Policy No: 42

Children's Mental Health and Wellbeing policy

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

Aim

At Alderley Edge Community Primary School we firmly believe that it is important to ensure that the mental health and wellbeing needs of our whole school community are recognised and met. We understand that mental health is a crucial factor which can affect learning and achievement. The DFE recognises that "in order to help children succeed; schools have a role to play in supporting them to be resilient and mentally healthy" We aim to enable the children to acquire and develop the knowledge and understanding skills, capabilities and attributes, which they need for mental, emotional, social and physical wellbeing now and in the future.

This policy should be read in conjunction with the following policies: SEND, PSHE, Healthy School, Behaviour, Safeguarding, PE

School Mission Statement

An Inclusive Community Inspiring Lifelong Learners

School Aims

- We provide a secure, safe and nurturing environment where children flourish.
- We provide all children with an exciting range of experiences and opportunities to recognise their own qualities regardless of need, ensuring that there is equality of opportunity.
- We provide a broad and balanced curriculum that inspires children to maximise their potential.
- We promote mutual respect, understanding and tolerance so enabling children to embrace diversity.
- We foster an ethos of teamwork to ensure continuous improvement and the highest standards of achievement and behaviour.
- We enable children to develop self-confidence, resilience and independence taking ownership of their learning and enabling them to meet future challenges.

We promote professional relationships and mutual respect between all members of the school community thus modelling positive behaviours and attitudes for our children.

Objectives

At our school we will:

- ✓ Help children to understand and explain their emotions by providing them with appropriate vocabulary an opportunities to express themselves
- ✓ Help children to feel comfortable in sharing concerns or worries by modelling how adults also have worries and how they deal with them and then providing a forum for them to share if necessary
- ✓ Help children to socially form and maintain relationships by using learning partners
- ✓ Promote self-esteem and ensure children know they are valued for who they are through house points, tokens, child of the week etc.
- ✓ Encourage children to be confident and take risks by providing opportunities to do so
- ✓ Help children to develop emotional resilience and to manage challenges through P4C lessons

To meet these objectives we will ensure the following:

- ✓ ACHIEVING - Children will be supported and guided in their learning and developing of skills of confidence and self-esteem at home, at school and in the community ACTIVE- Have opportunities to play, creatively, cooperatively and in sports, which will contribute to healthy growth and development
- ✓ HEALTHY- Access to appropriate health care agencies, support in learning to make healthy choices and opportunities to create healthy meals through the DT curriculum. Children are encourages to eat healthy snacks and fruit is provided for KS1
- ✓ INCLUDED- To feel part of our school family and to be included and valued regardless of race, gender or disability, encouraging a sense of belonging
- ✓ NURTURED- Accessing a nurturing environment where everyone is treated with unconditional positive regard and mutual respect
- ✓ RESPECTED- Having opportunities to be heard, on an individual basis and via the school council where they can be involved in decision making
- ✓ RESPONSIBLE- Having opportunities to develop their own skill set through the promotion of the 5R's, having roles in the school and community, taking responsibility for themselves and others
- ✓ SAFE- Being protected from abuse, neglect or harm at home, school or in the community

We will pursue our aims through

- ✓ Universal whole school approaches, assemblies and class discussions/P4C
- ✓ Individualised support for specific difficulties – bereavement etc.
- ✓ Targeted support (with advice from external agencies)
- ✓ Differentiated curriculum
- ✓ Life skills programme
- ✓ Positive behaviour management

Through promoting positive mental health and well being we aim to address the Core Drivers which are the drivers for our curriculum that will enable us to shape learning around the needs and wants of our school and its community.

MR 2022

Core Drivers - ALPS

- Academic Excellence – our curriculum strives for excellence. We know that only our best is good enough and we work hard to maximise progress in learning for all children regardless of their starting points— academic, social and emotional, so that they can be the best they can be and make a positive difference to themselves and others in their community.

- Life Long Learning – our curriculum allows children to develop learning skills: readiness to learn, resilience, reflectiveness and resourcefulness to be the best learners they can be so that they are prepared for the challenges we will face.

