Mental health and wellbeing policy

Action	Policy to be reviewed annually		
	Committee	**Date**	**Completed**
Review	Sandrine Paillasse	March 2020	✓
Reported	Education Committee	12 May 2020	✓
Approved	Board of Governors	25 June 2019	✓

To be published on the following:	
Staff Portal	✓
School website	✓

1 Policy Statement

1.1 The School promotes the mental and physical health and emotional wellbeing of all its pupils. Wellbeing is at the forefront of the School's PSHE programme and promoting good mental health is a priority. The physical, mental and emotional health benefits of exercise are well documented and the school actively encourages sport for all. Through the school council, the school community has identified 10 key qualities that are fundamental to good mental health and wellbeing:

1. *Proper sleep patterns*
2. *Time for exercise*
3. *Eating healthily at regular times*
4. *Time to relax*
5. *Emotional resilience – accepting being 'good enough'*
6. *Sense of humour*
7. *Firm boundaries*
8. *Random acts of kindness*
9. *Walking in fresh air*
10. *A sense of perspective*

1.2 Mental health issues can and should be de-stigmatised by educating pupils, staff and parents. This is done through tutorials and PSHE with the pupils, through staff INSET and through parent discussion evenings and the pastoral forum for parents that take place twice termly. Positive mental health is also promoted through strong pastoral care, the sister scheme and an effective peer support and peer-educators system.

1.3 This policy aims to:

- describe the School's approach to mental health issues
- increase understanding and awareness of mental health issues so as to facilitate early intervention of mental health problems
- alert staff to warning signs and risk factors
- provide support and guidance to all staff, including non-teaching staff and governors, dealing with pupils who suffer from mental health issues
- provide support to pupils who suffer from mental health issues, their peers and parents/carers.

1.4 This policy has been authorised by the Governors, addressed to all members of Staff, Board of Governors and volunteers and, is available to parents on request and is published on the school website. This policy can be made available in large print or other accessible format if required. It applies wherever staff or volunteers are working with pupils even where this is away from the School, for example on an educational visit.

2 Child Protection Responsibilities

2.1 St Paul's Girls' School is committed to safeguarding and promoting the welfare of children and young people, including their mental health and emotional wellbeing, and expects all staff, Governors and volunteers to share this commitment. We recognise that children have a fundamental right to be protected from harm and that pupils cannot learn effectively unless they feel secure. We therefore aim to provide a school environment which promotes self-confidence, a feeling of self-worth and the knowledge that pupils' concerns will be listened to and acted upon. Every pupil should feel safe, be healthy, enjoy and achieve, make a positive contribution and achieve economic wellbeing (Every Child Matters, 2004, DfES).

2.2 The Board of Governors takes seriously its responsibility to uphold the aims of the

charity and its duty in promoting an environment in which children can feel secure and safe from harm. A nominated Governor instigates a review of the school's safeguarding procedures and reports to the Board annually, making any recommendations for improvements.

2.3 The High Mistress is responsible for ensuring that the procedures outlined in this policy are followed on a day-to-day basis.

2.4 The School has appointed a senior member of staff with the necessary status and authority (Designated Safeguarding Lead – Director of Pastoral Care) to be responsible for matters relating to child protection and welfare. Parents are welcome to approach the Designated Safeguarding Lead if they have any concerns about the welfare of any child in the school, whether these concerns relate to their own child or any other. If preferred, parents may discuss concerns in private with the child's form teacher, Head of Year or the High Mistress who will notify the Designated Safeguarding Lead in accordance with these procedures.

2.5 In addition to the child protection measures outlined in the School's Safeguarding (Child Protection) policy, the School has a duty of care to protect and promote a child or young person's mental or emotional wellbeing.

3 Background

3.1 One in ten young people between the ages of 5 and 16 will have an identifiable mental health issue at any one time. By the time they reach university this figure is as high as 1 in 6. Around 75% of mental health disorders are diagnosed in adolescence (s*ource: www.youngminds.org.uk*). See Appendix VII for further reading.

4 Identifiable mental health issues

4.1 It is important for staff to be alert to signs that a child might be suffering from mental health issues. Mental health issues come in many forms and manifest themselves in a wide range of ways including:

- Anxiety and Depression
- Eating disorders
- Self-harm
- Suicidal ideation

4.2 Two important elements enabling the School to identify mental health issues are the effective use of data (i.e. monitoring changes in pupils' patterns of attendance/academic achievement) and an effective pastoral system whereby staff know pupils well and can identify unusual behaviour.

