Wellbeing policy and procedures**

**2024 - 2025**

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Date: June 2024

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Date: June 2024

**(Date for next review: June 2025)**

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**1. Policy Statement**

*‘Mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a positive contribution to her or his community.’ (World Health Organisation)*

At Life Lodge, we aim to promote positive mental health for every member of our community, staff, young people, and their families.

In addition to promoting positive mental health, we aim to recognise and respond to mental ill health. A 2016 Education Support Partnership (ESP) survey suggested 84% of teachers have suffered from mental health problems at some point over the last two years. A 2017 report by the [Children’s Commissioner](http://www.telegraph.co.uk/news/2017/04/14/thousands-pinball-kids-care-emotionally-damaged-lack-stability/) for England also found that 580,000 young people – equivalent to the population of the city of Manchester – are receiving some form of social care or assistance with mental health problems. Statistics are still unfounded with regards to these figures post COVID-19, however, research that has been conducted, shows these figures are rising.

[Statistics also show that one in 10 children – an average of three in every classroom – has a diagnosable mental health problem,](https://www.theguardian.com/healthcare-network/2016/dec/07/government-breaking-promises-child-mental-health) and that 75% of mental health problems in adults have their roots in childhood. Evidence from Mind’s two-year project highlighted that people with Autistic Spectrum Conditions (ASC) are particularly vulnerable to developing mental health problems and approximately 70% of people with ASC are at risk of suffering from depression and severe anxiety - Supporting People Living with Autism Spectrum Disorder and mental health problems – A guide for practitioners and provider (October 2015).

By developing and implementing a practical, relevant, and effective mental health policy and procedures we can promote a safe and stable environment for students and staff affected both directly and indirectly by mental ill health.

**2. Policy Aims:**

The Policy Aims to:

* Promote positive mental health and wellbeing in all staff and students
* Increase understanding and awareness of positive mental health and mental health problems
* Promote a positive understanding and attitude towards mental health problems
* Alert staff to early warning signs of mental health problems
* Provide support to staff working with young people with mental health problems
* Provide support to students experiencing mental health problems
* Provide support and advice to those who may be affected by students experiencing mental health problems e.g., parents, carers, peers, staff
* Develop understanding of and use of accurate Mental Health terminology

In addition, due to the nature of the young people we work with at Life Lodge, we commit to providing and ensuring a high quality of education to all of its pupils, including pupils with social, emotional, and mental health (SEMH) difficulties, and to do everything it can to meet the needs of pupils with SEMH difficulties.

Through the successful implementation of this policy, we aim to:

* Promote a positive outlook regarding pupils with SEMH difficulties.
* Eliminate prejudice towards pupils with SEMH difficulties.
* Promote equal opportunities for pupils with SEMH difficulties.
* Ensure all pupils with SEMH difficulties are identified and appropriately supported – minimising the risk of SEMH difficulties escalating into physical harm.

We will work with the LA with regards to the following:

* The involvement of pupils and their parents in decision-making
* The early identification of pupils’ needs
* Collaboration between education, health, and social care services to provide support when required
* Greater choice and control for pupils and their parents over their support

**3. Scope and Legal Guidance**

This document describes the provision’s approach to promoting positive mental health and wellbeing. This policy is intended as guidance for young people, parents, staff, and Local Authority.

This policy should be read in conjunction with the following Life Lodge policies including, but not limited to, the following:

* Safeguarding Policy
* Positive Behaviour Policy
* Anti-Bullying Policy
* Child Protection Policy
* SEND Policy
* Behaviour for Learning Policy
* Medicines and Supporting Pupils with Medical Conditions Policy
* Self-Harm Policy

All relevant legislation and statutory guidance including, but not limited to, the following:

* Children and Families Act 2014
* Health and Social Care Act 2012
* Equality Act 2010 and 2014
* Education Act 2002
* Mental Capacity Act 2005
* Children Act 1989
* KCSIE 2023 and 2024

With regard to the following DfE and other Governmental guidance:

* DfE (2018) ‘Mental health and behaviour in provisions’
* DfE (2016) ‘Counselling in provisions: a blueprint for the future’
* DfE (2015) ‘Special educational needs and disabilities code of practice: 0 to 25’
* DfE (2023) ‘Statutory Guidance Keeping Children Safe in Education’
* DfE (2018) ‘Transforming Children’s and Young People’s Mental Health Provision: a green paper.’
* Mind (2015) ‘Supporting people living with autism spectrum disorder (ASD) and mental health problems – A guide for practitioners and providers.’
* Department of Health (2015) ‘Future in mind: Promoting, protecting and improving our children and young people’s mental health and wellbeing’ (2015)
* [PSHE Association Guidance.](http://www.inourhands.com/wp-content/uploads/2015/03/Preparing-to-teach-about-mental-health-and-emotional-wellbeing-PSHE-Association-March-2015-FINAL.pdf) Teacher Guidance - Preparing to teach about mental health and well-being.

**4. Common Mental Health difficulties**

**Anxiety**: Anxiety refers to feeling fearful or panicked, breathless, tense, fidgety, sick, irritable, tearful, or having difficulty sleeping. Anxiety can significantly affect a pupil’s ability to develop, learn and sustain and maintain friendships. Specialists reference the following diagnostic categories:

* **Generalised anxiety disorder**: This is 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**: This is a condition in which people have recurring and regular panic attacks, often for no obvious reason.
* **Obsessive-compulsive disorder (OCD)**: This is 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**: This is the excessive fear of an object or a situation, to the extent that it causes an anxious response such as a panic attack (e.g., provision phobia).
* **Separation anxiety disorder**: This disorder involves worrying about being away from home, or about being far away from parents, at a level that is much more severe than normal for a pupil’s age.
* **Social phobia**: This is an intense fear of social or performance situations.
* **Agoraphobia**: This refers to a fear of being in situations where escape might be difficult, or help would be unavailable if things go wrong.

**Depression**: Depression refers to feeling excessively low or sad. Depression can significantly affect a pupil’s ability to develop, learn or maintain and sustain friendships. Depression can often lead to other issues such as behavioural problems. Generally, a diagnosis of depression will refer to one of the following:

* **Major depressive disorder (MDD)**: A pupil with MDD will show several depressive symptoms to the extent that they impair work, social or personal functioning.
* **Dysthymic disorder**: This is less severe than MDD and characterised by a pupil experiencing a daily depressed mood for at least two years.