- Possibilities and Risks – our curriculum allows children to explore what is possible to be achieved when they identify goals based on consideration of people as unique individuals, with their own passions and ideas. We challenge children to extend their boundaries and develop independence.

- Social Intelligence – our children learn how to appreciate and respect differences and celebrate the richness of the diversity in our community and beyond, recognising all the benefits that this brings.

Physical environment

Our school grounds aim to offer a range of places where children can feel happy. Our outside spaces are designed to cater for children who wish to read quietly, role play, act and sing in a stage area, separate ball games and climbing areas and benches to sit. In the building itself, there are small areas/zones where children can take time out or talk to an adult away from the classroom.

We have a recent addition of a chillout zone where children can access some quiet space with supporting resources if necessary.

Children are encouraged to look after our school, keep it tidy and recycle which reinforces a citizenship message within school and among the local community.

Curriculum

The skills, knowledge and understanding needed by our students to keep themselves mentally healthy and safe are included as part of our PSHE and SRE schemes of work. These are delivered on a termly basis and at an age appropriate level

- Families and care
- Keeping clean
- Growing and changing
- Drugs education

We will offer support through targeted approaches for individuals or groups which may include

- Use of specific curriculum resources e.g. SEAL

- Worry boxes
- Mental health first aid kits
- Managing emotions using the 5 point scale
- Worry Monsters, Anxiety gremlins and CBT
- Mindfulness techniques
- Access to a mental health first aider (via in-school referral process)

Working with parents

Parents and carers are valued and welcomed within school and play a crucial part in supporting our mental health and well-being work. Parent Forum and regular parent surveys allow a voice into issues within school and this enables us to work together for the good of the children. Parents are encouraged to share information regarding any concerns they have and this will be addressed during meetings with the relevant adults in school. Appointments can be made to see the appropriate adults, by contacting the school office. This is particularly important where a child may present symptoms that are not observable within school, but which, nevertheless impact on the child and the family.

Identification and warning signs

There are sometimes obvious signs that a child is experiencing mental health or emotional wellbeing issues. Below is a list of some of these signs, which must be communicated to the relevant member of staff depending on the nature of the concern (Designated Safeguarding Lead or SENCO)

- Changes in eating/sleeping habits
- Becoming socially withdrawn
- Changes in activity or mood
- Talking/joking about self harm
- Expressing feelings of failure, uselessness or loss of hope
- Repeated physical pain, nausea
- Late or absent
- Approaches to learning
- Negative behaviours
- Change in cleanliness, clothes etc.

Pathways

Early identification is the key and as soon as a concern is raised the following approach must be used

- ✓ Speak to the designated safeguarding lead and/or SENCO
- ✓ If relevant, complete MyConcern
- ✓ Meet with parents and keep a record of meeting
- ✓ If referring to mental health first aider use school referral form
- ✓ Encourage parents to refer to GP/CAMHS if appropriate
- ✓ SDQ analysis
- ✓ Refer to other agencies if appropriate (CHECS/ CAMHS/VISYON)

Training

We recognise that we are not the experts when dealing with mental health issues, but we are the front line and often the first people to learn of a difficulty. With this in mind, training has been undertaken by staff using the Mind Ed online training, Tools for Schools training on resilience and the emotional classroom, whole school training on emotionally healthy schools.

As a minimum, all staff will have training on child protection and safeguarding in order to enable them to keep children safe.