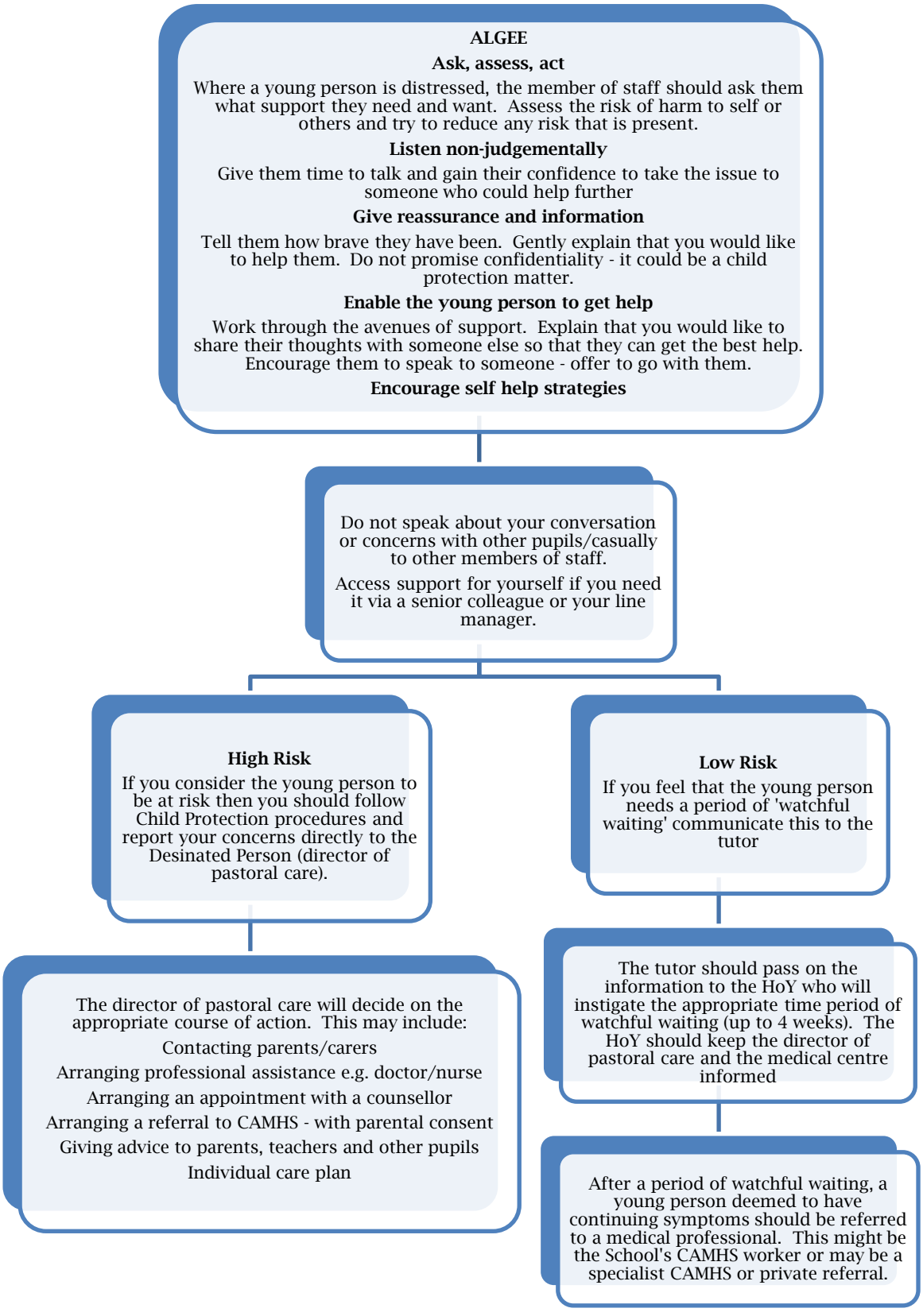
5 Signs and symptoms of mental or emotional concerns

5.1 These are outlined at Appendices I, II,III and IV

6 Procedures

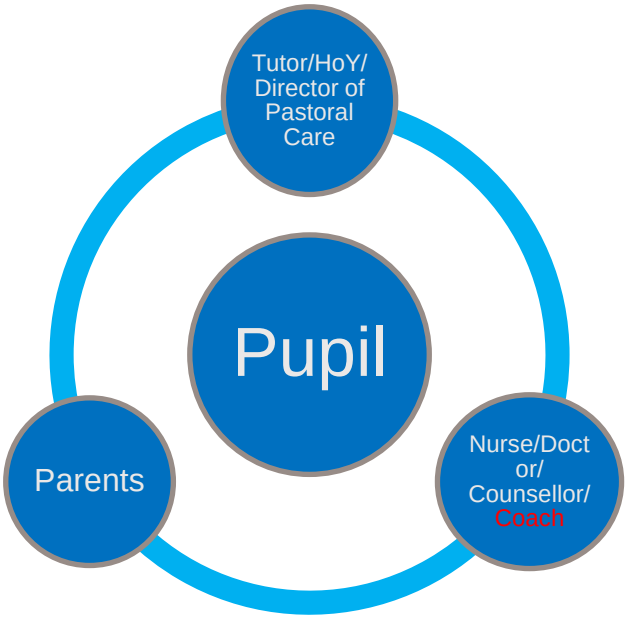
6.1 The most important role school staff play is to familiarise themselves with the risk factors and warning signs outlined at Appendices I, II,III and IV. *Figure 1* outlines the procedures that are followed if staff have a concern about a pupil, if another pupil raises concerns about one of their friends or, if an individual pupil speaks to a member of staff specifically about how they are feeling.

Figure 1 **Procedures following a concern**



6.2 The School aims to implement the following support structure:

Figure 2 **Wellbeing support structure**



7 Individual care plans and safety plans

7.1 Following consultation between the relevant members of the pastoral team a care plan would be agreed between the pastoral team, the pupil and, where appropriate, the pupil's parents. Where the student has disclosed thoughts of suicide, a specific safety plan will be agreed. The relevant teaching staff would be made aware of the care plan in order to provide the appropriate level of support for the pupil. The medical centre will agree a care plan, and if needed a safety plan, that may include confidential information. The care and safety plans will be reviewed and updated at regular intervals, agreed with the pupil and where appropriate their parents.

