WESTHOLME SCHOOL

Mental Health and Well-being Policy

Reviewed:	**February 2018**
Date of next review:	**February 2019**
Produced by:	Deputy Head – Pastoral, Head of Infant & Junior Schools, Head of Year 10/11 (DH) School Nurse

Monitoring, evaluation and review

The School will review this policy annually and assess its implementation and effectiveness. The policy will be promoted and implemented throughout the school.

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 contribution to her or his community. (World Health Organisation)*

At our school, we aim to promote positive mental health for every member of our staff and student body. We pursue this aim using both universal, whole school approaches and specialised, targeted approaches aimed at vulnerable students.

In addition to promoting positive mental health, we aim to recognise and respond to mental ill health. In an average classroom, three children will be suffering from a diagnosable mental health issue. By developing and implementing practical, relevant and effective mental health policies and procedures we can promote a safe and stable environment for students affected both directly and indirectly by mental ill health.

A school has an important role to play, acting as a source of support and information for both students and parents. This guidance is designed to empower our staff to spot and support students in need of help and to follow appropriate referral pathways and procedures. A well-developed and implemented policy can prevent students from falling through the gaps.

Scope

This document describes the school's approach to promoting positive mental health and wellbeing. This policy is intended as guidance for all staff including non-teaching staff and governors.

This policy should be read in conjunction with our First Aid Policy in cases where a student's mental health overlaps with or is linked to a medical issue, the SEND Policy where a student has an identified special educational need or disability and the Safeguarding Policy where there are concerns of a child protection nature.

The Policy Aims to:

- Promote positive mental health in all staff and students
- Increase understanding and awareness of common mental health issues
- Alert staff to early warning signs of mental ill health
- Provide support to staff working with young people with mental health issues
- Provide support to students suffering mental ill health and their peers and parents/carers

Lead Members of Staff - The Circle of Care:

Whilst all staff have a responsibility to promote the mental health of students, the main people who will be involved in the student's pastoral care whilst they are at Westholme are:

- School Nurse
- School Counsellor

- Form/Class Teacher
- Head of Year
- Deputy Headteachers: Infants/Juniors
- Deputy Headteacher: Pastoral
- Nursery Manager/ EYFS Leader
- Headteacher: Nursery/Infants/Juniors
- Principal

These people form the main **"Circle of Care"** which surrounds every student during their time at Westholme. Apart from the Principal there is no one person who has overall responsibility for any individual student and it follows therefore that information generally needs to be shared around this circle which is made up of a team of individuals who all play their part in providing the student with the care and support that they need. It will be explained to the student that these people will know about their situation but that the information will not go outside this circle of care (unless a safeguarding concern) if the student does not want it to. The student can identify the individual within the circle whom he/she feels most comfortable talking to if appropriate.

The various individuals within the Circle of Care will also:

- Inform the student's parents/carers and the student will always be encouraged to keep their parents informed. If however, a student has strong feelings about this and/or there would be concerns about a parent's reaction leading to a possible safeguarding issue, a decision will be made depending on the situation, age and competency of the student.
- Be aware of when it is essential for other professional bodies to be informed, such as social services or the Designated Safeguarding Lead (DSL) (see Safeguarding Policy).
- Monitor the help, support and progress of the students in their care and maintain communication with them;
- Maintain communication with the parents;
- Liaise with each other to decide if any other members of staff who have contact with the student should be made aware of the mental health issue and underlying concerns;
- Observe other students that may be affected and ensure that adequate support is given
- Remind friends that they are not responsible for their friend's mental health issue or recovery.
- Be mindful of other students' reactions to the mental health issue.

Any member of staff who is concerned about the mental health or wellbeing of a student should complete a record of concern; found on the safeguarding notice board at their site. Depending on the severity of the issue the Head of Year or Deputy Head Pastoral would coordinate a response at the Senior school and the Nursery Manager, Deputy Headteacher or Headteacher would take this responsibility at the Nursery, Junior and Infant schools. If there is a fear that the student is in danger of immediate harm then the normal child protection procedures should be followed with an immediate referral to the DSL or the Principal. If the student presents a medical emergency then the normal procedures for medical emergencies should be followed, including alerting the School Nurse and contacting the emergency services if necessary.

Where a referral to Children and Adolescent Mental Health Services (CAMHS) or East Lancashire Children and Adolescent Services (ELCAS) is appropriate, this will either be led

or managed by the School Nurse or parents will be asked to take their child to the GP where referrals can also be made.