Policy date: March 2022

Reviewed: every 2 years

Next review date: March 2024

APPENDIX

RISK FACTORS AND PROTECTIVE FACTORS TABLE

	RISK FACTORS	PROTECTIVE FACTORS
IN THE CHILD	• Genetic influences • Low IQ and learning disabilities • Specific development delay or neuro-diversity • Communication difficulties • Difficult temperament • Physical illness • Academic failure • Low self-esteem	• Secure attachment experience • Outgoing temperament as an infant • Good communication skills, sociability • Being a planner and having a belief in control • Humour • Problem solving skills and a positive attitude • Experiences of success and achievement • Faith or spirituality • Capacity to reflect
IN THE FAMILY	• Overt parental conflict including domestic violence • Family breakdown (including where children are taken into care or adopted) • Inconsistent or unclear discipline • Hostile and rejecting relationships • Failure to adapt to a child's changing needs • Physical, sexual, neglect or emotional abuse • Parental psychiatric illness • Parental criminality, alcoholism or personality disorder • Death and loss – including loss of friendship	• At least one good parent-child relationship (or one supportive adult) • Affection • Clear, consistent discipline • Support for education • Supportive long term relationship or the absence of severe discord
IN THE SCHOOL	• Bullying • Discrimination • Breakdown in or lack of positive friendships • Deviant peer influences • Peer pressure • Poor child to teacher relationships	• Clear policies on behaviour and bullying • 'Open door' policy for children to raise problems • A whole-school approach to promoting good mental health • Positive classroom management • A sense of belonging • Positive peer influences
IN THE COMMUNITY	• Socio-economic disadvantage • Homelessness • Disaster, accidents, war or other overwhelming events • Discrimination • Other significant life event	• Wider supportive network • Good housing • High standard of living • High morale school with positive policies for behaviour, attitudes and anti-bullying • Opportunities for valued social roles • Range of sport/leisure activities

ASSESSMENT, INTERVENTION AND SUPPORT TABLE

NEED	EVIDENCE BASED INTERVENTIONS	MONITORING
HIGH	CAMHS External agency EHCP	Individual care plan https://www.gov.uk/government/publications/supporting-pupils-at-school-withmedical-conditions--3; SDQ Myconcern
SOME NEED	School nurture group School nurse EP Life skills	
LOW NEED	School nurse	

Anxiety

Anxiety problems can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships. Children and young people may feel anxious for a number of reasons – for example because of worries about things that are happening at home or school, or because of a traumatic event. Symptoms of anxiety include feeling fearful or panicky, breathless, tense, fidgety, sick, irritable, tearful or having difficulty sleeping. If they become persistent or exaggerated, then specialist help and support will be required. Clinical professionals make reference to a number of diagnostic categories:

• generalised anxiety disorder (GAD) – a long-term condition which causes people to feel anxious about a wide range of situations and issues, rather than one specific event;

• panic disorder – a condition in which people have recurring and regular panic attacks, often for no obvious reason;

• obsessive-compulsive disorder (OCD) – a mental health condition where a person has obsessive thoughts (unwanted, unpleasant thoughts, images or urges that repeatedly enter their mind, causing them anxiety) and compulsions (repetitive behaviour or mental acts that they feel they must carry out to try to prevent an obsession coming true);

• specific phobias – the excessive fear of an object or a situation, to the extent that it causes an anxious response, such as panic attack (e.g. school phobia);

• separation anxiety disorder (SAD) – worry about being away from home or about being far away from parents/carers, at a level that is much more than normal for the child's age;

• social phobia – intense fear of social or performance situations;

• agoraphobia – a fear of being in situations where escape might be difficult, or help wouldn't be available if things go wrong.

While the majority of referrals to specialist services are made for difficulties and behaviours which are more immediately apparent and more disruptive (externalising difficulties), there are increasing levels of concern about the problems facing more withdrawn and anxious children, given the likelihood of poor outcomes in later life.

The strongest evidence supports prevention/early intervention approaches that include a focus on:

• regular targeted work with small groups of children exhibiting early signs of anxiety, to develop problem-solving and other skills associated with a cognitive behavioural approach; and

• additional work with parents/carers to help them support their children and reinforce small group work. Such work is likely to be especially effective when the parents/carers are themselves anxious and the children are younger. Where particular problems have been identified the strongest evidence supports:

• therapeutic approaches focusing on cognition and behaviour for children with specific phobias, generalised anxiety and obsessive compulsive disorder (in some cases doctors may consider using medicines alongside therapy if therapy alone is not working but this does not include anxiety related to traumatic experiences). This should include parents/carerswhere the child is under 11 or where there is high parental anxiety;