**Hyperkinetic disorders**: Hyperkinetic disorders refer to a pupil who is excessively easily distracted, impulsive or inattentive. If a pupil is diagnosed with a hyperkinetic disorder, it will be one of the following:

* **Attention deficit hyperactivity disorder (ADHD)**: This has three characteristic types of behaviour: inattention, hyperactivity, and impulsivity. While some children show the signs of all three characteristics, which is called ‘combined type ADHD,’ other children diagnosed show signs of only inattention, hyperactivity, or impulsiveness.
* **Hyperkinetic disorder**: This 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. The core symptoms must also have been present from before the age of seven, and must be evident in two or more settings, e.g., at provision and home.

**Attachment disorders**: Attachment disorders refer to the excessive distress experienced when a child is separated from a special person in their life, like a parent. Pupils suffering from attachment disorders can struggle to make secure attachments with peers. Researchers generally agree that there are four main factors that influence attachment disorders, these are:

* Opportunity to establish a close relationship with a primary caregiver.
* The quality of caregiving.
* The child’s characteristics.
* Family context.

**Eating disorders**: eating disorders are serious mental illnesses which affect an individual’s relationship with food. Eating disorders often emerge when worries about weight begin to dominate a person’s life.

**Substance misuse**: substance misuse is the use of harmful substances, e.g., drugs and alcohol.

**Deliberate self-harm**: Deliberate self-harm is a person intentionally inflicting physical pain upon themselves.

**Post-traumatic stress**: post-traumatic stress is recurring trauma due to experiencing or witnessing something deeply shocking or disturbing. If symptoms persist, a person can develop post-traumatic stress disorder.

**Suicidal Feelings:** Young people may experience complicated thoughts and feelings about wanting to end their own lives. Suicide is the act of intentionally taking your own life. Suicidal feelings can mean having abstract thoughts about ending your life or feeling that people would be better off without you. Or it can mean thinking about methods of suicide or making clear plans to take your own life.

**5. Roles and responsibilities**

The provision’s leadership as a whole is responsible for:

* **Preventing mental health and wellbeing difficulties**: By creating a safe and calm environment, where mental health problems are less likely to occur, the leadership can improve the mental health and wellbeing of the provision community and instil resilience in pupils. A preventative approach includes teaching pupils about mental wellbeing through the curriculum and reinforcing these messages in our activities and ethos.
* **Identifying mental health and wellbeing difficulties**: By equipping staff with the knowledge required, early and accurate identification of emerging problems is enabled.
* **Providing early support for pupils experiencing mental health and wellbeing difficulties**: By raising awareness and employing efficient referral processes, the provision’s leadership can help pupil’s access evidence-based early support and interventions.
* **Accessing specialist support to assist pupils with mental health and wellbeing difficulties**: By working effectively with external agencies, the provision can provide swift access or referrals to specialist support and treatment.
* **Identifying and supporting pupils with SEND**: As part of this duty, the provision’s leadership considers how to use some of the SEND resources to provide support for pupils with mental health difficulties that amount to SEND.
* **Identifying where wellbeing concerns represent safeguarding concerns**: Where mental health and wellbeing concerns could be an indicator of abuse, neglect or exploitation, the provision will ensure that appropriate safeguarding referrals are made in line with the Child Protection Policy.

The Local Governing body is responsible for:

* Fully engaging pupils with SEMH difficulties and their parents when drawing up policies that affect them.
* Identifying, assessing, and organising provision for all pupils with SEMH difficulties, whether or not they have an EHC plan.
* Endeavouring to secure the special educational provision called for by a pupil’s SEMH difficulties.
* Designating an appropriate member of staff to be the SENCO and coordinating provisions for pupils with SEMH difficulties.
* Taking all necessary steps to ensure that pupils with SEMH difficulties are not discriminated against, harassed or victimised.
* Ensuring arrangements are in place to support pupils with SEMH difficulties.
* Appointing an individual governor or sub-committee to oversee the provision’s arrangements for SEMH.

The Director is responsible for:

* Ensuring that those teaching or working with pupils with SEMH difficulties are aware of their needs and have arrangements in place to meet them.
* Ensuring that teachers monitor and review pupils’ academic and emotional progress during the course of the academic year.
* Ensuring that the staff have sufficient time and resources to carry out their functions, in a similar way to other important strategic roles within the provision.
* On an annual basis, carefully reviewing the quality of teaching for pupils at risk of underachievement, as a core part of the provision’s performance management arrangements.
* Ensuring that staff members understand the strategies used to identify and support pupils with SEMH difficulties.
* Ensuring that procedures and policies for the day-to-day running of the provision do not directly or indirectly discriminate against pupils with SEMH difficulties.
* Establishing and maintaining a culture of high expectations and including pupils with SEMH difficulties in all opportunities that are available to other pupils.
* Consulting health and social care professionals, pupils, and parents to ensure the needs of pupils with SEMH difficulties are effectively supported.
* Keeping parents and relevant staff up to date with any changes or concerns involving pupils with SEMH difficulties.
* Ensuring staff members have a good understanding of the mental health support services that are available in their local area, both through the NHS and voluntary sector organisations.

The Pastoral Manager is responsible for:

* Overseeing the whole-provision approach to mental health, including how this is reflected in policies, the curriculum and pastoral support, how staff are supported with their own mental health, and how the provision engages pupils and parents with regards to pupils’ mental health and awareness.
* Collaborating with the Director and Local Authority, as part of the SLT, to outline and strategically develop Mental Health, Well-being and SEMH policies/procedures and provisions for Life Lodge.
* Coordinating with the pastoral support team to provide a high standard of care to all young people who attend Life Lodge.
* Advising on the deployment of the provision’s budget and other resources in order to effectively meet the needs of young people with SEMH difficulties.
* Being a key point of contact with external agencies, especially the mental health support services, the LA, LA support services and mental health support teams.
* Providing professional guidance to colleagues about mental health and working closely with staff members, parents, and other agencies, including SEMH charities.
* Referring pupils with SEMH difficulties to external services to receive additional support where required.
* Overseeing the outcomes of interventions on pupils’ education and wellbeing.
* Liaising with parents of pupils with SEMH difficulties, where appropriate.
* Liaising with other provisions, educational psychologists, health, and social care professionals, and independent or voluntary bodies.
* Liaising with the potential future providers of education to ensure that pupils and their parents are informed about options and a smooth transition is planned.
* Leading mental health CPD.

