St Philip's School Mental Health and Wellbeing Policy

Date of approval	18/05/21 - Ben Walsh Headteacher, Andy Hill Deputy Headteacher, Debbie Battle, Designated Safeguarding Lead
Date of Review	18/05/22
Sent to	Jacqueline Van-West Director of Learning Support Services Orchard Hill College
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1. Procedure Statement

1.1 St Philips promotes the mental health, physical health and emotional wellbeing of all its staff and pupils. We understand that learning cannot take place without good emotional health. The deputy head teacher ensures that the behaviour and safety of all pupils is paramount and the wellbeing of pupils is at the forefront of the school's PSHE programme. Promoting good mental health is a priority. The physical, mental and emotional health benefits of exercise are well documented and the school actively encourages sport for all. St Philip's offer parents and pupils support through a designated team WEST (Wellbeing and Emotional Support Team). This team is led by the DSL (Designated Safeguarding/ Wellbeing Lead) who is a full time, wider leader.

1.2 Mental health issues can be de-stigmatised by educating pupils, staff and parents. This is achieved through tutorials and PSHE with the pupils, through staff Inset days and through the WEST. Individual sessions with parents, whose child is experiencing mental health or other social/ emotional difficulties are offered. The schools website also includes mental health awareness.

1.3 This procedure aims to:

- describe the school's approach to mental health issues for pupils
- to inform staff and parents of mental health issues so as to facilitate early intervention of potential mental health problems
- alert staff to warning signs and risk factors

1.4 This procedure has been authorised by OHCAT and the Governing body and is shared with all members of staff and volunteers. It is available to parents on our school website. It applies wherever staff or volunteers are working with pupils even when away from the school, for example on an educational visit.

2. Child Protection Responsibilities

2.1 This procedure should be read in conjunction with our overarching OHCAT Child Protection policy and the OHCAT Student Mental Wealth, Health and Wellbeing Policy.

2.2 The Designated Safeguarding/ Wellbeing Lead (DSL) and senior leaders are responsible for ensuring that this procedure is followed.
2.3 In addition to the child protection measures outlined in the School's Child Protection policy and procedures, the School has a duty of care to protect and promote the mental and emotional wellbeing of the young people at the school.

3. Background

3.1 Children and young people with learning disabilities are:

- 33 times more likely to have an autistic spectrum disorder
- 8 times more likely to have ADHD
- 6 time more likely to have a conduct disorder
- 4 times more likely to have an emotional disorder
- 3 times more likely to experience schizophrenia
- 1.7 times more likely to have a depressive disorder

There is a higher risk to those with greater support needs, particularly if they are unable to communicate their feelings or communicate their distress. Having a learning disability is also likely to reduce a child's capacity for finding creative and adaptive solutions to life's challenges. All of these factors are known to have a negative impact on mental health, putting young people with learning disabilities at greater risk of developing mental health problems.

Children and young people with ASC are at much higher risk of developing mental health problems. 70% of children with ASC will have a mental health concern at some point in their life with 40% having two or more. (http://www.youngminds.org.uk/assets/0000/9596/chapter3.pdf).

3.2 Risk Factors for adolescence

- Hormonal changes may make young people more prone to extremes of emotion, anxiety and depression
- Concerns about appearance may lead to depression, anxiety , excessive dieting and over exercising which could lead to an eating disorder
- Experimenting with alcohol and drugs may lead to a substance misuse problem or other mental health problem
- Increased risk taking behaviour may result in major adverse life events which may lead to the development of a mental illness
- Increased autonomy and independence can provoke anxiety in some young people, as can the pressure to achieve and make decisions about their future
- Wanting to be accepted by peers can lead young people to do things they wouldn't normally do and can lead to distress about not fitting in with their peer group
- Limited knowledge of how to manage emotions
- Young people may be experiencing events which lead to strong emotions for the first time, such as a relationship break up, and may not know how to manage these feelings. This could lead to them using substances, self-harming or relieving some of their distress through over/ under eating

3.3 Factors contributing to Mental Health in people with Learning Disabilities (LD)

It is only recently that there has been recognition that people with LD can develop the same mental health problems as the general population and that prevalence rates of mental illness are higher for LD populations. As for the general population, a combination of biological, psychological and social factors can lead to the development of mental health problems. People with an LD tend to be more vulnerable to these factors as outlined in the below.