• specific individual child-focused programmes which show recovery in 50-60% of C&YP include Coping Cat and FRIENDS. On the other hand, group-based interventions are likely to be almost as effective. The programmes have been shown to be effective when delivered by different professionals, including teachers; • education support, training in social skills and some behaviour-focused interventions are highly effective for social phobia (e.g. Social Effectiveness Therapy);

• for obsessive compulsive disorders, professionally administered Exposure and Response Prevention (ERP) and cognition-focused interventions are most effective; and

• trauma-related problems require special adaptations of therapy (e.g.Trauma focused CBT) including sexual trauma. Trauma and grief component therapy is effective for trauma and can be delivered in school (e.g. Cognitive Behavioral Intervention for Trauma in Schools). There is also evidence to support:

• for anxiety, the use of play-based approaches to develop more positive child/parent relationships or to enable the child to express themselves; and

• psychoanalytic family psychotherapy (focusing on the 'internal' world of family members and their unconscious processes) has reported some positive outcomes especially when trauma is involved.

Conduct disorders (E.g. defiance, aggression, anti-social behaviour, stealing and fire-setting)

Overt behaviour problems often pose the greatest concern for practitioners and parents/carers, because of the level of disruption that can be created in the home, school and community. These problems may manifest themselves as verbal or physical aggression, defiance or anti-social behaviour.

In the clinical field, depending on the severity and intensity of the behaviours they may be categorised as Oppositional Defiant Disorder (a pattern of behavioural problems characterised chiefly by tantrums and defiance which are largely confined to family, school and peer group) or Conduct Disorder (a persistent pattern of anti-social behaviour which extends into the community and involves serious violation of rules).

Around 4-14% of the child and adolescent population may experience behaviour problems. Many children with attention deficit hyperactivity disorder (ADHD) will also exhibit behaviour problems. Such problems are the most common reason for referral to mental health services for boys, and the earlier the problems start, the more serious the outcome. There is, however, evidence to support the effectiveness of early intervention.

Intervention for primary school pupils

The strongest evidence supports prevention/early intervention approaches that include a focus on:

• the whole school environment, particularly addressing bullying; and

• teaching social and emotional skills in combination with:

- working with parents/carers (families at risk may be difficult to engage) where possible in the school context as there is a high risk of dropout of families at greater risk. Individual child oriented interventions are less effective than ones which involve parents/carersalthough programmes are available including the Coping Power Program: CBT Problem-solving skills training which involve parents/carers to some degree; and
- small group sessions for children with a focus on developing cognitive skills and positive social behaviour and staff training as part of a multisystem intervention. Interventions designed to change how teachers behave are not likely to produce clinically significant improvements in individual children in the absence of other concurrent interventions, notably parent reinforcement of classroom contingency management.

Where particular problems have been identified evidence supports starting as early as possible and giving a 'booster' intervention at the end of primary school, where possible. The strongest evidence supports:

- working with parents/carers in a structured way to address behavioural issues through education and training programmes (these are particularly effective for younger children with less severe behavioural problems and include: The Incredible Years Program, Triple P-Positive Parenting Program and The Oregon Social Learning Centre (OSLC) Program); and
- parent training programmes combined with interventions with the child to promote problem-solving skills and positive social behaviours. There is also evidence to support:
- well-established nurture groups to address emerging social, emotional and behavioural difficulties;
- play-based approaches to developing more positive child/parent relationships or for enabling a child to express themselves;
- specific classroom management techniques to support primary school pupils, including strategies using token systems for delivering rewards and sanctions (though the impact is limited to the period and context of the intervention itself) and changing seating arrangements in classrooms from groups to rows; and

- ‘self-instruction’ programmes (programmes that children can learn to use on their own to manage their own behaviour) in combination with parental support may be moderately effective if accompanied by parental involvement.