Teaching staff are responsible for:

* Being aware of the signs of SEMH difficulties.
* Planning and reviewing support for their pupils with SEMH difficulties in collaboration with parents, the Pastoral Manager and, where appropriate, the pupils themselves.
* Setting high expectations for every pupil and aiming to teach them the full curriculum, whatever their prior attainment.
* Planning lessons to address potential areas of difficulty to ensure that there are no barriers to every pupil achieving their full potential, and that every pupil with SEMH difficulties will be able to study the full national curriculum.
* Being responsible and accountable for the progress and development of the pupils in their class.
* Being aware of the needs, outcomes sought, and support provided to any pupils with SEMH difficulties.
* Keeping the relevant figures of authority up to date with any changes in behaviour, academic developments and causes of concern. The relevant figures of authority include Pastoral Manager/Director/Designated Safeguarding Lead

Life Lodge Alternative Education works in collaboration with mental health support workers who are trained professionals who act as a bridge between education provisions and mental health agencies.

**6. Concerns**

Any member of staff who is concerned about the mental health or well-being of a student should speak to the Director or a member of the Pastoral Team.

If there is a fear that the student is in danger of immediate harm, then the normal safeguarding procedures should be followed with an immediate referral to the Designated Safeguarding Lead/ Deputy Designated Safeguarding Lead.

If the student presents a medical emergency, then the normal procedures for medical emergencies should be followed, including alerting first aid staff, and contacting the emergency services if necessary.

**7. Intervention and Support**

* **Child and Adolescent Mental Health Services (CAMHS) Referral**

Where a referral to Child and Adolescent Mental Health Services (CAMHS), is appropriate, this will be led and managed by the Head of Pastoral Care and Support. **Guidance about referring to Child and Adolescent Mental Health Services (CAMHS) is provided in Appendix F**.

* **Mental Health Risk Assessment and Emotional Well-being Plan**

A mental health risk assessment or an individual emotional well-being plan will be completed for students who have significant mental health needs. These documents should be drawn up involving the student, the parents, provision staff and where possible relevant health professionals. These plans can include:

* Details of a student’s condition
* Diagnosis, medication, and any side effects
* Who to contact in an emergency?
* Risks, signs, worries/concerns
* Ways to reduce the risk
* Response to risks/ what to do in an emergency

# (See Appendix F)

Mental Health Risk Assessments and Emotional Well-being Plans will be managed by the Pastoral Team in liaison with the young person, family, and designated key person. They will be reviewed on a termly basis or earlier dependent upon changes in circumstances.

* **Teaching about Positive Mental Health and Well-being**

The Personal, Social and Health Education (PSHE), the Relationships and Sex Education (RSE) and the Spiritual, Moral, Social and Cultural development (SMSC) Curriculum has a wide range of content, allowing for differentiation across the provision. This enables all students to access lessons and learn the keys skills around keeping themselves and others physically and mentally safe.

Following the PSHE Association ‘Preparing to Teach about Mental Health and Emotional Wellbeing’ lessons are planned across all key stages. Opportunity for students to gain experience in a number of skills, linking to key themes such as recognising and understanding feelings to promoting emotional wellbeing and healthy and unhealthy coping strategies.

In line with governmental legislation in 2020 and 2023 , as part of the RSE and SMSC curriculum, other key themes such as building an individual’s resilience and understanding of healthy relationships and managing anxiety will give an emphasis on a continual theme of students having the confidence and skills to ask for help for themselves or for others. The specific content of lessons will be determined by the specific needs of the cohort we’re teaching but there will always be an emphasis on enabling students to develop the skills, knowledge, understanding, language, and confidence to seek help, as needed, for themselves or others.

Life Lodge will be guided by the [PSHE Association Guidance1](http://www.inourhands.com/wp-content/uploads/2015/03/Preparing-to-teach-about-mental-health-and-emotional-wellbeing-PSHE-Association-March-2015-FINAL.pdf) to ensure that we teach mental health and emotional wellbeing issues in a safe and sensitive manner which helps rather than harms. This is established with positive classroom management and working in small groups to promote positive behaviour, social development, and high self-esteem. The provision develops and maintains pupils’ social skills, for example, through one-to-one social skills training and where appropriate, parents have a direct involvement in any intervention regarding their child and offering support to parents in the management and development of their child.

Other strategies that are promoted by Life Lodge:

* Peer mentoring is used to encourage and support pupils suffering with SEMH difficulties.
* Provision-based counselling is offered to pupils who require it and delivered by qualified and trained staff members.
* Provision-based counselling will often take the form of talking therapy, drawing on creative approaches where appropriate and necessary.
* Supporting the pupil’s teacher to help them manage the pupil’s behaviour.
* Additional educational one-to-one support for the pupil.
* One-to-one therapeutic work with the pupil delivered by mental health specialists.

**Signposting**

We will ensure that staff, students, and parents are aware of sources of support within provision and in the local community. What support is available within our provision and local community, who it is aimed at and how to access it is outlined in Appendix D

We will display relevant sources of support in communal areas and will regularly highlight sources of support to students within workshops and meetings and in relevant parts of the curriculum. Whenever we highlight sources of support, we will increase the chance of student help-seeking by ensuring students understand:

* What help is available?
* Who is it aimed at?
* How to access it?
* Why to access it?
* What is likely to happen next?

**8. Warning Signs**

Life Lodge is committed to identifying Mental Health difficulties at the earliest stage possible. Staff are trained to know how to identify possible mental health problems and understand what to do if they spot signs of emerging difficulties. These warning signs should **always** be taken seriously and staff observing any of these warning signs should report and record concerns on CPOMS and communicate their concerns with lead members of staff to follow safeguarding policy and procedures.

* **Possible warning signs include:**
* Physical signs of harm that are repeated or appear non-accidental
* Unexplained increase in rigid and repetitive behaviour and thinking e.g., talking to the self
* Changes in eating and sleeping patterns Increased isolation from friends or family, becoming socially withdrawn
* Changes in activity and mood
* Lowering of academic achievement/deterioration in skills
* Talking or joking about self-harm or suicide Misuse of medication, recreational drugs, and/or alcohol
* Expressing feelings of failure, uselessness, or loss of hope Changes in clothing – e.g., long sleeves in warm weather
* Secretive behaviour e.g., getting changed secretively
* Repeated physical pain or nausea with no evident cause
* An increase in lateness or absenteeism Increase in physical aggression towards others and self

When the provision suspects that a pupil is experiencing mental health difficulties, the following graduated response is employed:

* An assessment is undertaken to establish a clear analysis of the pupil’s needs
* A plan is set out to determine how the pupil will be supported
* Action is taken to provide that support
* Regular reviews are undertaken to assess the effectiveness of the provision, and changes are made as necessary

**9. Managing Disclosures**

A student may choose to disclose concerns about themselves or a peer to any member of staff, so all staff need to know how to respond appropriately to a disclosure.