8 Confidentiality and information sharing

8.1 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 may not be 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.** It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on a member of staff to do so.

8.2 It is likely that a pupil will present at the medical centre in the first instance. Young people with mental health problems typically visit the medical centre more than their peers, often presenting with a physical concern. This gives the medical team a key role in identifying mental health issues early. If a pupil confides in a member of the school medical team then they should be encouraged to speak to their tutor or head of year. After nursing assessment, any immediate concern for a pupil's mental health would be reported to the school doctor and an appointment made. **Confidentiality will be maintained within the boundaries of safeguarding the pupil**. The school doctor will decide what information is appropriate to pass on to parents and the Director of Pastoral Care. Gillick competence will also be considered. The Director of Pastoral Care may decide to share relevant information with certain

colleagues on a need to know basis. Parents should be involved wherever possible, although the pupil's wishes should always be taken into account.

8.3 Parents must disclose to the Director of Pastoral Care any known mental health problem or any concerns they may have about a pupil's mental health or emotional wellbeing. This includes any changes in family circumstances that may impact the pupil's wellbeing.

9 Records and reporting

9.1 Further guidance on procedures for specific mental health concerns is given at Appendices I, II,III and IV.

10 Mental Health First Aid

10.1 In order to ensure adequate mental health first aid provision and awareness it is our policy that:

- There are sufficient numbers of trained personnel to support those pupils who are experiencing mental and/or emotional difficulties.
- A qualified youth mental health first aider is always available during normal school hours (see section 11.4 for definition of 'qualified youth mental health first aider' and section 12.1 for hours of work).

11 Responsibilities under the policy relating to mental health first aid

11.1 The School Nurse is responsible for:

- Maintaining accurate records of all mental health first aid given in the medical centre.

11.2 The Designated Safeguarding Lead is responsible for:

- Maintaining accurate records of all safeguarding and child protection issues.

11.3 Qualified youth mental health first aiders (Appendix VI) 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

11.4 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. See Appendix VI for a list of current youth mental health first aiders.

11.5 All staff have a duty of care towards the pupils and should respond accordingly when first aid situations arise. New staff are briefed about the St Paul's medical department and where to find information and help. All staff are reminded regularly about the specific medical and emotional needs of students within the school community and they are asked to familiarise themselves with the serious medical conditions poster, which details those students with medical needs that require specific action to support their mental/emotional wellbeing. The list of qualified

Youth Mental Health First Aiders is published on the intranet/recorded in this policy and is updated annually.

12 Staffing of the medical centre

12.1 The School has a full-time nurse in attendance in the medical room during normal working hours, 8.30am to 4.0pm, Monday to Friday during term time. If she is absent, adequate first aid cover is put in place. If the nurse is on a long-term absence, the Director of Pastoral Care will organise for a replacement/agency nurse to be available.

12.2 The medical centre is staffed by the school nurse who is a registered nurse (RNC). The medical centre is open throughout the school day. If the school nurse is off-site for any reason staff will be informed and a notice will be displayed on the door of the medical centre giving details of how to obtain help.

12.3 The school doctor is available in school every Tuesday afternoon and Thursday morning. The counsellors/coach are available Tuesday to Thursday:

Tuesday	
	Dawn Grantham, school counsellor
Wednesday	Dawn Grantham, school counsellor
	Emma Clare, coach
Thursday	Emma Clare, coach
	Shan Rixon, art therapist

Up to six sessions with the counsellor / coach are available. After this time a referral may be made to an appropriate external provider and an in-school care plan will be agreed to support the pupil within the school environment. Any further sessions with the school counsellor are agreed at the discretion of the Director of Pastoral Care.

Parental permission is not sought for access to counselling provision; the counsellors use the Gillick competency guidelines[1].

13 Staff Roles/Procedures

13.1 Procedures for dealing with specific mental health issues are given as follows:

- anxiety and depression (Appendix I)
- eating disorders (Appendix II)
- self-harm (Appendix III)
- suicidal ideation (Appendix IV)
- bereavement (Appendix V)

If the Director of Pastoral Care or the school nurse is not available, one of the deputy desginated safeguarding leads, a qualified youth mental health first aider (see Appendix VI) or the school office should be contacted.

13.2 A record will be kept of all incidents and the first aid treatment/support given. A copy should be kept by the school nurse in an electronic log book in the medical centre and be recorded in the individual pupil/staff health file and on CPOMS. Records are kept for a minimum of eight years in accordance with guidelines for storage of medical and nursing records.

[1] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/
https://www.nhs.uk/conditions/consent-to-treatment/children/

13.3 If an incident that is linked to a mental health concern is serious, an incident report form should be completed. Detailed procedures are outlined in the school's first aid policy which is available on the school website.

14 Absence from school

14.1 If a pupil is absent from school for any length of time then appropriate arrangements will be made to provide study material. This may be in discussion with any medical professionals who may be treating a pupil.

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

15 Reintegration to school

15.1 Should a pupil require some time out of school, the School will be fully supportive of this and every step will be taken in order to ensure a smooth reintegration back into school when they are ready.