Individual Care Plans
An individual care plan for pupils causing concern or who receive a diagnosis pertaining to their mental health can be drawn up if felt appropriate. This would involve the pupil, the parents and relevant health professionals. This can include:

- Details of a pupil's condition
- Special requirements and precautions
- Medication and any side effects
- What to do, and who to contact in an emergency
- The role the school can play
- Related risk assessment.

Teaching about Mental Health
The skills, knowledge and understanding needed by our students to keep themselves and others physically and mentally healthy and safe are included as part of our developmental PSHE curriculum, Assemblies, Circle Times and within form activities.

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.

We will follow the PSHE Association Guidance to ensure that we teach mental health and emotional wellbeing issues in a safe and sensitive manner which helps rather than harms.

Signposting
We will ensure that staff, students and parents are aware of sources of support within school and in the local community. The support that is available is included on the Wellbeing page on the school's website. Other details' relating to national organisations is also included.

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

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

Warning Signs
School staff may become aware of warning signs which indicate a student is experiencing mental health or emotional wellbeing issues. These warning signs should **always** be taken

seriously and staff observing any of these warning signs should communicate their concerns via the record of concern sheets which should then be passed to the DSL.

Possible warning signs include:

- Physical signs of harm that are repeated or appear non-accidental
- Changes in eating / sleeping habits
- Increased isolation from friends or family, becoming socially withdrawn
- Changes in activity and mood
- Lowering of academic achievement
- Talking or joking about self-harm or suicide
- Abusing drugs or alcohol
- Expressing feelings of failure, uselessness or loss of hope
- Changes in clothing – e.g. long sleeves in warm weather
- Secretive behaviour
- Skipping PE or getting changed secretively
- Lateness to or absence from school
- Repeated physical pain or nausea with no evident cause
- An increase in lateness or absenteeism

Managing disclosures

A student may choose to disclose concerns about themselves or a friend 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 their 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 F: "Talking to students when they make mental health disclosures".

All disclosures must be recorded in writing and passed to the lead DSL for that site. This written record should include:

- Date
- The name of the member of staff to whom the disclosure was made
- Main points from the conversation
- Agreed next steps

This information should be shared with the DSL who will store the record appropriately and offer support and advice about next steps.

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. If a student is below the age of 16 and is potentially in danger of harm then it may be necessary to inform relevant adults.

It is ideally advisable to share disclosures with a colleague; this helps to safeguard staff's own emotional wellbeing as they are then no longer solely responsible for the student. Furthermore it ensures continuity of care in the case of absence and it provides an extra source of ideas and support. We should explain this to the student and discuss with them who it would be most appropriate and helpful to share this information with.

Parents must always be informed, unless we are aware of child protection issues, and students may choose to tell their parents themselves. The DSL will decide if they'll allow a student to inform their parents first. If this is the case, the student should be given 24 hours to share this information before the school contacts parents. Staff should always give students the option of us informing parents for them or with them unless it is believed that the student is at risk of serious harm.

If a child gives staff reason to believe that there may be underlying child protection issues, parents should not be informed and the child protection protocol should be followed. (See Safeguarding policy).

Working with Parents

Where it is deemed appropriate to inform parents, staff need to be sensitive in their approach. Before disclosing to parents staff 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 school, at their home or somewhere neutral?
- Who should be present? Consider parents, the student, and 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, denial or fear during the first conversation. Staff should be accepting of this (within reason) and give the parent time to reflect.

Staff should always highlight further sources of information and give them leaflets to take away where possible as they will often find it hard to take much in whilst coming to terms with the news that is being shared. Sharing sources of further support aimed specifically at parents can also be helpful too e.g. parent helplines and forums. See Appendix C: "Further information and sources about common mental health issues".

Staff should always provide clear means of contacting us with further questions and consider booking in a follow up meeting or phone call right away as parents often have many

questions as they process the information. Finish each meeting with an agreed next step and always keep a record of the meeting on the student's confidential record.

Working with All Parents

Parents are often very welcoming of support and information from the school 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 on our school website
- Ensure that all parents are aware of who to talk to, and how to get access to this support, if they have concerns about their own child or a friend of their child
- Make our Mental Health Policy easily accessible on the school's website
- Keep parents informed about the mental health topics their children are learning about in Senior School PSHE through the parental handbook.