If a student chooses to disclose concerns about their own mental health or that of a friend to a member of staff, the member of staff’s response should always be calm, supportive, and non-judgemental.

Staff should listen, rather than offer advice and our first thoughts should be of the student’s emotional and physical safety rather than of exploring ‘Why?’ For more information about how to handle mental health disclosures sensitively **see appendix D**.

All disclosures should be recorded on CPOMS under safeguarding. This written record should include:

* Date
* Student’s name
* The name of the member of staff to whom the disclosure was made
* Factual recount of the conversation/ any concerns raised

This information will then be shared with Life Lodge Safeguarding Leads and the Designated Mental Health First Aiders who will offer additional support and advice about next steps. **See appendix F for guidance about making a referral to CAMHS**.

**10. Confidentiality**

We should be honest with regards to the issue of confidentiality. If it is necessary for us to pass our concerns about a student on, then we should discuss with the student:

* Who we are going to talk to
* What we are going to tell them
* Why we need to tell them

We should never share information about a student without first telling them. Ideally, we would receive their consent, though there are certain situations when information must always be shared with another member of staff and / or a parent – refer to safeguarding policy and procedures.

**11. Working with Parents**

Where it is deemed appropriate to inform parents, we need to be sensitive in our approach. Before disclosing to parents, we should consider the following questions (on a case-by-case basis):

* Can the meeting happen face to face? This is preferable.
* Where should the meeting happen? At provision, at their home or somewhere neutral?
* Who should be present? Consider parents, the student, and/or other members of staff.
* What are the aims of the meeting?

It can be shocking and upsetting for parents to learn of their child’s issues, and many may respond with anger, fear, denial or upset during the first conversation. We should be accepting of this (within reason) and give the parent time to reflect.

Further sources of information including parent help lines and forums should be shared and as appropriate books/leaflets to take away as parents will often find it hard to take information in whilst coming to terms with the news that you’re sharing.

Clear means of contacting staff with further questions should always be provided along with a follow up meeting or phone call as parents often have many questions as they process the information. Finish each meeting with agreed next steps and always keep a brief record of the meeting on the child’s confidential record.

**12. Working with All Parents**

Parents are often very welcoming of support and information from the provision about supporting their children’s emotional and mental health. In order to support parents, we will:

* Highlight sources of information and support about common mental health issues through displays and information leaflets
* Ensure that all parents are aware of who to talk to, and how to get about this, if they have concerns about their own child or a friend of their child
* Make our mental health policy easily accessible to parents
* Share ideas about how parents can support positive mental health in their children through information sessions
* Keep parents informed about the mental health topics their child will be learning about in PSHE

**13. Supporting Peers**

When a student is suffering from mental health issues, it can be a challenging time for their friends. Friends often want to support but do not know how. In the case of self-harm or eating disorders, it is possible that friends may learn unhealthy coping mechanisms from each other. In order to keep peers safe, we will consider on a case-by-case basis which friends may need additional support. Support will be provided either in one to one or group settings and will be guided by conversations by the student who is suffering and their parents with whom we will discuss:

* What it is helpful for friends to know and what they should not be told
* How friends can best support
* Things friends should avoid doing / saying which may inadvertently cause upset
* Warning signs that their friend help (e.g., signs of relapse)

Additionally, we will want to highlight with peers:

* Where and how to access support for themselves
* Safe sources of further information about their friend’s condition
* Healthy ways of coping with the difficult emotions they may be feeling

**14. Training**

All staff will receive regular training about recognising and responding to mental health issues. Staff will also receive regular training on looking after their own mental health and well-being.

Life Lodge will also have designated staff that will be trained as mental health first aiders.

Training opportunities for staff that require more in-depth knowledge will be considered as part of our performance management process and additional CPD will be supported throughout the year where it becomes appropriate due developing situations.

**15. Policy Review**

This policy will be reviewed every year as a minimum. It is next due for review in June 2025.

Additionally, this policy will be reviewed and updated as appropriate due to new legislation and/ or changes within the organisation - any changes made to this policy are communicated to all members of staff. This policy is reviewed in light of any serious SEMH related incidents. All members of staff are required to familiarise themselves with this policy as part of their induction programme **see Appendix H.**

If you have a question or suggestion about improving this policy, this should be addressed to the Head of Pastoral Support.

**Appendix A: Further information and sources of support about common mental health issues**

# Prevalence of Mental Health and Emotional Wellbeing Issues

* 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around 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 significant 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.
* The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.
* Over 8,000 children aged under 10 years old suffer from severe depression.
* 3.3% or about 290,000 children and young people have an anxiety disorder.
* 72% of children in care have behavioural or emotional problems - these are some of the most vulnerable people in our society.

Below, we have sign-posted information and guidance about the issues most commonly seen in provision-aged children. The links will take you through to the most relevant page of the listed website with specific pages that are aimed primarily at parents, but they are listed here because we think they are useful for provision staff too.

Support on all of these issues can be accessed via [Young Minds](http://www.youngminds.org.uk/for_parents/whats_worrying_you_about_your_child/self-harm) (www.youngminds.org.uk), [Mind](http://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/#.VMxpXsbA67s) (www.mind.org.uk) and (for e-learning opportunities) [Minded](https://www.minded.org.uk/course/view.php?id=89) [(www.minded.org.uk)](http://www.minded.org.uk/). Mind has also produced a detailed document ‘Supporting people living with autism spectrum disorder and mental health problems – A guide for practitioners and providers (October 2015).

**Deliberate Self-harm**

Self-harm describes any behaviour where a young person causes harm to themselves in order to cope with thoughts, feelings or experiences they are not able to manage in any other way. It most frequently takes the form of cutting, burning, or non-lethal overdoses in adolescents, while younger children and young people with special needs are more likely to pick or scratch at wounds, pull out their hair or bang or bruise themselves.

**Online support**

[SelfHarm.co.uk:](https://www.selfharm.co.uk/) www.selfharm.co.uk

[National Self-Harm Network:](http://www.nshn.co.uk/) www.nshn.co.uk

**Books**

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Provisions: A Guide to Whole Provision Support and Practical Strategies*. London: Jessica Kingsley Publishers

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*.London: Jessica Kingsley Publishers

Carol Fitzpatrick (2012) *A Short Introduction to Understanding and Supporting Children and Young People Who Self-Harm*.London: Jessica Kingsley Publishers

**Depression**

Difficulties are a normal part of life for all of us, but for someone who is suffering from depression these difficulties may be more extreme. Feelings of failure, hopelessness, numbness, or sadness may invade their day-to-day life over an extended period of weeks or months and have a significant impact on their behaviour and ability and motivation to engage in day-to-day activities.