15.2 The Director of Pastoral Care will work alongside the Director of Studies, the Head of Year (HoY), the school medical team, the pupil and their parents to draw up an appropriate care plan. The pupil should have as much ownership as possible with regards the support provided in school so that they feel they have control over the situation. If a phased return to school is deemed appropriate, this will be agreed with the parents.

15.3 The School will consider whether the pupil will benefit from being identified as having a special educational need or disability (SEND) and may work alongside the Learning Support coordinator where special provision might be required.

15.4 If a significant period of time has elapsed where a pupil's return to school might not be considered to be in their best interests, the Director of Pastoral Care will liaise with the pupil's parents, in consultation with the High Mistress and on a case by case basis, to support an application to another educational establishment.

Appendix I

Anxiety and Depression

Anxiety disorders

Anxiety is a natural, normal feeling we all experience from time to time. It can vary in severity from mild uneasiness through to a terrifying panic attack. It can vary in how long it lasts, from a few moments to many years.

All children and young people get anxious at times; this is a normal part of their development as they grow up and develop their 'survival skills' so they can face challenges in the wider world. In addition, we all have different levels of stress we can cope with - some people are just naturally more anxious than others and are quicker to get stressed or worried.

Concerns are raised when anxiety is **getting in the way of a child's day to day life, slowing down their development, or having a significant effect on their schooling or relationships**. It is estimated that 1 in 6 people will suffer from General Anxiety Disorder at some point in their lives.

Anxiety disorders include:

- Generalised anxiety disorder (GAD)
- Panic disorder and agoraphobia
- Acute stress disorder (ASD)
- Separation anxiety
- Post-traumatic stress disorder
- Obsessive-compulsive disorder (OCD)
- Phobic disorders (including social phobia)

Symptoms of an anxiety disorder

These can include:

Physical effects

- Cardiovascular – palpitations, chest pain, rapid, heartbeat, flushing
- Respiratory – hyperventilation, shortness of breath
- Neurological – dizziness, headache, sweating, tingling and numbness
- Gastrointestinal – choking, dry mouth, nausea, vomiting, diarrhoea
- Musculoskeletal – muscle aches and pains, restlessness, tremor and shaking

Psychological effects

- Unrealistic and/or excessive fear and worry (about past or future events)
- Mind racing or going blank
- Decreased concentration and memory
- Difficulty making decisions
- Irritability, impatience, anger
- Confusion
- Restlessness or feeling on edge, nervousness
- Tiredness, sleep disturbances, vivid dreams
- Unwanted unpleasant repetitive thoughts

Behavioural effects

- Avoidance of situations
- Repetitive compulsive behaviour e.g. excessive checking
- Distress in social situations
- Urges to escape situations that cause discomfort (phobic behaviour)

First Aid for anxiety disorders

Follow the ALGEE principles (see *Figure 1* in main policy)

How to help a pupil having a panic attack

- If you are at all unsure whether the pupil is having a panic attack, a heart attack or an asthma attack, and/or the person is in distress, call the nurse immediately. If you are off site, call an ambulance straight away. If you are sure that the pupil is having a panic attack, move them to a quiet safe place if possible.
- Help to calm the pupil by encouraging slow, relaxed breathing in unison with your own. Encourage them to breathe in and hold for 3 seconds and then breathe out for 3 seconds.
- Be a good listener, without judging.
- Explain to the pupil that they are experiencing a panic attack and not something life threatening such as a heart attack.
- Explain that the attack will soon stop and that they will recover fully.
- Assure the pupil that someone will stay with them and keep them safe until the attack stops.

Many young people with anxiety problems do not fit neatly into a particular type of anxiety disorder. It is common for people to have some features of several anxiety disorders. A high level of anxiety over a long period will often lead to depression and long periods of depression can provide symptoms of anxiety. Many young people have a mixture of symptoms of anxiety and depression as a result.

Depression

A clinical depression is one that lasts for at least 2 weeks, affects behaviour and has physical, emotional and cognitive effects. It interferes with the ability to study, work and have satisfying relationships. Depression is a common but serious illness and can be recurrent. In England if affects at least 5% of teenagers, although some estimates are higher. Rates of depression are higher in girls than in boys.

Depression in young people often occurs with other mental disorders, and recognition and diagnosis of the disorder may be more difficult in children because the way symptoms are expressed varies with the developmental age of the individual. In addition to this, stigma associated with mental illness may obscure diagnosis.

Risk Factors

- Experiencing other mental or emotional problems
- Divorce of parents
- Perceived poor achievement at school
- Bullying
- Developing a long-term physical illness
- Death of someone close
- Break up of a relationship

Some people will develop depression in a distressing situation, whereas others in the same situation will not.

Symptoms

Effects on emotion: sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, helplessness, hopelessness

Effects on thinking: frequent self-criticism, self-blame, worry, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see you in a negative light, thoughts of death or suicide

Effects on behaviour: crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation. Engaging in risk taking behaviours such as self-harm, misuse of alcohol and other substances, risk-taking sexual behaviour.

Physical effects: chronic fatigue, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight loss or gain, irregular menstrual cycle, unexplained aches and pains.

First Aid for anxiety and depression
Follow the ALGEE principles shown in *Figure 1* of the main policy

The most important role school staff can play is to familiarise themselves with the risk factors and warning signs outlined above and to make the director of pastoral care (designated teacher for safeguarding children) aware of any child causing concern.