Supporting Peers

When a student is suffering from mental health issues, it can be a difficult 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 needs 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

The School Counsellor may help to guide staff/provide the support for pupils in these circumstances.

Training

Training opportunities for staff who require more in depth knowledge will be considered as part of the performance management process and additional CPD will be supported throughout the year where it becomes appropriate due to developing situations with one or more students.

Where the need to do so becomes evident, training sessions will be held for relevant staff to promote learning or understanding about specific issues related to mental health.

Suggestions for individual, group or whole school CPD should be discussed with the Principal or Headteacher who can also highlight sources of relevant training and support for individuals as needed.

Appendix A: Eating Disorders Policy

The Policy: We are committed to creating a caring, friendly environment where every member of the school can thrive. Students should feel able to talk to staff and receive the support they need according to their individual circumstances.

Aims: The central aims of this policy are:

- to promote safety, welfare and good physical and mental health;
- to ensure, as far as is possible, that every student in this School is able to benefit from and make his/her full contribution to the life of the School, consistent always with the needs of the school community;
- to ensure that staff are fully informed about procedure involving a student with an eating disorder.
- To involve parents wherever appropriate

1. What are eating disorders?

There are three major types of eating disorders; anorexia; bulimia and binge eating disorder. What they all have in common is that the sufferer uses food and their weight as a way of coping with any problems or difficulties they might be having. Eating disorders are a serious mental health issue that may affect up to 5% of the population. Often eating disorders start in early adolescence.

2. What eating disorders are not

They are *not* attention seeking. Like any behaviour, an eating disorder may be used to attract attention, but this is not usually the focus of problem. If an eating disorder is being used in order to gain attention, one must look to find the reasons as to why someone is in such dire need of attention.

3. Risk factors associated with eating disorders

It is acknowledged by Westholme School that the likelihood of eating disorders occurring amongst its students may be increased due to a common tendency amongst high achieving pupils to be ‘perfect’.

Westholme School’s overriding concern is the welfare of the students – all other considerations, academic related or otherwise, are subsidiary.

Anorexia nervosa, bulimia nervosa and ***compulsive***, or ***'binge', eating disorder*** are three illnesses that have separate and distinct criteria for the purposes of diagnoses. Doctors are very precise about the factors that need to be present before one of these labels can be formally applied.

It is impossible to completely separate signs and symptoms of the eating disorders. There is a lot of overlap and many experience all three illnesses to a greater or lesser degree at some point.

However, there are major common threads running through each eating disorder which includes low self-esteem, self-hatred, disgust at weight and shape, obsession with food, mood swings and depression.

The major problem with eating disorders is that chemical changes in the body, not least the brain, cause it to quickly become addictive. Something that began as an attempt to bring control into a life takes complete control over the thoughts and actions of the sufferer and becomes a force too strong and complex to be sorted out alone.

4. Recognising the Warning Signs

Realising that someone has an eating disorder can be difficult for a variety of reasons:

- The most usual age for people to show signs of an eating disorder is early teens. This is a time of physical and emotional upheaval for both boys and girls and it is not always easy to tell that development is not quite as it should be.
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- Many people have some sort of hang up, problem or a peculiar relationship around food and drink. Some refuse to eat vegetables, some are vegetarian, some won't touch hot or spicy foods. Sorting out what is a fad and what is a problem can often be quite difficult.

5. Anorexia Nervosa

Below are some of the physical, psychological and behavioural signs of Anorexia Nervosa; this list is not exhaustive however:

- Rapid weight loss or, failure to develop and gain expected weight during a growth spurt.
- Hormone disturbance – shows as an absence of periods in females and affects sperm development in males, but may only become evident as a lack of interest in sex in late teenage years.
- Loss of calcium from bones means that bones may break more easily than would be expected in someone young.
- Other physical effects of starvation and dehydration may include constipation, swollen stomach and ankles, dizziness, poor circulation shown in coldness, blue fingers and toes, and growth of fine downy hair on the face and body.
- Fears around being 'fat' and overweight and being weighed.
- Fears around shape - the mind of an anorexic shows them as 'fat' when they look in the mirror when others see them as a virtual skeleton.
- A belief that the more weight they lose the closer they come to being worthwhile.