**Online support**

Mind/ [Depression Alliance: www.depressionalliance.org/information/what-depression](http://www.depressionalliance.org/information/what-depression)

**Books**

Christopher Dowrick and Susan Martin (2015) *Can I Tell you about Depression? A guide for friends, family and professionals*.London: Jessica Kingsley Publishers

**Anxiety, panic attacks and phobias**

Anxiety can take many forms in children and young people, and it is something that each of us experiences at low levels as part of normal life. When thoughts of anxiety, fear or panic are repeatedly present over several weeks or months and/or they are beginning to impact on a young person’s ability to access or enjoy day-to-day life, intervention is needed.

**Online support**

[Anxiety UK:](https://www.anxietyuk.org.uk/) [www.anxietyuk.org.uk](http://www.anxietyuk.org.uk/)

**Books**

Lucy Willetts and Polly Waite (2014) *Can I Tell you about Anxiety? A guide for friends, family, and professionals*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2015) *A Short Introduction to Helping Young People Manage Anxiety*. London: Jessica Kingsley Publishers

**Obsessions and Compulsions**

Obsessions describe intrusive thoughts or feelings that enter our minds which are disturbing or upsetting; compulsions are the behaviours we one may carry out in order to manage those thoughts or feelings. For example, a young person may be constantly worried that their house will burn down if they don’t turn off all switches before leaving the house. They may respond to these thoughts by repeatedly checking switches, perhaps returning home several times to do so. Obsessive compulsive disorder (OCD) can take many forms – it is not just about cleaning and checking.

**Online support**

[OCD UK: www.ocduk.org/ocd](http://www.ocduk.org/ocd)

**Books**

Amita Jassi and Sarah Hull (2013) *Can I Tell you about OCD? A guide for friends, family, and professionals*.London: Jessica Kingsley Publishers

Susan Conners (2011) *The Tourette Syndrome & OCD Checklist: A practical reference for parents and teachers*.San Francisco: Jossey-Bass

**Suicidal Feelings**

Young people may experience complicated thoughts and feelings about wanting to end their own lives. Suicide is the act of intentionally taking your own life. Suicidal feelings can mean having abstract thoughts about ending your life or feeling that people would be better off without you. Or it can mean thinking about methods of suicide or making clear plans to take your own life.

**Online support**

[Prevention of young suicide UK – PAPYRUS:](https://www.papyrus-uk.org/) [www.papyrus-uk.org](http://www.papyrus-uk.org/)

[On the edge: ChildLine spotlight report on suicide:](http://www.nspcc.org.uk/preventing-abuse/research-and-resources/on-the-edge-childline-spotlight/) www.nspcc.org.uk/preventing-abuse/researchand-resources/on-the-edge-childline-spotlight/

**Books**

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*.London: Jessica Kingsley Publishers

Terri A. Erbacher, Jonathan B. Singer and Scott Poland (2015) *Suicide in Provisions: A Practitioner’s Guide to Multi-level Prevention, Assessment, Intervention, and Postvention*. New York: Routledge

**Eating Problems**

Food, weight, and shape may be used as a way of coping with, or communicating about, difficult thoughts, feelings, and behaviours that a young person experiences day to day. Some young people develop eating disorders such as anorexia (where food intake is restricted), binge eating disorder and bulimia nervosa (a cycle of bingeing and purging). Other young people, particularly those of primary or preprovision age, may develop problematic behaviours around food including refusing to eat in certain situations or with certain people. This can be a way of communicating messages the child does not have the words to convey.

**Online support**

[Beat – the eating disorders charity:](http://www.b-eat.co.uk/get-help/about-eating-disorders/) [www.b-eat.co.uk/about-eating-disorders](http://www.b-eat.co.uk/about-eating-disorders)

[Eating Difficulties in Younger Children and when to worry:](http://www.inourhands.com/eating-difficulties-in-younger-children/) [www.inourhands.com/eating-difficultiesin-younger-children](http://www.inourhands.com/eating-difficulties-in-younger-children)

**Books**

Bryan Lask and Lucy Watson (2014) *Can I tell you about eating disorders? A Guide for Friends, Family and Professionals*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Provisions: A Guide to Whole Provision Support and Practical Strategies*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2012) *Eating Disorders Pocketbook*. Teachers’ Pocketbooks

**Appendix B: Guidance and advice documents**

* Mental health and behaviour in provisions (November 2018)
* Counselling in provisions: a blueprint for the future (February 2016)
* Special educational needs and disabilities code of practice: 0 to 25 (November 2020)
* Statutory Guidance Keeping Children Safe in Education (September 2020)
* Transforming Children and Young People’s Mental Health Provision: A Green Paper (December 2017)

* [Mental health and behaviour in provisions](http://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2) - departmental advice for provision staff. Department for Education (2014)

* Supporting people living with autism disorder and mental health problems – A guide for practitioners and providers (October 2015)

* [Counselling in provisions: a blueprint for the future](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416326/Counselling_in_schools_-240315.pdf) - departmental advice for provision staff and counsellors. Department for Education (2015)

* [Teacher Guidance: Preparing to teach about mental health and emotional wellbeing](http://www.inourhands.com/wp-content/uploads/2015/03/Preparing-to-teach-about-mental-health-and-emotional-wellbeing-PSHE-Association-March-2015-FINAL.pdf) (2015).

PSHE Association. Funded by the Department for Education (2015)

* [Keeping children safe in education](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/372753/Keeping%20_children_safe_in_education.pdf) - statutory guidance for provisions and colleges. Department for Education (2016) or current version

* [Supporting pupils at provision with medical conditions](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/349435/Statutor%20y_guidance_on_supporting_pupils_at_school_with_medical_conditions.pdf) - statutory guidance for governing bodies of maintained provisions and proprietors of academies in England. Department for Education (2016)

* Healthy child programme from 5 to 19 years old is a recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. Department of Health (2009)

* [Future in mind – promoting, protecting and improving our children and young people’s mental health and wellbeing](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf) - a report produced by the Children and Young People’s Mental Health and Wellbeing Taskforce to examine how to improve mental health services for children and young people. Department of Health (2015)

* NICE guidance on social and emotional wellbeing in primary education

* [NICE guidance on social and emotional wellbeing in secondary education](http://www.nice.org.uk/guidance/ph20)