Depression

Feeling low or sad is a common feeling for children and adults, and a normal reaction to experiences that are stressful or upsetting. When these feelings dominate and interfere with a person’s life, it can become an illness. According to the Royal College of Psychiatrists, depression affects 2% of children under 12 years old, and 5% of teenagers. Depression can significantly affect a child’s ability to develop, to learn or to maintain and sustain friendships. There is some degree of overlap between depression and other problems. For example, around 10% to 17% of children who are depressed are also likely to exhibit behaviour problems. Clinicians making a diagnosis of depression will generally use the categories major depressive disorder (MDD – where the person will show a number of depressive symptoms to the extent that they impair work, social or personal functioning) or dysthymic disorder (DD – less severe than MDD, but characterised by a daily depressed mood for at least two years).

The strongest evidence supports prevention/early intervention approaches that include a focus on:

• regular work with small groups of children focusing on cognition and behaviour – for example changing thinking patterns and developing problem solving skills – to relieve and prevent depressive symptoms. Where particular problems have been identified the strongest evidence supports:

• therapeutic approaches focusing on cognition and behaviour, family therapy or inter-personal therapy lasting for up to three months (in severe cases these interventions are more effective when combined with medication);

• psychoanalytic child psychotherapy may also be helpful for children whose depression is associated with anxiety;

• family therapy for children whose depression is associated with behavioural problems or suicidal ideation; and

• for mild depression, non-directive supportive counselling.

Hyperkinetic disorders (e.g. disturbance of activity and attention)

Although many children are inattentive, easily distracted or impulsive, in some children these behaviours are exaggerated and persistent, compared with other children of a similar age and stage of development. When these behaviours interfere with a child’s family and social functioning and with progress at school, they become a matter for professional concern. Attention Deficit Hyperactivity Disorder (ADHD) is a diagnosis used by clinicians. It involves three characteristic types of behaviour – inattention, hyperactivity and impulsivity. Whereas some children show signs of all three types of behaviour (this is called ‘combined type’ ADHD), other children diagnosed show signs only of inattention or hyperactivity/ impulsiveness. Hyperkinetic disorder is another diagnosis used by clinicians. It is a more restrictive diagnosis but is broadly similar to severe combined type ADHD, in that signs of inattention, hyperactivity and impulsiveness must all be present. These core symptoms must also have been present before the age of seven, and must be evident in two or more settings.

The strongest evidence supports:

• use of medication, where ADHD is diagnosed and other reasons for the behaviour have been excluded. These treatments have few side-effects and are effective in 75% of cases when there is no depression or anxiety accompanying ADHD. High doses can be avoided if behavioural treatments accompany medication;

• introduction of parent education programmes and individual behavioural therapy where there is insufficient response to medication. These need to be provided in the school as well as home, as they do not appear to generalise across settings;

• for children also experiencing anxiety, behavioural interventions may be considered alongside medication; and

• for children also presenting with behavioural problems (e.g. conduct disorder, Tourette's Syndrome, social communication disorders), appropriate psychosocial treatments may also be considered by medical professionals. Evidence also supports:

• making advice about how to teach children with ADHD-like behaviour in their first two years of schooling widely available to teachers, and encouraging them to use this advice.

Attachment disorders

Attachment is the affectionate bond children have with special people in their lives that lead them to feel pleasure when they interact with them and be comforted by their nearness during times of stress. Researchers generally agree that there are four main factors that influence attachment security: opportunity to establish a close relationship with a primary caregiver; the quality of caregiving; the child's characteristics; and the family context. Secure attachment is an important protective factor for mental health later in childhood, while attachment insecurity is widely recognised as a risk factor for the development of behaviour problems.

The strongest evidence supports:

• video feedback-based interventions with the mothers of pre-school children with attachment problems, with a focus on enhancing maternal sensitivity. Evidence also supports: • use of approaches which use play as the basis for developing more positive child/parent relationship

Eating disorders

The most common eating disorders are anorexia nervosa and bulimia nervosa. Eating disorders can emerge when worries about weight begin to dominate a person's life. Someone with anorexia nervosa worries persistently about being fat and eats very little. They lose a lot of weight and if female, their periods may stop. Someone with bulimia nervosa also worries persistently about weight. They alternate between eating very little, and then binging. They vomit or take laxatives to control their weight. Both of these eating disorders affect girls and boys but are more common in girls.