- Feelings of paranoia that people are staring at them because they are fat and 'ugly'.
- If challenged, they deny that have a problem and refuse to believe they are dangerously thin.
- They are unable to accept rational argument around their eating habits and weight.
- Personality changes may include violence, mood swings and depression.
- Sufferers become secretive around food, their body and their eating habits. They may claim to have eaten when they have not.
- Rituals and superstition may build up around food and drink: specific times when 'meals' may be eaten, precise measurements of portions and the way food is prepared and presented. Being faced with the need to eat outside of these conditions may lead to panic.
- Excessive exercise is often linked to eating disorders as is inappropriate use of large numbers of laxatives or diuretics.
- Panic attacks.

6. Bulimia

Below are some of the physical, psychological and behavioural signs of Bulimia; however this list is not exhaustive:

- Weight may stay steady or fluctuate.
- Hormone disturbance may lead to absence of periods in girls.
- Physical effects of vomiting may include worn tooth enamel, sore throat, bloodshot eyes, puffy face through infected salivary glands, calluses on hands and fingers from inducing vomiting.
- Total preoccupation with thoughts of food.
- Feeling totally out of control during binges.
- Fear of weight gain.
- Self evaluation is centred on weight and shape.
- Personality changes, violence, mood swings and depression.
- A need to succeed and a feeling that no achievement is enough.
- Self hatred, feelings of shame, guilt, and low self esteem.
- Large amounts of food may disappear during binges.
- Students may become secretive and avoid socialising especially where food is involved.
- Sufferers may disappear to the lavatory after meals.
- Evidence of purgative medicines may be found for example laxatives, diuretics etc.
- Other techniques to counter the effects of food, e.g. excessive exercise or fasting.
- Associated problems may include self harm by other methods.

7. Binge Eating Disorder

Below are some of the physical, psychological and behavioural signs of Binge Eating Disorder; however this list is not exhaustive:

- There may be steady or sudden weight gain or marked fluctuation in weight if yoyo dieting is involved.
- Feelings of disgust around weight and shape.

- Feelings of distress, self hatred, low self esteem, secretiveness around binges.
- All available money is spent on obtaining food, such as biscuits, cakes, sweets and other high calorific foods.

NB. Boys often manifest an eating disorder by excessive exercise. Sometimes they lock themselves away in their rooms to do this. It is easily missed because exercise can be such a fundamental part of their lives. Often they will not be conscious of restricting food, they will say that they want to develop a 'six pack' or change their shape. They can become quite ill – this phenomenon is on the increase in the UK.

8. The Grey Area

Many young people use food at times to cope with uncomfortable life situations. Once food is found to work, briefly, against feelings of pain, fear, desperation, loneliness, low self esteem, we are into the 'Grey Area' of eating disorders – unless, or until, it goes further.

Students in the 'grey area' may use food to cope. Their behaviour may never become extreme, however desperate they may feel inside. It may not be noticeable at all.

Sometimes the 'grey area' becomes a way of living, which is sustained over many years. It is so much more subtle in behaviour and effect than that of a full eating disorder, and people are not 'in denial' of the situation. They are simply unaware they inhabit a problem area. It may never become extreme. Although officially acknowledged as **'partial syndrome - anorexia bulimia or binge eating'**, it is unlikely to be picked up by a doctor. However, sometimes the 'grey area' is one that young people pass through on their way to a full-blown eating disorder.

It becomes a problem because people function better if they find ways to express negative and/or angry feelings and get rid of them, instead of using food as an emotional crutch. There are more positive and creative tools that students can use to help them feel confident in their abilities and self worth.

As Eating Disorders can often start in early teenage years, Staff at Westholme may encounter students that could be a) prior to the start of an eating disorder, b) in the early stages of an eating disorder or c) perhaps more established eating disorders when students enter into the sixth form.

It is vital that staff be vigilant and look out for any possible warning signs and report those concerns on to the HoY, Deputy Head (Pastoral) and/or the School Nurse.

9. Advice for Staff and Teachers if a problem is suspected.

- DO make it known to the student that you are available to listen;
- DO remain calm and non-judgemental at all times;
- DO encourage the student to be open with you and reassure them that they can get the help they need if they are willing to talk;
- DO endeavour to enable the student to feel in control by asking what help they feel they need etc.;

- DO report the matter to the HoY, Deputy Head (Pastoral) and/or School Nurse as soon as you become aware of the problem, and inform the student that you are doing this;
- DO NOT dismiss a student's reasons for distress as invalid or trivial;
- DO NOT promise confidentiality.