Following the report, the director of pastoral care will decide on the appropriate course of action and will record it on CPOMS. This may include:

- Contacting parents/carers
- Arranging professional assistance e.g. doctor, nurse
- Arranging an appointment with a counsellor
- Arranging a referral to CAMHS or private referral – with parental consent
- Giving advice to parents, teachers and other pupils

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 need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a pupil is at serious risk of causing themselves harm, then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on you to do so.

Appendix II

Eating Disorders

Definition of Eating Disorders
Anyone can get an eating disorder regardless of their age, gender or cultural background. People with eating disorders are preoccupied with food and/or their weight and body shape and are usually highly dissatisfied with their appearance. The majority of eating disorders involve low self-esteem, shame, secrecy and denial.

Anorexia nervosa and bulimia nervosa are the major eating disorders. People with anorexia live at a low body weight, beyond the point of slimness and in an endless pursuit of thinness by restricting what they eat and sometimes compulsively over-exercising. In contrast, people with bulimia have intense cravings for food, secretively overeat and then purge to prevent weight gain (by vomiting or use of laxatives, for example).

Risk Factors

The following risk factors, particularly in combination, may make a young person more vulnerable to developing an eating disorder:

Individual Factors

- Difficulty expressing feelings and emotions
- A tendency to comply with others' demands
- Very high expectations of achievement / perfectionism

Family Factors

- A home environment where food, eating, weight or appearance have a disproportionate significance
- An over-protective or over-controlling home environment
- Poor parental relationships and arguments
- Neglect or physical, sexual or emotional abuse
- Overly high family expectations of achievement

Social Factors

- Being bullied, teased or ridiculed due to weight or appearance
- Pressure to maintain a high level of fitness/low body weight for e.g. sport or dancing

Warning Signs

School staff may become aware of warning signs which indicate a pupil is experiencing difficulties that may lead to an eating disorder. These warning signs should **always** be taken seriously and staff observing any of these warning signs should seek further advice from the Designated Safeguarding Lead or from the medical centre.

Physical Signs

- Weight loss
- Dizziness, tiredness, fainting
- Feeling Cold
- Hair becomes dull or lifeless
- Swollen cheeks
- Callused knuckles
- Tension headaches

- Sore throats / mouth ulcers
- Tooth decay

Behavioural Signs

- Restricted eating
- Skipping meals
- Scheduling activities during lunch
- Strange behaviour around food
- Wearing baggy clothes
- Wearing several layers of clothing
- Excessive chewing of gum/drinking of water
- Increased conscientiousness
- Increasing isolation / loss of friends
- Believes they are fat when they are not
- Secretive behaviour
- Visits the toilet immediately after meals
- Excessive exercise

Psychological Signs

- Preoccupation with food
- Sensitivity about eating
- Denial of hunger despite lack of food
- Feeling distressed or guilty after eating
- Self-dislike
- Fear of gaining weight
- Moodiness
- Excessive perfectionism

Staff Roles

The most important role school staff can play is to familiarise themselves with the risk factors and warning signs outlined above and to make the Director of Pastoral Care (Designated Safeguarding Lead) aware of any child causing concern.

Following the report, the Director of Pastoral Care / DSL will decide on the appropriate course of action and record it on CPOMS and in medical files. This may include:

- Contacting parents/carers
- Arranging professional assistance e.g. doctor, nurse
- Arranging an appointment with a counsellor
- Arranging a referral to CAMHS, EDU or private referral – with parental consent
- Giving advice to parents, teachers and other pupils
- Write up a care plan for the student

The Director of Pastoral Care may ask the medical centre to weigh the pupil and to monitor their weight on a regular, individual basis. The medical team will, in a supportive way, establish the student's dietary and exercise habits, assess their physical and psychological condition, explore their personal views of their weight and any precipitants to their current behaviour and family issues. The school doctor will also establish their height, and record their BMI, comparing this with previous measurements. In line with the privacy notice, parents may be consulted. Where appropriate, students will be advised to see one of the school counsellors.

On review, if there is further weight loss or other cause for concern, the medical team will decide whether specialist treatment needs to be sought.

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 need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a pupil is at serious risk of causing themselves harm, then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on you to do so.

Management of eating disorders in school

Exercise and activity – PE and games
Taking part in sports, games and activities is an essential part of school life for all pupils. Excessive exercise, however, can be a behavioural sign of an eating disorder. If the Director of Pastoral Care and medical team deem it appropriate they may liaise with PE staff to monitor the amount of exercise a student is doing in school. They may also request that the PE staff advise parents of a sensible exercise programme for out of school hours. All PE teachers at the School will be made aware of which pupils have a known eating disorder. The School will not discriminate against pupils with an eating disorder and will enable them whenever appropriate, to be involved in sports. Advice will be taken from medical professionals, however, and the amount and type of exercise will be closely monitored. Students may be asked to stop until they are deemed healthy enough to resume activity.

When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school or is always tired because their eating disorder is disturbing their sleep at night, the form tutor, Head of Year and the medical team will initially talk to the parents/carers to work out how to help prevent their child from falling behind. The Learning Support Coordinator may be involved in this process. If applicable, the school nurse will consult with the professional treating the student. This information will be shared with the relevant pastoral/ teaching staff on a need to know basis and to inform the ICP.