Biological Factors

Brain damage
Not all people with LD have brain damage. For those who do, these can cause structural and psychological changes to the way the brain functions, increasing vulnerability.

Sensory impairments
Sensory impairment can create a barrier to social integration and lead to disablement and problems with self-image.

Psychological

Self-worth
Society values achievements such as high social status, independence, employment, relationships and family. People with intellectual disabilities may have difficulty attaining these, which may affect their self-esteem.

Self-image
People with LD may feel they are different to other people due to either their cognitive or physical disabilities or may feel inferior to others because of their reliance on the support of others. Poor self-image can contribute to mental health problems.

Stigma
There is often additional suffering caused by attitudes of rejection and stigma towards people with a LD.

Social
Exposure to adverse life events
People with LD are more likely to have been exposed to abuse, trauma, rejection, harassment and exploitation.

3.4 Adverse childhood experiences (ACE's)
ACE's such as those outlined below can have severe detrimental long-term effects on children and their lives going into adulthood

- Parental Separation
- Domestic Violence
- Mental Illness
- Alcohol Abuse
- Drug Use
- Incarceration

Experiencing multiple ACE's increases the adverse effects – those with 4 or more ACE's are:-

- **Twice** as likely to binge drink or have a bad diet
- **Three** times more likely to be a smoker
- **Five** times more likely to have sex under the age of 16
- **Six** times more likely to have caused or to have an unplanned pregnancy
- **Seven** times more likely to be involved in violence
- **Eleven** times more likely to be using crack cocaine or be incarcerated

See - http://www.cph.org.uk/wp-content/uploads/2014/05/ACE-infographics-BMC-Medicine-FINAL-3.pdf

4. Diagnosed neurodevelopmental disorders within St Philips

4.1

Autism

- Autism is a neurodevelopmental condition which is now widely recognised as being on a broad spectrum. The word 'spectrum' is used because, while all people with autism share three main areas of difficulty, their condition will affect them in very different ways.
- social communication difficulties
- social interaction challenges you
- repetitive and restrictive behaviour;
- over- or under-sensitivity to light, sound, taste or touch;
- highly focused interests of hobbies;
- extreme anxiety;

- meltdowns and shutdowns.

- ADHD / ADD (now referred to as ADHD - inattentive type)

A young person with ADHD or ADHD – Inattentive type, shows disruptive behaviours which cannot be explained by any other psychiatric condition and are not in keeping with those of the same aged people with similar intelligence and development. The behaviours are normally first noticed in early childhood and are more extreme than simply "misbehaviour". The impact of these behaviours can prevent the child from developing sustainable relationships with friends, parents, teachers and other adults. Children and young people with ADHD or ADD are at increased risk of developing depression and other emotional problems.

The main characteristics of a young person with ADHD or ADHD – Inattentive type are:
Hyperactivity - lots of energy and feeling the need to move about or fidget and sometimes resulting in poor sleep
Impulsivity - an inability to self-regulate thoughts, feelings and actions
Inattention - difficulty concentrating and remembering information

4.2 Mental Health difficulties and Conditions within St Philips

- Depression

Depression is a state of low mood that lasts at least two weeks and affects the young person's behaviour and has physical, emotional and cognitive effects. It also interferes with the ability to study, work and to have satisfying relationships. When severe, it can increase the risk of self-harm, substance misuse and suicide.

- Anxiety

Anxiety can vary in severity from mild uneasiness through to a terrifying panic attack. It can last for a few moments to a few years. It is often triggered by stress in the young person's life. Usually anxiety is a response to outside forces.

- OCD (Obsessive-compulsive disorder)

This is a form of anxiety but can be very disabling. Obsessional thoughts and compulsive behaviours accompany the feelings of anxiety. These obsessional recurrent thoughts and/or images cannot be dispelled by the young person. These can include thoughts of contamination or harm or something awful happening to them or someone else. These then consist of repetitive behaviours or mental activity such as counting silently or repeating certain words or phrases internally. The young person feels compelled to behave in this way to reduce anxiety.