10. Procedure for Care of a Student with a suspected eating disorder:

A student who has a suspected eating disorder will be asked to see the School Nurse about receiving support. The nurse will ascertain the extent of the problem, discuss any underlying issues and explain their options (namely, to gain a referral through their GP or for the school nurse to make a referral through other external agencies e.g. CAMHS/ELCAS. The School is happy to allow a student with an eating disorder to continue with their studies and life in school as long as the student complies with the following expectations:

- That he/she is willing to address the underlying issues that are causing the problems and therefore will accept a referral for support;
- That he/she cooperates with treatment and care plans and maintains the agreed BMI
- That he/she talks to the appropriate staff member (rather than other students) if he/she is in emotional distress;

Physical exercise restriction may be imposed until target weight is gained (in anorexia). This would always be decided in conjunction with the specialist health care agencies and the PE Department.

NB In some situations, the School may not be able to implement the necessary Welfare Plans and Nursing Care Plans. Some students will be better managed at home or in a clinic situation.

The Circle of Care

The main people who will be involved in the student's pastoral care whilst they are at Westholme are:

- School Nurse
- Form/Class Tutor
- The Head of Year
- Deputy Headteachers: Infants/Juniors
- Deputy Headteacher: Pastoral
- Nursery Manager/ EYFS Leader
- Headteacher: Nursery/Infants/Juniors
- School Counsellor
- Principal

These people form the main "Circle of Care" which surrounds every student during their time at Westholme. Apart from the Principal there is no one person who has overall responsibility for any individual student and it follows therefore that information generally needs to be shared around this circle which is made up of a team of individuals who all play their part in providing the student with the care and

support that they need. It will be explained to the student that these people will know about their situation but that the information will not go outside this circle of care if the student does not want it to. The student can identify the individual within the circle whom he/she feels most comfortable talking to if appropriate.

The various individuals within the Circle of Care will also:

- Inform the student's parent/s and the student will always be encouraged to keep their parents informed. If however, a student has strong feelings about this and/or there would be concerns about a parent's reaction leading to a possible safeguarding issue, a decision will be made depending on the situation, age and competency of the student.
- Be aware of when it is essential for other professional bodies to be informed, such as social services or the Child Protection Officer (see Safeguarding Policy);
- Monitor the help, support and progress of the students in their care and maintain communication with them;
- Maintain communication with the parents;
- Liaise with each other to decide if any other members of staff who have contact with the student should be made aware of the eating disorder and underlying concerns;
- Observe other students that may be affected and ensure that adequate support is given
- Remind friends that they are not responsible for their friend's eating disorder or recovery.
- Be mindful of other students' reactions to the eating disorder.

Strategy to prevent the spread of eating disorders within the school

- Close monitoring of students who have been in contact with another student with an eating disorder.
- Informal discussion groups with pupils in their form class/ close friends, led by a member of the Pastoral team and/or School Nurse.
- Information about Eating Disorders is delivered as part of Westholme's PSHE programme, ensuring raised awareness and understanding within the student body.
- Encouraging an open attitude to eating disorders, where students and staff feel comfortable to discuss and raise concerns where necessary.
- Training opportunities are offered to relevant staff that have a particular interest in the subject. This will be refreshed at regular intervals to keep knowledge up to date.
- Eating disorders will periodically feature in INSET for staff.

Parents will be encouraged to endorse the school's approach to eating disorders and pastoral care and work in partnership with the school. Parents are welcome to discuss their concerns or queries with the school nurse or pastoral staff at any time.

Useful Contact
B-eat
fyp@b-eat.co.uk
help@b-eat.co.uk – will support everyone involved
Youth helpline – 0845 834 7650

Appendix B: Self-Injury Policy

The Policy: We are committed to creating a caring, friendly environment where every member of the school can thrive.

Aims: The central aims of this policy are:

- to promote safety, welfare and good physical and mental health;
- to ensure, as far as is possible, that every student in this School is able to benefit from and make his/her full contribution to the life of the School, consistent always with the needs of the school community;
- to ensure that all staff know how to manage a situation involving self injury.
- To keep parents informed as appropriate

1. What is Self-Injury?

- Self-injury is a coping mechanism. An individual harms their physical self to deal with emotional pain, or to break feelings of numbness by arousing sensation.
- Self-injury is any deliberate, non-suicidal behaviour that inflicts physical harm on the body and is aimed at relieving emotional distress. It can become a natural response to the stresses of day-to-day life and can escalate in frequency and severity.
- Self-injury can include, but is not limited to, scratching, cutting, burning, banging and bruising, non-suicidal overdosing and even deliberate bone-breaking.
- People who self-injure usually make a great effort to hide their injuries and scars, and are often uncomfortable about discussing their emotional inner or physical outer pain. It can be difficult for young people to seek help perhaps due to the stigma associated with seeking help for mental health issues.