Pupils Undergoing Treatment for/Recovering from Eating Disorders

The decision about how, or if, to proceed with a pupil's schooling while they are suffering from an eating disorder should be made on a case by case basis. Input for this decision should come from discussion with the pupil, their parents, school staff and members of the multi-disciplinary team treating the pupil.

The reintegration of a pupil into school following a period of absence should be handled sensitively and carefully and again, the pupil, their parents, school staff and members of the multi-disciplinary team treating the pupil should be consulted during both the planning and reintegration phase.

Further Considerations

Any meetings with a pupil, their parents or their peers regarding eating disorders should be recorded on CPOMS and in medical files including:

- Dates and times
- A care plan
- Concerns raised
- Details of anyone else who has been informed

Appendix III

Self-Harm

Introduction

Recent research indicates that up to one in ten young people in the UK engage in self-harming behaviours. Girls are thought to be more likely to self-harm than boys. School staff can play an important role in preventing self-harm and also in supporting pupils, peers and parents of pupils currently engaging in self-harm.

Definition of Self-Harm

Self-harm is any behaviour where the intent is to deliberately cause harm to one's own body for example:

- Cutting, scratching, scraping or picking skin
- Swallowing inedible objects
- Taking an overdose of prescription or non-prescription drugs
- Swallowing hazardous materials or substances
- Burning or scalding
- Hair-pulling
- Banging or hitting the head or other parts of the body
- Scouring or scrubbing the body excessively
- Not looking after their needs properly, emotionally or physically
- Eating distress
- Addiction, for example to alcohol or drugs

Self-harm is a common precursor to suicide, and children and young people who deliberately self-harm may kill themselves by accident.

Self-harm may help a person by:

- Providing relief from being emotionally overwhelmed and distressed
- Reducing tension
- Distraction from current difficulties
- Escaping from the situation
- Feeling 'something'
- Feeling in control
- Punishing themselves
- So that they can take care of themselves afterwards

Self-harm is sometimes unhelpfully thought of in terms of 'attention-seeking behaviour'. It needs to be respected as the best way of coping that the student knows about at the time. It is vital that students not be punished for their behaviour but be provided with adequate support. It is not a healthy way of coping, and messages and support must be given to students to prevent others from being encouraged to engage in this behaviour.

Risk Factors

The following risk factors, particularly in combination, may make a young person particularly vulnerable to self-harm:

Individual Factors:

- Depression/anxiety
- Poor communication skills
- Low self-esteem

- Poor problem-solving skills
- Hopelessness
- Impulsivity
- Drug or alcohol abuse
- Other mental health issues such as bipolar disorder

Family Factors

- Unreasonable expectations
- Neglect or physical, sexual or emotional abuse
- Poor parental relationships and arguments
- Depression, self-harm or suicide in the family

Social Factors

- Difficulty in making relationships/loneliness
- Being bullied or rejected by peers

Warning Signs

School staff may become aware of warning signs which indicate a pupil is experiencing difficulties that may lead to thoughts of self-harm or suicide. These warning signs should **always** be taken seriously and staff observing any of these warning signs should seek further advice from the Director of Pastoral Care.

Possible warning signs include:

- Changes in eating/sleeping habits (e.g. pupil may appear overly tired if not sleeping well)
- Increased isolation from friends or family, becoming socially withdrawn
- Changes in activity and mood e.g. more aggressive or introverted than usual
- 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. always wearing long sleeves, even in very warm weather
- Unwillingness to participate in certain sports activities e.g. swimming

Staff Roles in working with pupils who self-harm

Pupils may choose to confide in a member of school staff if they are concerned about their own welfare or that of a peer. School staff may experience a range of feelings in response to self-harm in a pupil such as anger, sadness, shock, disbelief, guilt, helplessness, disgust and rejection. However, in order to offer the best possible help to pupils it is important to try and maintain a supportive and open attitude – a pupil who has chosen to discuss their concerns with a member of school staff is showing a considerable amount of courage and trust.

Pupils need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a pupil is at serious risk of harming themselves then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on you to do so.

Any member of staff who is aware of a pupil engaging in or suspected to be at risk of engaging in self-harm should consult the Director of Pastoral Care.

Following the report, the Director of Pastoral Care will decide on the appropriate course of action.

An assessment of risk should be undertaken at the earliest stage, by the medical or pastoral teams, and should enquire about and consider the student's:

- Level of planning and intent
- Frequency and nature of thoughts and actions
- Signs or symptoms of a mental health disorder such as depression
- Evidence or disclosure of substance misuse
- Previous history of self-harm or suicide in the wider family or peer group
- Delusional thoughts or behaviour

The level of risk may fluctuate, and a point of contact with a backup should be agreed to allow the young person to make contact if they need to

It is important not to:

- Panic or try quick solutions
- Dismiss what the young person says, their feelings or behaviour
- Believe that the young person who has threatened to harm themselves in the past will not carry it out in the future
- Disempower the young person
- See it as attention seeking or manipulative
- Trust appearances, as many young people learn to cover up their distress

The resulting course of action may include:

- Contacting parents / carers
- Arranging professional assistance e.g. doctor, nurse, social services
- Arranging an appointment with a counsellor
- Arranging a referral to CAMHS or private referral – with parental consent
- Immediately removing the pupil from lessons if their remaining in class is likely to cause further distress to themselves or their peers
- **In the case of an acutely distressed pupil, the immediate safety of the pupil is paramount, and an adult should remain with the pupil at all times**
- **If a pupil has self-harmed in school a first aider / the nurse should be called for immediate help**

Further Considerations

Any meetings with a pupil, their parents or their peers regarding self-harm should be recorded on CPOMS and in medical files including:

- Dates and times
- Care plan
- Concerns raised
- Details of anyone else who has been informed

It is important to encourage pupils to let staff know if one of their group is in trouble, upset or showing signs of self-harming. Friends can worry about betraying confidences, so they need to know that self-harm can be very dangerous and that by seeking help and advice for a friend they are taking responsible action and being a good friend. They should also be aware that their friend will be treated in a caring and supportive manner.

The peer group of a young person who self-harms may value the opportunity to talk to a member of staff either individually or in a small group. Any member of staff wishing for further advice on this should consult either the Director of Pastoral Care or the Director of Senior School.

When a young person is self-harming it is important to be vigilant in case close contacts with the individual are also self-harming. Occasionally schools discover that a number of pupils in the same peer group are harming themselves.

Appendix IV

Suicide Prevention

Key definitions

- **At risk**

A student who is defined as high risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behaviour suggesting the onset or deterioration of a mental health condition. The student may have thought about suicide including potential means of death and may have a plan. In addition, the student may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. The situation would necessitate a referral, as documented in the following procedures.

- **Suicide**

Death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour.

- **Suicide attempt**

A self-injurious behaviour for which there is evidence that the person had at least some intent to kill themselves. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

- **Suicidal ideation**

Thinking about, considering, or planning for self-injurious behaviour which may result in death. There are two kinds of suicidal ideation: passive and active. In passive suicidal ideation, the individual may be thinking about suicide but has no plans to take their own life. Active suicidal ideation, on the other hand, is not only thinking about it but having the intent to take one's own life; this may include planning how to do it. Suicidal ideation is one of the symptoms of both major depression and the depression found in bipolar disorder.

A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.

Risk factors

Risk factors for suicide are characteristics or conditions that increase the chance that a person may try to take their life. Suicide risk tends to be highest when someone has several risk factors at the same time. The most frequently cited risk factors for suicide are:

- Major depression (feeling down in a way that impacts your daily life) or bipolar disorder (severe mood swings)
- Substance abuse
- Unusual thoughts and behaviour or confusion about reality
- Personality traits that create a pattern of intense, unstable relationships or trouble with the law
- Impulsivity and aggression, especially along with a mental disorder
- Previous suicide attempt or family history of a suicide attempt or mental disorder
- Serious medical condition and/or pain

It is important to bear in mind that most people with mental disorders or other suicide risk factors do not engage in suicidal behaviour.

Protective factors for suicide

Protective factors for suicide are characteristics or conditions that may help to decrease a person's suicide risk. While these factors do not eliminate the possibility of suicide, especially in someone with risk factors, they may help to reduce that risk.

Protective factors for suicide include:

- Receiving effective mental health care
- Positive connections to family, peers, community
- The skills and ability to solve problems

Note that protective factors do not entirely remove risk, especially when there is a personal or family history of depression or other mental disorders. Certain young people are more vulnerable; some examples are listed below:

- **Young people living with mental and/or substance use disorders**

While most people with mental disorders do not engage in suicidal behaviour, people with mental disorders account for more than 90 percent of deaths by suicide. Mental disorders, in particular depression or bi-polar (manic-depressive) disorder, alcohol or substance abuse, schizophrenia and other psychotic disorders, borderline personality disorder, conduct disorders, and anxiety disorders are important risk factors for suicidal behaviour among young people. Not all people suffering from these mental disorders are engaged in treatment, therefore School staff may play a pivotal role in recognising and referring the student to treatment that may reduce risk.

- **Young people who engage in self-harm or have attempted suicide**

Suicide risk among those who engage in self-harm is significantly higher than the general population. Whether or not they report suicidal intent, people who engage in self-harm are at elevated risk for dying by suicide within 10 years. Additionally, a previous suicide attempt is a known predictor of suicide death. Many adolescents who have attempted suicide do not receive necessary follow- up care.

- **LGBTQ**

Lesbian, gay, bisexual, transgender, or questioning young people are four times more likely, and questioning young people are three times more likely, to attempt suicide as their straight peers. Suicidal behaviour among LGBTQ young people can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimisation. For those young people with baseline risk for suicide (especially those with a mental disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ which elevate the risk of suicidal behaviour for LGBTQ young people.

- **Young people bereaved by suicide**

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are at increased risk for suicide themselves.

- **Young people living with medical conditions and disabilities**

Several physical conditions are associated with an elevated risk for suicidal behaviour. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive styles that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behaviour than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

Prevention

- **Education**

As part of our care for the welfare of our students, the School believes it has a duty to educate and inform young people on mental health issues, including suicidal ideation and suicide. We are committed to developing a programme of age-appropriate, student-centred psycho-education and skills training for pupils. We seek to:

a. Provide accurate information about mental health issues which affect young people
b. Provide opportunities for young people to acquire knowledge and understanding about the consequence of poor or ill mental health
c. Provide opportunities for pupils to be equipped with knowledge, attitudes, protective factors and skills they need to make healthy choices, to promote good self-care and develop coping strategies, to look after others (self-esteem, coping skills, problem-solving skills, decision-making skills and self-disclosure)
d. Enable pupils to identify sources of appropriate personal support
e. Provide opportunities to educate parents
f. Provide opportunities to educate staff

- **The Language around suicide**

Using sensitive and appropriate language can help build awareness and understanding to increase empathy and support.