The strongest evidence supports:

• the primary aim of intervention is restoration of weight and in many cases inpatient treatment might be necessary;

• for young people with anorexia nervosa, therapeutic work with the family, taking either a structural systemic or behavioural approach may be helpful even when there is family conflict; and

• for young people with bulimia nervosa, individual therapeutic work focusing on cognition and behaviour, for example to change thinking patterns and responses. Evidence also supports:

• early intervention because of the significant risk of ill-health and even death among sufferers of anorexia;

• school-based peer support groups as a preventative measure (i.e. before any disordered eating patterns become evident) may help improve body esteem and self-esteem; and

• when family interventions are impracticable, cognitive-behavioural therapy may be effective.

Substance misuse

Substance misuse can result in physical or emotional harm. It can lead to problems in relationships, at home and at work. In the clinical field, a distinction is made between substance abuse (where use leads to personal harm) and substance dependence (where there is a compulsive pattern of use that takes precedence over other activities). It is important to distinguish between young people who are experimenting with substances and fall into problems, and young people who are at high risk of long-term dependency.

This first group will benefit from a brief, recovery-oriented programme focusing on cognitions and behaviour to prevent them to move into more serious use.

The second group will require ongoing support and assessment, with careful consideration of other concurrent mental health issues.

The strongest evidence supports:

• Therapeutic approaches which involve the family rather than just the individual; this assists communication, problem-solving, becoming drug-free and planning for relapse prevention. These approaches are especially helpful with low-level substance users, and when combined with cognitive behavioural therapy or treatments focusing on motivation;

• A variation of family therapy known as ‘one-person family therapy’, where families cannot be engaged in treatment; and

• Multi-Systemic Therapy, Multi-dimensional Family Therapy and the Adolescent Community Reinforcement Approach and other similar approaches (which consider wider factors such as school and peer group), where substance misuse is more severe, and part of a wider pattern of problems.

Evidence also supports:

• The introduction of programmes, delivered in community settings or schools and which focus on developing skills that enhance resilience, as a preventative measure as substance abuse is connected to other problems that can be addressed within these settings.

Deliberate self-harm

Common examples of deliberate self-harm include ’overdosing’ (self-poisoning), hitting, cutting or burning oneself, pulling hair or picking skin, or self-strangulation. The clinical definition includes

attempted suicide, though some argue that self-harm only includes actions which are not intended to be fatal. It can also include taking illegal drugs and excessive amounts of alcohol. It can be a coping mechanism, a way of inflicting punishment on oneself and a way of validating the self or influencing others.

The strongest evidence supports:

• brief interventions engaging the child and involving the family, following a suicide attempt by a child or young person;

• assessment of the child for psychological disturbance or mental health problems which, if present, should be treated as appropriate. At times, brief hospitalisation may be necessary; and

• some individual psychodynamic therapies (Mentalisation Based Treatment) and behavioural treatments (Dialectic Behaviour Therapy).

Post-traumatic stress

If a child experiences or witnesses something deeply shocking or disturbing they may have a traumatic stress reaction. This is a normal way of dealing with shocking events and it may affect the way the child thinks, feels and behaves. If these symptoms and behaviours persist, and the child is unable to come to terms with what has happened, then clinicians may make a diagnosis of post-traumatic stress disorder (PTSD).

The strongest evidence supports:

• therapeutic support focused on the trauma and which addresses cognition and behaviour especially regarding sexual trauma and some can be delivered in schools such as Trauma and grief component therapy and Cognitive Behavioural Intervention for Trauma in Schools (CBITS). Trauma focused CBT should be adapted appropriately to suit age, circumstances and level of development.

The evidence specifically does not support:

• prescription of drug treatments for children and young people with PTSD; or

• the routine practice of 'debriefing' immediately following a trauma.