2. **Self-harm** is a wider definition, that includes eating disorders, self-injury and drug /alcohol misuse.

3. What self-injury is not

It is *not* attention seeking. Like any behaviour, self-injury may be used to attract attention, but this is not usually the focus of chronic, repetitive self-injury. If self-injury is being used in order to gain attention, one must look to find the reasons as to why someone is in such dire need of attention.

4. Risk factors associated with self-injury

Self-injury is a coping mechanism and it is important to recognise and respond to the underlying reasons.

Risk factors include, but are not limited to:

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

It is important to recognise that none of these risk factors may appear to be present. Sometimes it is the outwardly happy, high-achieving person with a stable background who is suffering internally and hurting themselves in order to cope.

5. Warning signs that may be associated with self-injury

As noted above, there may be no warning signs, but some of the things below might indicate that a pupil is suffering internally which may lead to self-injury:

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

6. Suicide

Self-injury is an attempt to cope and manage, it is not suicidal behaviour. However, it is recognised that the emotional distress that leads to self-injury can also lead to suicidal thoughts and actions. It must also be recognised that self injury can also lead to unintentional consequences due to over injury or complications. It is therefore of the utmost importance that all incidents of self-injury are taken seriously and that the underlying issues and emotional distress are thoroughly investigated and necessary emotional support given in order to minimise any greater risk. Any mention of suicidal intent should always be taken seriously and acted upon as a matter of urgency (see para 9 below).

7. Physical signs that self-injury may be occurring

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

8. Advice for Staff and Teachers when self-injury is suspected.

- DO make it known to the student that you are available to listen;
- DO remain calm and non-judgemental at all times;
- DO encourage the student to be open with you and reassure them that they can get the help they need if they are willing to talk;
- DO endeavour to enable the student to feel in control by asking what they would like to happen and what help they feel they need etc.
- DO report the matter to the HoY, Deputy Head (Pastoral) and/or School Nurse as soon as you become aware of the problem, and inform the student that you are doing this.
- DO NOT dismiss a student's reasons for distress as invalid or trivial;

- DO NOT ask a student to show you their scars or describe their self-injury;
- DO NOT ask a student to stop self-injuring - you may be removing the only coping mechanism they have;
- DO NOT promise confidentiality.

9. In a situation where someone confides in you that they have self injured there and then:

- Remain calm
- Ascertain the extent of the injury
- Contact the nurse immediately for **all** suspected overdoses and severe bleeding (1112 / emergency mobile 07788 645713). Alternatively ring 999 for an ambulance and then let reception and the nurse know;
- For less severe injuries explain to the student that they must attend the nurse to have their cuts assessed and dressed properly. Contact the nurse to let her know you are on your way and then escort the student up there.
- Report any mention of suicidal feelings or behaviour as a matter of urgency to the nurse;

10. Procedure

A student who is self injuring will be asked to talk to the nurse about receiving support. The nurse will discuss the underlying reasons for the self injury and explain their options (namely, to gain a referral through their GP or for the school nurse to make a referral through other external agencies e.g. CAMHS/ELCAS. The School is happy to allow a student who is self injuring to continue with their studies and life in school as long as the student complies with the following expectations:

- That he/she is willing to address the underlying issues that are causing the student to self injure and therefore will accept a referral for support;
- That he/she is open and honest with the nurse about the extent of the injuries and sees the school nurse as appropriate for injuries to be assessed, treated and dressed;
- That he/she does not display open wounds/injuries;
- That he/she talks to the appropriate staff member (rather than other students) if he/she is in emotional distress;

11. The Circle of Care

The main people who will be involved in the student's pastoral care whilst they are at Westholme are:

- School Nurse
- Form/Class Tutor
- The Head of Year
- Deputy Headteachers: Infants/Juniors
- Deputy Headteacher: Pastoral
- Nursery Manager/ EYFS Leader
- Headteacher: Nursery/Infants/Juniors
- School Counsellor
- Principal

These people form the main "Circle of Care" which surrounds every student during their time at Westholme. Apart from the Principal, there is no one person who has overall responsibility for any individual student and it follows therefore that information generally needs to be shared around this circle which is made up of a team of individuals who all play their part in providing the student with the care and support that they need. It will be explained to the student that these people will know about their situation but that the information will not go outside this circle of care if the student does not want it to. The student can identify the individual within the circle whom he/she feels most comfortable talking to if appropriate.

