# St John Fisher RC Primary School

# Positive Mental Health Policy

LOVE LEARN ACHIEVE

**St John Fisher Mission Statement**

The school, in partnership with parents, carers and with the parish of St John Fisher, offers to each one of its children a Catholic education centred on Christ, which enables them to grow in God's love, learning to be the best they can be in accordance with Christian values.

| | | |
|---|---|---|
| **Approved by:** | Mrs. K. Blom | **Date:** January 2022 |
| **Last reviewed on:** | January 2022 | |
| **Next review due by:** | January 2024 | |

## 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 Organization)*

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

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 pupils affected both directly, and indirectly by mental ill health.

## 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 medical policy in cases where a pupil's mental health overlaps with or is linked to a medical issue and the SEND policy where a pupil has an identified special educational need.

## The Policy Aims to:

- Promote positive mental health in all staff and pupils
- 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 pupils with mental health issues
- Provide support to pupils suffering mental ill health and their peers and parents/carers

## Lead Members of Staff

Whilst all staff have a responsibility to promote the mental health of pupils. Staff with a specific, relevant remit include:

- Janine Kenna - Designated safeguarding lead (DSL)
- Claire Higgins & Claire Ellerker – Deputy designated safeguarding leads
- Claire Higgins - Mental health lead
- Claire Higgins - Lead mental health first aider
- Claire Higgins - Inclusion Manager
- Anne Groombridge – Mental health first aider

- Sarah Nash - Mental Health team member

Any member of staff who is concerned about the mental health or wellbeing of a pupil should speak to the mental health lead in the first instance. If there is a fear that the pupil is in danger of immediate harm then the normal child protection procedures should be followed with an immediate referral to the designated safeguarding lead or deputy DSLs. If the pupil presents a medical emergency then the normal procedures for medical emergencies should be followed, including alerting the first aid staff and contacting the emergency services if necessary.

Where a referral to CAMHS is appropriate, this will be led and managed by Claire Higgins, mental health lead.

## Mental Health First Aid

A qualified youth mental health first aider is someone who has undertaken a 12-hour training module approved by MHFA England and holds a valid certificate of competence. Mental Health First Aid is used in over 16 countries worldwide and was introduced into England by the National Institute for Mental Health England (NIMHE) in 2007. MHFA does not prepare people to become therapists. It does, however, enable people to recognise the symptoms of mental ill health, how to provide initial help (first aid) and how to guide a person towards appropriate professional help. The certificate must be issued by an approved organisation and must be renewed every three years.
Currently our trained Mental Health First Aiders are **Miss Claire Higgins** and **Mrs Anne Groombridge.**
Qualified youth mental health first aiders are responsible for:

- Responding promptly to calls for assistance
- Providing first aid support within their level of competence
- Summoning medical help as necessary
- Recording details of support given

All staff have a duty of care towards the pupils and should respond accordingly when first aid situations arise. All staff are reminded regularly about the specific medical and emotional needs of pupils within the school community.

## Warning Signs

School staff may become aware of warning signs which indicate a pupil is experiencing mental health or emotional wellbeing difficulties. These warning signs should **always** be taken seriously and staff observing any of these warning signs should communicate their concerns with Claire Higgins, our mental health and emotional wellbeing lead.

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
- 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