* [What works in promoting social and emotional wellbeing and responding to mental health problems in provisions?](http://www.ncb.org.uk/areas-of-activity/education-and-learning/partnership-for-well-being-and-mental-health-in-schools/what-works-guidance-for-schools)  Advice for provisions and framework document written by Professor Katherine Weare. National Children’s Bureau (2015) 

**Appendix C: Sources or provision support and in the local community**

**Provision Support**

* Head of Pastoral Care and Support **–** Designated Safeguarding Lead
* Director – Deputy Designated Safeguarding Lead

**Local and National Support**

* Independent local support groups in individual local authorities
* Local GP Surgery
* Young Minds Child and Adolescent Mental Health

(www.youngminds.org.uk)

* Mind, the mental health charity

[(www.mind.org.uk)](http://www.mind.org.uk/)

* NHS UK – Children and Young People’s Services

**Appendix D: Talking to students when they make mental health disclosures**

The advice below is from students themselves, in their own words, together with some additional ideas to help you in initial conversations with students when they disclose mental health concerns. This advice should be considered alongside the provision safeguarding policy and procedures.

## Focus on listening

*“She listened, and I mean REALLY listened. She didn’t interrupt me or ask me to explain myself or anything, she just let me talk and talk and talk. I had been unsure about talking to anyone, but I knew quite quickly that I’d chosen the right person to talk to and that it would be a turning point.”*

If a student has come to you, it’s because they trust you and feel a need to share their difficulties with someone. Let them talk. Just letting them pour out what they’re thinking will make a huge difference and marks a huge first step in recovery. Up until now they may not have admitted even to themselves that there is a problem.

## Don’t talk too much

*“Sometimes it’s hard to explain what’s going on in my head – it doesn’t make a lot of sense and I’ve kind of gotten used to keeping myself to myself. But just ‘cos I’m struggling to find the right words doesn’t mean you should help me. Just keep quiet, I’ll get there in the end.”*

The student should be talking at least three quarters of the time. If that’s not the case, then you need to redress the balance. You are here to listen, not to talk. Sometimes the conversation may lapse into silence. Try not to give in to the urge to fill the gap, but rather wait until the student does so. This can often lead to them exploring their feelings more deeply. Of course, show that you understand and are supportive. Don’t feel an urge to over-analyse the situation or try to offer answers. For now, your role is simply one of supportive listener. So, make sure you’re listening!

## Don’t pretend to understand

*“I think that all teachers got taught on some course somewhere to say ‘I understand how that must feel’ the moment you open up. YOU DON’T – do not even pretend to, it’s not helpful, it’s insulting.”*

The concept of a mental health difficulty such as an eating disorder or obsessive-compulsive disorder (OCD) can seem completely alien if you have never experienced these difficulties first-hand. You may find yourself wondering why on earth someone these things to themselves would do, however, you must not explore those feelings with the sufferer. Instead listen hard to what they are saying and encourage them to talk, and you will slowly start to understand what steps they might be ready to take in order to start making some changes.

## Do not be afraid to make eye contact

*“She was so disgusted by what I told her that she couldn’t bear to look at me.”*

It is important to try to maintain a natural level of eye contact (even if you have to think very hard about doing so and it does not feel natural to you at all). If you make too much eye contact, the student may interpret this as if you are staring at them. They may think that you are horrified about what they are saying or think they are a ‘freak.’ On the other hand, if you do not make eye contact at all then a student may interpret this as you are being disgusted by them – to the extent that you cannot bring yourself to look at them. Therefore, trying to maintain natural eye contact will convey a positive message to the student.

## Offer support

*“I was worried how she’d react, but my Mum just listened then said, ‘How can I support you?’ – No-one had asked me that before and it made me realise that she cared. Between us we thought of some really practical things she could do to help me stop self-harming.”*

Never leave this kind of conversation without agreeing next steps. These will be informed by your conversations with appropriate colleagues. Whatever happens, you should have some form of next steps to carry out after the conversation because this will help the student to realise that you are working with them to move things forward.

## Acknowledge how hard it is to discuss these issues

*“Talking about my bingeing for the first time was the hardest thing I ever did. When I was done talking, my teacher looked me in the eye and said, ‘That must have been really tough’ – he was right, it was, but it meant so much that he realised what a big deal it was for me.”*

It can take a young person weeks or even months to admit they have a problem to themselves, let alone share that with anyone else. If a student chooses to confide in you, you should feel proud and privileged that they have such a high level of trust in you. Acknowledging both how brave they have been, and how glad you are they chose to speak to you, conveys positive messages of support to the student.

## Do not assume that an apparently negative response is actually a negative response

*“The anorexic voice in my head was telling me to push help away so I was saying no. But there was a tiny part of me that wanted to get better. I just couldn’t say it out loud or else I’d have to punish myself.”*

Despite the fact that a student has confided in you and may even have expressed a desire to get on top of their illness, which does not mean they’ll readily accept help. The illness may ensure they resist any form of help for as long as they possibly can. Do not be offended or upset if your offers of help are met with anger, indifference, or insolence, it’s the illness talking, not the student.