The various individuals within the Circle of Care will also:

- Maintain up-to-date records of students experiencing self-injury, incidents of self-injury and all other concerns surrounding the issue;
- Inform the student's parents if appropriate. The student will always be encouraged to keep their parents informed. If however, a student has strong feelings about this a decision will be made depending on the age and competency of the student. Parents will generally be informed unless:
  (i) a student is deemed to be competent to make the decision otherwise, or
  (ii) it is deemed to be in the best interests of the student for the parents not to know
- Be aware of when it is essential for other professional bodies to be informed, such as social services or the Child Protection Officer (see Safeguarding Policy);
- Monitor the help, support and progress of the students in their care and maintain communication with them;
- Maintain communication with the parents;
- Liaise with each other to decide if any other members of staff who have contact with the student should be made aware of the self-injury and underlying concerns;
- Observe other students that may be affected and ensure that adequate support is given:

How to talk to parents about self-harm

Consider the best set up - It can be understandably difficult for a parent to hear about their child's self-harming so think about the best way to facilitate this conversation. Things you'll want to consider include:

- face to face or on the phone?
- should the student be present?
- how can the room set up be as comfortable as possible?

Plan the conversation - Have a simple plan of the points you want to make to ensure you cover them all during the conversation as things don't always go according to plan. A little preparation will ensure parents go away with the information they need from you.

Take a practical rather than an emotional approach – Conversations of this type have the capacity to become very emotional and unproductive in terms of outcomes for the student. Try to talk about self-harm in the most matter-of-fact way possible with no judgement or assumptions. Focus on practical steps forward rather than dwelling on why the student is turning to self-harming behaviours.

Explain self-harm in simple terms - Self-harm can feel like a very alien concept to people who've not experienced it, which can make it seem utterly terrifying. Explain to parents that it's a coping mechanism used by a lot of young people in order to manage difficult thoughts, feelings and emotions.

Reassure parents about recovery - Parents need to understand that their child has a very good chance of overcoming their self-harm. The key lies in a combination of helping their son or daughter work through their underlying emotions and developing healthy coping mechanisms to replace their current self-harm responses. Consider with parents what support the school can provide and where external help is needed and explore how this can be accessed. Remind parents that recovery is a journey and that their child needs time and support in order to stop.

Give parents practical ideas for helping - Before talking to their parents, have a discussion with the student to explore practical ways in which their parents could support them. This will often include simple things like spending quality time together, decreasing the student's responsibilities within the home temporarily or regularly supporting them by listening non-judgementally.

Signpost further information help - Signpost websites like youngminds.org.uk and selfharm.co.uk where parents can find further information, support and ideas in their own time.

Encourage them to seek support for themselves - Parents and siblings of young people who are self-harming can find the situation very difficult and are vulnerable to developing their own unhealthy coping responses. Highlight the need for parents and siblings to seek support if needed.

Keep an open door - Encourage parents to come back to you with questions – the initial conversation can be overwhelming and their questions are likely to arise afterwards.

Parents will be encouraged to:

- Endorse the school's approach to self-injury and pastoral care;
- Work in partnership with the school;

Further information can be found:-

http://www.lifesigns.org.uk/

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

Prevalence of Mental Health and Emotional Wellbeing Issues[1]

[1] Source: Young Minds

- 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 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.
- 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 school-aged children. The links will take you through to the most relevant page of the listed website. Some pages are aimed primarily at parents but they are listed here because we think they are useful for school staff too.

Support on all of these issues can be accessed via Young Minds (www.youngminds.org.uk), Mind (www.mind.org.uk) and (for e-learning opportunities) Minded (www.minded.org.uk).

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: www.selfharm.co.uk
National Self-Harm Network: www.nshn.co.uk

Books
Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School 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

Ups and downs are a normal part of life for all of us, but for someone who is suffering from depression these ups and downs 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
Depression Alliance: 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: 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 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

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. Some young people never act on these feelings though they may openly discuss and explore them, while other young people die suddenly from suicide apparently out of the blue.