- Attachment disorder

Attachment disorder is defined as the condition in which individuals have difficulty forming lasting relationships. They often show nearly a complete lack of ability to be genuinely affectionate to others. They typically fail to develop a conscience and do not learn to trust.

- Psychosis

Psychosis is a general term to describe a mental health problem in which young people experience changes in thinking, perception, mood and behaviour which can severely disrupt life.

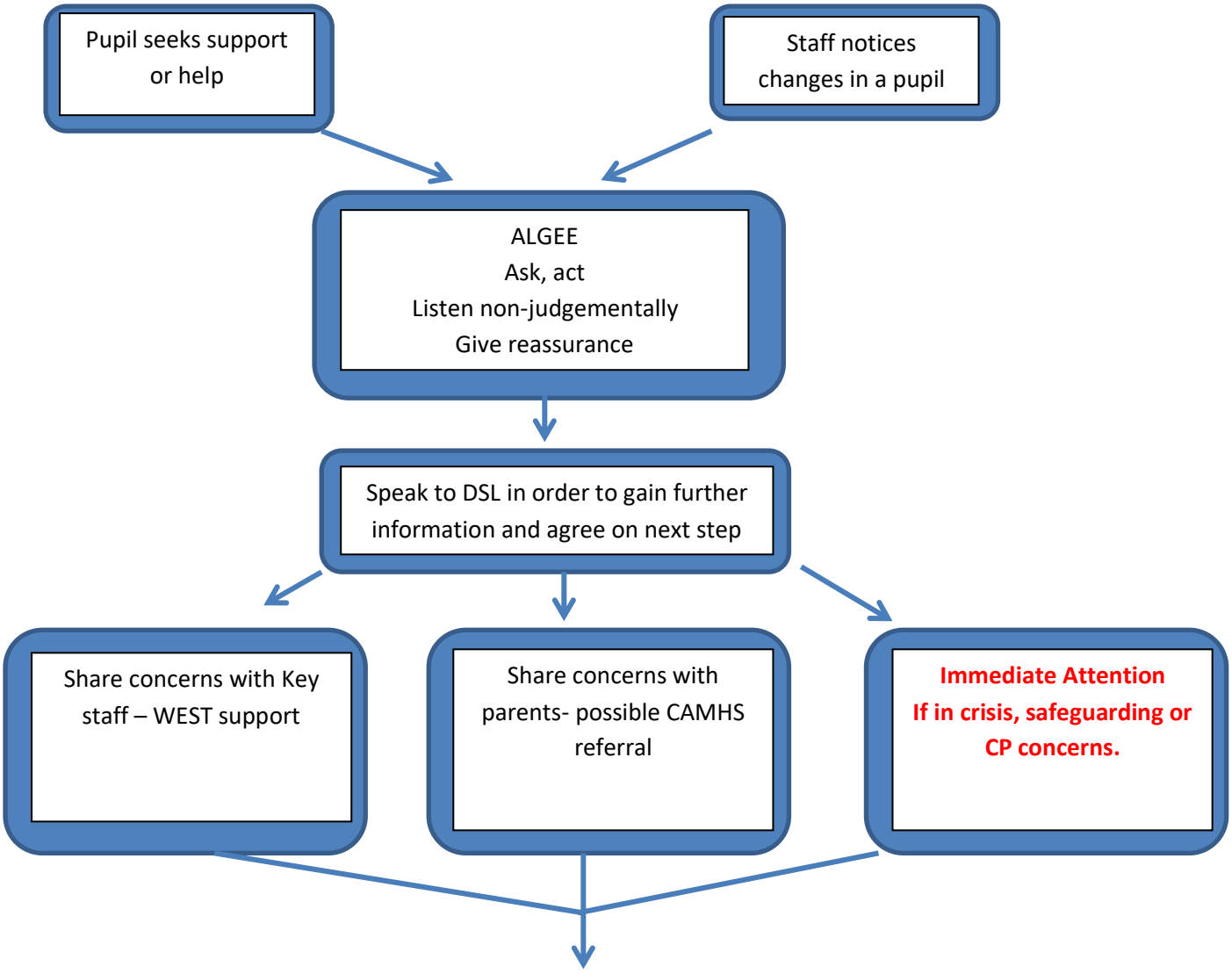
- Self-harm (including use of food)