## Never break your promises

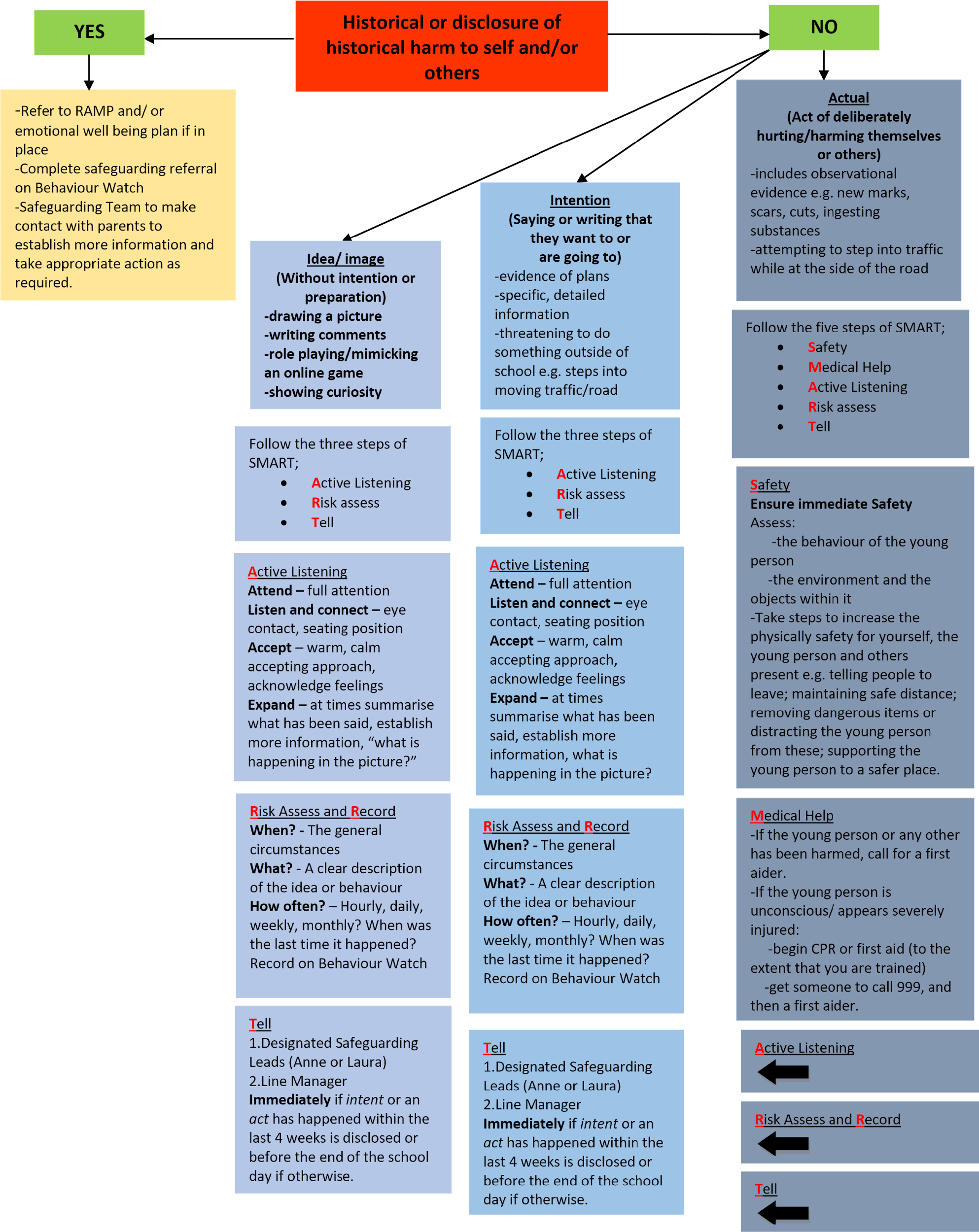
*“Whatever you say you’ll do you have to do or else the trust we’ve built in you will be smashed to smithereens. And never lie. Just be honest. If you’re going to tell someone, just be upfront about it, we can handle that, what we can’t handle is having our trust broken.”*

Primarily, a student wants to know they can trust you. That means if they want you to keep their issues confidential and you cannot then you must be honest. Explain that, whilst you cannot keep it a secret, you can ensure that it is handled within the provision’s policy of confidentiality and that only those who need to know about it in order to help will know about the situation. You can also be honest about the fact you do not have all the answers or are not exactly sure what will happen next. Consider yourself the student’s ally rather than their saviour and think about which next steps you can take together, always ensuring you follow relevant policies and consult appropriate colleagues.

**Appendix E: Flowchart responding to Risky Distress**

**Immediate Response Protocol – Responding to Risky Distress**

# Harm to Self and/or others



**Appendix F: What makes a good CAMHS referral?**

## If the referral is urgent, it should be started by phone so that CAMHS can advise of best next steps. Have the family had an early help referral? Have they completed the process?

**Before making the referral, have a clear outcome in mind, what do you want CAMHS to do? You might be looking for advice, strategies, or support.**

**You must also be able to supply evidence regarding prior intervention and support that has been offered to the pupil by staff and the impact of this. CAMHS will always ask ‘What have you tried?’ so be prepared to supply relevant evidence, reports, and records.**

## General considerations

* Have you met with the parent(s)/carer(s) and the referred child/children?
* Has the referral to CAMHS been discussed with a parent / carer and the referred pupil?
* Has the pupil given consent for the referral?
* Has a parent / carer given consent for the referral?
* What is the parent/carer pupil’s attitudes to the referral?

## Basic information

* Is there a child protection plan in place?
* Is the child looked after?
* Name and date of birth of referred child/children
* Address and telephone number
* Diagnosis
* Who has parental responsibility?
* Surnames if different to child’s
* GP details
* What is the ethnicity of the pupil / family?
* Will an interpreter be needed?
* Are there other agencies involved?

## Reason for referral

* What are the specific difficulties that you want CAMHS to address?
* How long has this been a problem and why is the family seeking help now?
* Is the problem situation-specific or more generalised?
* Your understanding of the problem/issues involved.

## Further helpful information

* Who else is living at home and details of separated parents if appropriate?
* Name of provision
* Who else has been or is professionally involved and in what capacity?
* What interventions is the child currently receiving e.g., provision counselling?
* Has there been any previous contact with our department?
* Has there been any previous contact with social services?
* Details of any known protective factors
* Any relevant history i.e., family, life events and/or developmental factors • Are there any recent changes in the pupil’s or family’s life?
* Are there any known risks, to self, to others or to professionals?
* Is there a history of developmental delay e.g., speech and language delay?

The screening tool below will help to guide whether or not a CAMHS referral is appropriate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INVOLVEMENT WITH CAMHS** | |  | **DURATION OF DIFFICULTIES** | |
|  | Current CAMHS involvement – **END OF SCREEN\*** |  | 1-2 weeks |
|  | Previous history of CAMHS involvement |  | Less than a month |
|  | Previous history of medication for mental health issues |  | 1-3 months |
|  | Any current medication for mental health issues |  | More than 3 months |
|  | Developmental issues e.g., ADHD, ASD, LD |  | More than 6 months |

### \* Ask for consent to telephone CAMHS clinic for discussion with clinician involved in young person’s care

***Tick the appropriate boxes to obtain a score for the young person’s mental health needs.***

|  |  |  |
| --- | --- | --- |
| **MENTAL HEALTH SYMPTOMS** | | |
|  | 1 | Panic attacks (overwhelming fear, heart pounding, breathing fast etc) |
|  | 1 | Mood disturbance (low mood – sad, apathetic; high mood – exaggerated / unrealistic elation) |
|  | 2 | Depressive symptoms (e.g., tearful, irritable, sad) |
|  | 1 | Sleep disturbance (difficulty getting to sleep or staying asleep) |
|  | 1 | Eating issues (change in weight / eating habits, negative body image, purging or binging) |
|  | 1 | Difficulties following traumatic experiences (e.g., flashbacks, powerful memories, avoidance) |
|  | 2 | Psychotic symptoms (hearing and / or appearing to respond to voices, overly suspicious) |
|  | 2 | Delusional thoughts (grandiose thoughts, thinking they are someone else) |
|  | 1 | Hyperactivity (levels of over-activity & impulsivity above what would be expected; in all settings) |
|  | 2 | Obsessive thoughts and/or compulsive behaviours (e.g., handwashing, cleaning, checking) |