Online support
Prevention of young suicide UK – PAPYRUS: www.papyrus-uk.org

On the edge: ChildLine spotlight report on suicide: www.nspcc.org.uk/preventing-abuse/research-and-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 Schools: 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 preschool 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: www.b-eat.co.uk/about-eating-disorders

Eating Difficulties in Younger Children and when to worry: 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 Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

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

Appendix D: Guidance and advice documents

Mental health and behaviour in schools - departmental advice for school staff. Department for Education (2014)

Counselling in schools: a blueprint for the future - departmental advice for school staff and counsellors. Department for Education (2015)

Teacher Guidance: Preparing to teach about mental health and emotional wellbeing (2015). PSHE Association. Funded by the Department for Education (2015)

Keeping children safe in education - statutory guidance for schools and colleges. Department for Education (2014)

Supporting pupils at school with medical conditions - statutory guidance for governing bodies of maintained schools and proprietors of academies in England. Department for Education (2014)

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 - 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

What works in promoting social and emotional wellbeing and responding to mental health problems in schools? Advice for schools and framework document written by Professor Katherine Weare. National Children's Bureau (2015)

Appendix E: Data Sources

Children and young people's mental health and wellbeing profiling tool collates and analyses a wide range of publically available data on risk, prevalence and detail (including cost data) on those services that support children with, or vulnerable to, mental illness. It enables benchmarking of data between areas

ChiMat school health hub provides access to resources relating to the commissioning and delivery of health services for school children and young people and its associated good practice, including the new service offer for school nursing

Health behaviour of school age children is an international cross-sectional study that takes place in 43 countries and is concerned with the determinants of young people's health and wellbeing.

Appendix F: 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 relevant school policies on pastoral care and child protection and discussed with relevant colleagues as appropriate.

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. Ask occasional open questions if you need to in order to encourage them to keep exploring their feelings and opening up to you. 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, you should interject occasionally, perhaps with questions to the student to explore certain topics they've touched on more deeply, or to show that you understand and are supportive. Don't feel an urge to over-analyse the situation or try to offer answers. This all comes later. 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 – don't 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've never experienced these difficulties first hand. You may find yourself wondering why on earth someone would do these things to themselves, but don't explore those feelings with the sufferer. Instead listen hard to what

they're saying and encourage them to talk and you'll slowly start to understand what steps they might be ready to take in order to start making some changes.

Don't 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's important to try to maintain a natural level of eye contact (even if you have to think very hard about doing so and it doesn't feel natural to you at all). If you make too much eye contact, the student may interpret this as you 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 don't make eye contact at all then a student may interpret this as you being disgusted by them – to the extent that you can't bring yourself to look at them. Making an effort to maintain natural eye contact will convey a very 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 and the schools' policies on such issues. 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're 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.

Don't 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, that doesn't mean they'll readily accept help. The illness may

ensure they resist any form of help for as long as they possibly can. Don't 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."*

Above all else, a student wants to know they can trust you. That means if they want you to keep their issues confidential and you can't then you must be honest. Explain that, whilst you can't keep it a secret, you can ensure that it is handled within the school'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 don't have all the answers or aren't 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 G: What makes a good CAMHS referral?[2]

If the referral is urgent it should be initiated by phone so that CAMHS can advise of best next steps

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

You must also be able to provide evidence to CAMHS about what intervention and support has been offered to the pupil by the school 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 CMHS 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 are 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
- 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 school
- Who else has been or is professionally involved and in what capacity?
- Has there been any previous contact with our department?
- Has there been any previous contact with social services?
- Details of any known protective factors

[2] Adapted from Surrey and Border NHS Trust

- 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
- Are there any symptoms of ADHD/ASD and if so have you talked to the Educational psychologist?

The screening tool on the following page will help to guide whether or not a CAMHS referral is appropriate.

***** If the young person does not consent to you making a referral,**
you can speak to the appropriate CAMHS service anonymously for advice ***

INVOLVEMENT WITH CAMHS	
	Current CAMHS involvement – **END OF SCREEN***
	Previous history of CAMHS involvement
	Previous history of medication for mental health issues
	Any current medication for mental health issues
	Developmental issues e.g. ADHD, ASD, LD

DURATION OF DIFFICULTIES	
	1-2 weeks
	Less than a month
	1-3 months
	More than 3 months
	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 overactivity & impulsivity above what would be expected; in all settings)
	2	Obsessive thoughts and/or compulsive behaviours (e.g. hand-washing, 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 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 school		History of social services involvement
	Excluded from school (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