Self-harm is a behaviour and not an illness; people self-harm to cope with emotional distress or to communicate that they are distressed. Eating disorders involve a disturbance of eating patterns, or weight controlling behaviour, which results in impairment to health.
[taken from the MHFA first aid Youth manual 2017]

- Suicidal Ideation

Suicidal thoughts, also known as suicidal ideation, are thoughts about how to kill oneself, which can range from a detailed plan to a fleeting consideration and does not include the final act of killing oneself. The majority of people who experience suicidal ideation do not carry it through. Some may, however, make suicide attempts. Some suicidal ideations can be deliberately planned to fail or be discovered, while others might be carefully planned to succeed.

5. How St Philip's supports pupils with mental, social or emotional difficulties



Universal	Targeted	Specialist
Class teams monitor and "check in" with pupil's daily	School Health Practitioner	School Health Practitioner
WEST Team Department meetings	WEST Team Transactional analysis practitioner	WEST Team Specialist therapy such as drama therapy, art therapy, parental counselling, Life story work
DSL Student support worker ELSA PSHE coordinator School health drop in Healthy school's coordinator	DSL Student Support Worker ELSA PSHE coordinator School health drop in School Educational Psychologist	CAMHS Transactional analysis practitioner School Educational Psychologist
TENDER and other wellbeing charities	Drama/ Art therapy Healing Together Programme	

5. How St Philip's supports pupils with mental, social or emotional difficulties

5.1 The majority of staff at St Philips School have been trained in Mental Health First Aid (MHFA). All management and other key staff have been trained fully in the two day MHFA.

6. How the school monitors Mental Health and Emotional Wellbeing

6.1 The school uses a range of assessment tools to monitor pupil's wellbeing. For example the;

- Strength and Difficulties Questionnaire (SDQ)
- Boxhall Profile
- Revised Children's Anxiety and Depression Scale (RACADS)
- Childs automatic thought scale (CATs)
- SIMS (behaviour and reward tracking system)
- Multi Element Plans

These assessments are used in conjunction with staff and parent knowledge and results are interpreted and checked with an Educational Psychologist when needed. Assessment tools will never be used in isolation. They are a useful tool when baselining interventions and when completing CAMHS referrals.

6.2 Multi-disciplinary meetings are held in order to assess the needs of pupils and a follow up meeting with parents/carers will then be set up.

6.3 If a pupil is absent from school for any length of time for a mental health difficulty, then appropriate arrangements will be made to send work home. This may be in discussion with any medical professionals who may be treating a pupil.

6.4 Should a pupil require some time out of school, the school will be fully supportive of this and every step will be taken in order to ensure a smooth reintegration back into school when they are ready. This would include a phased return, extra support, an adapted timetable, safe areas and regular reviews of the pupil.

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

7. Confidentiality and information sharing

7.1 Parents must disclose to the school any known mental health problems or any other concerns they may have about a pupil's mental health or emotional wellbeing. This includes any changes in family circumstances that may impact the pupil's wellbeing.

Further Reading and Useful Links
Young Minds: http://www.youngminds.org.uk/for_parents
b-eat: http://www.b-eat.co.uk/
Childline: http://www.childline.org.uk
Mind: http://www.mind.org.uk/
NHS: http://www.nhs.uk/livewell/mentalhealth/Pages/Mentalhealthhome.aspx
Mental Health Foundation: http://www.mentalhealth.org.uk/
Stem4: http://www.stem4.org.uk/
Royal College of Psychiatrists: http://www.rcpsych.ac.uk/expertadvice/youthinfo/parentscarers.aspx

References

LaVigna, G. W., & Willis, T. J. (2005)- A Positive Behavioural Support Model for Breaking the Barriers to Social and Community inclusion- *Learning Disability Review*, *10*(2), 16–23.