### Impact of above symptoms on functioning - circle the relevant score and add to the total

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Little or none | Score = 0 | Some | Score = 1 | Moderate | Score = 2 | Severe | Score = 3 |

|  |  |  |
| --- | --- | --- |
| **HARMING BEHAVIOURS** | | |
|  | 1 | History of self-harm (cutting, burning, pinching etc) |
|  | 1 | History of thoughts about suicide |
|  | 2 | History of suicidal attempts (e.g., deep cuts to wrists, overdose, attempting to hang self) |
|  | 2 | Current self-harm behaviours |
|  | 2 | Anger outbursts or aggressive behaviour towards children or adults |
|  | 5 | Verbalised suicidal thoughts\* (e.g., talking about wanting to kill self / how they might do this) |
|  | 5 | Thoughts of harming others\* or actual harming / violent behaviours towards others |

### \* If yes – call CAMHS team to discuss an urgent referral and immediate risk management strategies

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Social setting - for these situations you may also need to inform other agencies (e.g., Child Protection)** | | | | |
|  | Family mental health issues |  |  | Physical health issues |
|  | History of bereavement/loss/trauma |  |  | Identified drug / alcohol use |
|  | Problems in family relationships |  |  | Living in care |
|  | Problems with peer relationships |  |  | Involved in criminal activity |
|  | Not attending/functioning in provision |  |  | History of social services involvement |
|  | Excluded from provision (FTE, permanent) |  |  | Current Child Protection concerns |

### How many social setting boxes have you ticked? Circle the relevant score and add to the total –

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 0 or 1 | Score = 0 | 2 or 3 | Score = 1 | 4 or 5 | Score = 2 | 6 or more | Score = 3 |

**Add up all the scores for the young person and enter into scoring table:**

|  |  |  |
| --- | --- | --- |
| Score 0-4 | Score 5-7 | Score 8+ |
| Give information/advice to the young person | Seek advice about the young person from CAMHS Primary Mental Health Team | Refer to CAMHS clinic |

**\*\*\* If the young person does not consent to you making a referral, you can speak to the appropriate**

**HYMs (CAMHS) service anonymously for advice \*\*\***

**Appendix G – Mental Health Risk Assessment and Emotional Well Being Plan**

|  |
| --- |
| **Harm to self** |
| ‘Sometimes, when some young people feel really sad or really angry, they might do things to hurt themselves. It does not mean they are a bad person, but they might need help with their feelings.’ |
| Do you get *thoughts* about hurting yourself on purpose?     * When?      * What?      * How often?     Do you ever *feel* like hurting yourself on purpose?     * When?      * What?      * How often?   Do you ever make *plans* to hurt yourself?     * When?      * What?      * How often?   Do you ever make *plans* to hurt yourself?     * When?      * What?      * How often? |
| **Harm to self** |
| What gets you to the point where you feel like hurting yourself?     * When?      * What?      * How often? |
| Have you *ever* hurt yourself on purpose?     * When?      * How? |
| Do you think you might hurt yourself on purpose *today*?     * When?      * How? |
| What can I do to help you keep safe?    What needs to change so that you won’t feel like hurting yourself so much?    What might help you feel just a little bit better?    What other things help you to cope? |

|  |
| --- |
| **Suicide** |
| ‘Sometimes, when some young people feel really sad or desperate, they might wish they were not alive anymore. Sometimes they might think about killing themselves. It does not mean they are a bad person, but they might need help with their feelings.’ |

|  |
| --- |
| Do you get *thoughts* about killing yourself?    When?      What?      How often?    Do you ever *feel* like killing yourself?    When?      What?      How often? |
| Do you ever make *plans* to kill yourself?    When?      What?      How often? |

|  |
| --- |
| **Suicide** |
| What gets you to the point where you feel like killing yourself? |
| Have you *ever* tried to kill yourself?    When?      What?      How often? |
| *As you sit with me right now*, have you got plans to kill yourself?    When?      How? |
| What can I do to help you keep safe?        What needs to change so that you will not feel like killing yourself?        What might help you feel just a little bit better?        What helps you to cope? |
| **Plans to hurt other people or damage property** |
| What gets you to the point where you feel like hurting other people or damaging things?    Have you *ever* hurt other people or damaged things?    When?      What?      How often? |
| Have you *ever* hurt other people or damaged things?    When?      What?      How often? |
| Do you think you might hurt someone or damage something *today*?    Who?  What?      When?      How? |
| What can I do to help everyone stay safe?        What needs to change so that you will not feel like hurting other people or damaging things?        What might help you feel just a little bit better?        What helps you to cope? |

**Emotional Well-Being Plan**

**Name:**

**Date:**

**Diagnosis:**

**Medication:**

**Emergency contact:**

**Purpose of the plan**

**Who created and agreed the plan?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Risk** | **Signs** | **Worries or concerns that you may have**    **Fast – immediate issues that can impact on how you**  **are feeling**    **Slow – concerns that don’t arise immediately**    **Both** | **Reducing the Risk**  **Preventative and Proactive** | **Response to risk** |
|  |  |  |  |  |

**Appendix H: Staff Positive Mental Health and Well-being Policy Quick Quiz**

**Positive Mental Health and Well Being Policy**

**September 2021**

1. Who has a responsibility to promote the mental health and well-being of students?

1. What percentage of people with ASC are at risk of suffering from depression and severe anxiety?

1. Who are the lead members of staff with specific responsibilities?

1. What does CAMHS stand for?

1. If you have a concern about the mental health and well-being of a student/family members or staff members, what should you do?
2. Please list 6 possible warning signs that a student is experiencing mental health problem

1. How would you manage a mental health disclosure from a student?

1. What might be included on a mental health risk assessment and emotional well-being plan?

1. What would you do if a student asks you to keep a mental health disclosure confidential?

1. Name two external services that can be accessed for mental health support.

**I have read, understand, and know how to apply the Positive Mental Health and Well Being Policy at Life Lodge Alternative Education.**

**Signed:**

**...................................................................................................................................................**

**Print:**

**......................................................................................................................................................**

**Date:**

**..............................................**