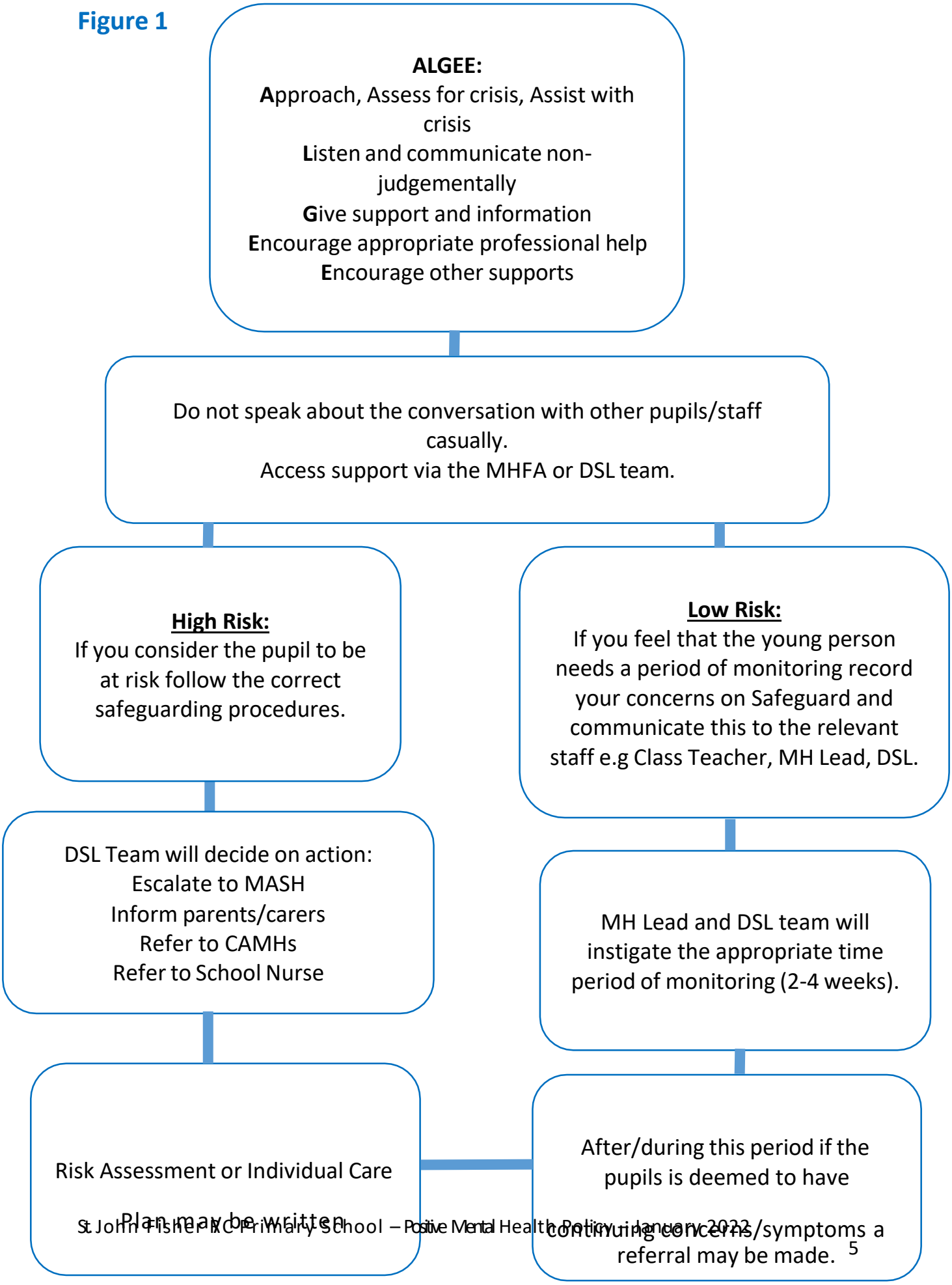
## Managing disclosures

The most important role school staff play is to familiarise themselves with the risk factors and warning signs outlined in Appendix A. A pupil 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 pupil 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.

Figure 1 outlines the procedures that are followed if staff have a concern about a pupil, if another pupil raises concerns about one of their friends or, if an individual pupil speaks to a member of staff specifically about how they are feeling.

**Figure 1**


ALGEE:
Approach, Assess for crisis, Assist with crisis
Listen and communicate non-judgementally
Give support and information
Encourage appropriate professional help
Encourage other supports
Do not speak about the conversation with other pupils/staff casually.
Access support via the MHFA or DSL team.
High Risk:
If you consider the pupil to be at risk follow the correct safeguarding procedures.
Low Risk:
If you feel that the young person needs a period of monitoring record your concerns on Safeguard and communicate this to the relevant staff e.g Class Teacher, MH Lead, DSL.
DSL Team will decide on action:
Escalate to MASH
Inform parents/carers
Refer to CAMHs
Refer to School Nurse
MH Lead and DSL team will instigate the appropriate time period of monitoring (2-4 weeks).
Risk Assessment or Individual Care Plan may be written
After/during this period if the pupils is deemed to have continuing concerns/symptoms a referral may be made.