Due regard;
St Philips Wellbeing Offer
KCSIE 2021
Suicide Prevention/: Procedure and Strategy UK Parliament 2020 https://researchbriefings.files.parliament.uk/documents/CBP-8221/CBP-8221.pdf
Suicide Prevention Strategy 2012
A Whole School Framework for emotional wellbeing and mental health – ncb -2016
https://www.ncb.org.uk/sites/default/files/uploads/files/NCB%20School%20Well%20Being%20Framework%20Leaders%20Resources_0.pdf
Future in Mind –DFE- 2015
The link between pupil health and wellbeing and attainment – NAHT- 2014

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Enough is Enough – centre for social justice- 2014 updated – see
Linkhttps://www.ncb.org.uk/sites/default/files/uploads/files/NCB%20School%20Well%20Being%20Framework%20Leaders%20Resources_0.pdf
Appendices

Appendix 1- **Depression and learning disabilities**

Appendix 2- **Anxiety and learning disabilities**

Appendix 3- **Serious mental illnesses and learning disabilities**

Appendix 4- **Self Harm**

Appendix 5 - **Suicidal behaviour**

Appendices
Appendix 1

Depression and learning disabilities

Depression is the most common mental disorder experienced by people with a learning disability. However, it can be difficult to diagnose depression in someone with a learning disability, because some of the symptoms of depression experienced by the general population can be a part of the 'usual' behaviour or presentation of someone with a learning disability. It is therefore important to consider whether there have been any changes in the person's usual behaviour that might in fact signal depression.

Commons symptoms that you might see in someone experiencing depression:

• Increased tearfulness, crying without any reason	• Self-injurious behaviour
• Irritability	• Property damage
• Restlessness	• Weight loss
• Aggression	• Total social withdrawal
• Changes in appetite – eating too little or too much	• Unwillingness to use speech

• Severe sleep disturbance – difficulty sleeping or waking up too early in the morning	• Slowness in thought and movement
• Deterioration in social and self-help skills	

Appendix 2

Anxiety and learning disabilities

Anxiety problems in children with a learning disability can be overlooked due to communication difficulties. Children and young people with learning disabilities may not have insight into their emotions or feelings, and can struggle to communicate these feelings verbally. Therefore it can sometimes be more useful to look at observable behaviours they may exhibit rather than relying on their own reports of their feelings. It is also worth noting that children with learning disabilities are more likely to talk about the physical sensations of anxiety because of the difficulty of describing their emotional state. In children with more severe learning disabilities, symptoms of anxiety can often be misdiagnosed as challenging behaviour. The more profound the disability, the more likely a child will demonstrate anxiety through their behaviour, Some conditions such as autism, Asperger's Syndrome and ADHD can have increased anxiety as part of the symptoms, which may be due to neurological differences in the way the brain functions. Children and young people with these conditions can really benefit from help to recognise and manage their anxiety, although the underlying condition will remain.

Common symptoms of anxiety that might be described by children and young people include:

Emotions	**Thoughts**	**Physical**
• Irritability	• Worry about past/future events	• Dry mouth
• Impatience	• Mind racing or going blank	• Pounding heart or rapid heartbeat
• Anger	• Poorer concentration and memory	• Chest pain
• Confusion	• Trouble making decisions	• Blushing
• Feeling on edge		• Shortness of breath
• Nervousness		• Dizziness
• Excessive fear		• Headache
		• Sweating
		• Tingling or numbness

		• Stomach pains
		• Nausea, vomiting, diarrhoea
		• Muscle aches and pains (neck, shoulders, back
		• Restlessness
		• Tremors, shaking
		• Difficulty sleeping

Common symptoms you may observe in a child's behaviour include: • Avoiding situations or people • Obsessive compulsive behaviour • Distress in social situations • Increased use of alcohol, other drugs • Self-injurious behaviour • Aggressive, disruptive, defiant • Self-soothing behaviours • Clingy or over demanding • Withdrawal • Over-activity • Seeming to freeze • Repetitive questioning

Appendix 3

Serious mental illnesses and learning disabilities

Diagnosis of a serious mental illness such as schizophrenia or bipolar disorder in someone with a learning disability is difficult and rarely made, particularly in children and young people with a learning disability. Diagnoses of these illnesses often rely on people's description of their internal experiences, which people with a learning disability may be unable to articulate clearly. However, there are some common symptoms of psychosis, schizophrenia and bipolar disorder of which it is worth being aware.

Common Symptoms Psychosis	**Common Symptoms Schizophrenia**	**Common Symptoms Bipolar disorder**
• Hearing people talking when nobody is around	• Delusions – false beliefs, such as being persecuted or being under outside control	• Depression - see symptoms listed above
• Seeing things that are not really there	• Hallucinations – false perceptions, such as seeing, hearing, feelings, tasting or smelling things which are not actually there	• Mania - increased energy and over activity - Elevated mood - Need for less sleep than usual - Irritability - Rapid thinking and speech - Lack of inhibitions - Grandiose delusions - Lack of insight
• Developing strange thoughts	• Difficulties with thinking, concentration and memory	
• Behaving in an odd manner	• Loss of motivation	
• Difficulty in thinking clearly	• Social withdrawal	
• Losing interest in daily activities		

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The difference between mania and depression for people with a learning disability is not as distinct as it is for the general population. People with a learning disability are also more likely to experience rapid cycling (more than four episodes of either mania or depression in a year) than the general population.

Appendix 4

Self-harm

People with a learning disability, especially those with more complex needs, often engage in self injurious behaviour (SIB). Very commonly, SIB is a result of the person's inability to communicate a range of emotions, needs and wants.

- Cutting, scratching, or pinching skin, enough to cause bleeding or a mark which remains on the skin
- Banging or punching objects or self to the point of bruising or bleeding
- Ripping and tearing skin
- Carving words or patterns into skin
- Interfering with the healing of wounds
- Burning skin with cigarettes, matches or hot water
- Compulsively pulling out large amounts of hair
- Deliberately overdosing on medications when this is NOT meant as a suicide attempt.

In addition to those listed above, common types of self-injury in people with a learning disability include:

- head hitting
- self-biting
- eye gouging
- repeated vomiting
- eating non-edible substances (pica)

Appendix 5

Suicidal behaviour

[Type text]

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Suicidal thinking and high risk taking behaviour in those with a learning disability should always be investigated.

The method chosen by a person with a learning disability may not have any lethal potential but may have been chosen because the person believed it would be fatal, so the intent is still there. Research has found that the seriousness of the suicidal behaviour does not always link with the level of intention to die. This may be more pronounced amongst people with a learning disability due to their inability to link cause and effect and greater impulsivity.

Important signs that a person may be suicidal are:

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves; seeking access to pills, weapons, or other means
- Talking, drawing or writing about death, dying or suicide
- Hopelessness
- Rage, anger, seeking revenge
- Acting recklessly or engaging in risk activities, seemingly without thinking
- Feeling trapped, like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life.
- People may show one or may of these signs and some may show signs not on this list.

If you have seen some warning signs of the person feeling suicidal, engage the person in discussion about your observations. If you suspect someone may be at risk of suicide, let the person know that you are concerned about them and are willing to help. It is important to ask them directly about suicidal thoughts. Do not avoid using the word 'suicide'. It is important to ask the question without dread, and without expressing a negative judgement. The question must be direct and to the point. For example, you could ask:

- "Are you having thought of suicide?" or • "Are you thinking about killing yourself?"

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The person with a learning disability may not understand the term ‘suicide’. You may need to use the words such as “kill yourself” or ‘make yourself die” instead. Use concrete terms, and avoid words with double meanings or idioms. Remember to check their understanding by asking them to explain in their own words what they have heard.

People with a learning disability may often want to give you what they think is the “right” answer. Therefore they may say “yes” when in fact the answer is “no” or vice versa. It is important to tell them that you want to hear how they are really feeling and that you are not there to judge them. You’re there to help them either way.

If you appear confident in the face of the suicide crisis, this can be reassuring for the suicidal person. Although some people think that asking about suicide can put the idea in the person’s mind, this is not true. Another myth is that someone who talks about suicide isn’t really serious. Remember that talking about suicide may be a way for the person to indicate just how badly they are feeling.