## Individual Care Plans

It may be helpful to draw up an individual care plan for pupils causing continued significant concern or who receive a diagnosis pertaining to their mental health. This should be drawn up involving 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

## Confidentiality

Pupils may choose to confide in a member of school staff if they are concerned about their own welfare or that of a peer. Pupils should be made aware that it is not possible for staff to offer complete confidentiality. If a member of staff considers a pupil is at serious risk of causing themselves harm then confidentiality cannot be kept. If we deem it is necessary for us to pass our concerns about a pupil on then we should discuss with the pupil:

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

Ideally we would receive the pupils consent, though there are certain situations when information must always be shared with another member of staff and / or a parent.
Disclosures will be recorded following the schools safeguarding procedures, these are automatically shared with each of the DSL team. Staff may also seek advice from the Mental Health First Aiders.

Parents must always be informed if there is a concern about their child's presentation which could put them at harm either physically, or emotionally. If a child gives us reason to believe that there may be underlying child protection issues, parents may not be informed, if it is believed the child could be put further at risk but the designated safeguarding team, [Janine Kenna, Claire Ellerker, Claire Higgins] must be informed immediately.

## Signposting

We will ensure that staff, pupils and parents are aware of sources of support within school and in the local community. What support is available within our school and local community, who it is aimed at and how to access it is outlined on the Local Offer www.merton.gov.uk/localoffer

We will regularly highlight sources of support to pupils within relevant parts of the curriculum. Whenever we highlight sources of support, we will increase the chance of pupil/parent help-seeking by ensuring pupils/parents understand:

- What help is available
- Who it is aimed at
- How to access it

- Why to access it
- What is likely to happen next

## Teaching about Mental Health

The skills, knowledge and understanding needed by our pupils to keep themselves and others physically and mentally healthy and safe are included as part of our developmental PSHE curriculum.

The specific content of lessons will be determined by the age and specific needs of the cohort we're teaching but there will always be an emphasis on enabling pupils 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.

## 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 school, at their home or somewhere neutral?
- Who should be present? Consider parents, the pupil, 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 difficulties and many may respond with anger, fear or upset during the first conversation. We should be accepting of this (within reason) and give the parent time to reflect.

We should always highlight further sources of information where possible as they will often find it hard to take much in whilst coming to terms with the news that's being shared. Sharing sources of further support aimed specifically at parents can also be helpful too e.g. parent helplines and forums.

We 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 agreed next step and always keep a brief record of the meeting on the child'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
- 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 our regular information evenings
- Keep parents informed about the mental health topics their children are learning about in PSHE and share ideas for extending and exploring this learning at home

## Supporting Peers

When a pupil 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 pupil 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

## Training

As a minimum, all staff will receive regular training about recognising and responding to mental health difficulties as part of their regular child protection training in order to enable them to keep pupils safe.

We will introduce staff to the MindEd learning portal which provides free online training suitable for staff wishing to know more about a specific issue.

Training opportunities for staff who 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 with one or more pupils.

## Policy Review

This policy will be reviewed every 3 years as a minimum. It is next due for review in January 2025.

Additionally, this policy will be reviewed and updated as appropriate on an ad hoc basis. If you have a question about this policy, this should be addressed to Claire Higgins our mental health lead via phone 0208 540 2637 or email inclusion@st-johnfisher.merton.sch.uk

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

## Prevalence of Mental Health and Emotional Wellbeing Issues[1]

- 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

[1] Source: Young Minds

### 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 B: 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 C: 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 D: 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/carers 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?

[2] Adapted from Surrey and Border NHS Trust

- 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?
- 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.

For further support and advice, our primary contacts are:

**Professional's advisory line** 0208 288 8061 ssg-tr.spamertoncamhs@nhs.net

| 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 |

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