Helpful	Unhelpful
Ended their life	Commit suicide (suicide is not a crime)
Took their own life	Unsuccessful or failed suicide
Died by suicide	Thinking of doing something silly / stupid
Killed themselves	
Attempted to take their life	
Attempted suicide	
Engaged in suicide behaviours	

Intervention

If a young person is having thoughts of suicide, they will usually communicate this. However, this is unlikely to be an explicit verbal communication about suicide. Few young people feel that they can be open about suicidal thinking or tell someone when they are struggling with their emotional health and wellbeing. When suicide is part of a young people's thinking, they usually show this in their behaviour, in how they interact and in how they communicate. The only way to check is to ask the young person directly and clearly about suicide.

Behavioural clues	Verbal clues	Situational clues
- Sudden or unexpected changes in behaviour and personality - Quality of academic work declines - Lack of energy - Withdrawal - Prevailing sadness - Loss of interest in activities - Changes in sleep and eating habits - Neglect of personal appearance - Substance abuse - Prized possessions given away - Insufficient problem-solving skills	- Preoccupations with talking or writing about death - Talk about taking one's own life - Verbal or written remarks about sense of failure, worthlessness, and/or isolation - Frequent complaints about physical symptoms that are often related to emotions, such as stomach aches, headaches or fatigue	- Loss of a relationship / relationship problems - Death of a close friend of family member - Loss of self-esteem; failure to achieve expectations - Home issues, such as divorce - Family history of psychiatric difficulties - Major life event or chronic stressor - Serious illness, physical or mental - Abuse - Social isolation

Assessment and referral

When a student is identified by a member of staff as potentially suicidal, i.e. verbalises about suicide, presents overt risk-factors such as agitation or intoxication, the act of self-harm occurs, or a student self-refers, the student will be seen by the Director of Pastoral Care / DSL within the same school day to assess risk and facilitate referral.
If the DSL is not available, for example if the concern arises on a trip, action should not be delayed.

Guidance for young people – how to support a friend
You may feel unsure how to help, but your friend will really appreciate your concern – even if they find it difficult to say this. You can start by letting them know you want to help and can be trusted. The best thing to do is listen and be there for them.
You don't need to have ready answers or solutions. Being there for them and listening to them is often enough.

- If you want to ask how they are, find a space and time when you could talk privately.
- Offer to speak to them again the next day to see how they are.
- Offer to spend more time with them.
- Ask open questions like: "how are you feeling? Or "what makes you say that?"
- Listen to what they say, without judging.
- If they don't feel like talking, let them know you would like to help and are there for them.
- They may go over the story time and time again. That's fine – it's part of the healing process.
- Remember than if they're showing anger, it is because of the pain they're going through, not because of you.
- Give them time to cry when they need too.

Suggest doing things that you know they enjoy. They might not feel ready, but it's important to make them feel included.

- If you think they need it, offer to help them get support by contacting a teacher, GP, school counsellor or a helpline.

You don't have to take everything on your shoulders. If you are helping a friend, make sure you have support for yourself. It is hard knowing that a friend is hurting, and you may find yourself struggling to cope:

- See the counsellor; book yourself an appointment via the portal
- Call Childline or Samaritans
- Speak to a teacher, the medical team, the Director of Pastoral Care

Apps to support your wellbeing

Stay Alive
Stay alive is a free suicide prevention app that helps its users to stay safe from acting on their thoughts of suicide. Downloading this app means that the help and information someone may need when managing thoughts of suicide is easily accessible, helping them to stay safe.

Self-Help Anxiety Management This app is helpful for helping the user manage their anxiety. The anxiety tracker can help the user better understand things that make them feel anxious, whilst the self-help toolkit allows them to learn new skills around anxiety management.

Moodometer
This NHS app allows the user to track and understand influence behind their mood. Acting like a mood diary, this app can be helpful in identifying triggers that can impact on low mood and suggest ways to lift your mood.

Calm Harm
This app can be used to help the user manage urges to self-harm. It's a private app and can be password protected. The help and advice provide suggestions of 5-15-minute categorised activities that can help the user 'ride the wave' of an urge to self-harm.

Talk life
Talk Life is a free online peer-to-peer support network for those battling with mental health issues.

Guidance for staff and parents - How to ask about suicide ?

"Are you thinking about suicide?". By using the word suicide, the member of staff supporting the young person will be signalling that it is OK to talk openly about their thoughts of suicide.

Conversation starters:

- It sounds like you're thinking about suicide. Is that right?
- It sounds like life feels too hard for you right now, and you want to kill yourself. Is that right?
- Are you telling me you want to kill yourself / end your life / die / die by suicide?
- Sometimes, when people are feeling the way you are, they think about suicide. Is that what you are thinking about?
- When you say you don't want to be here anymore, do you mean you would rather be dead?

If the young person is not having thoughts of suicide, they will tell you so. If you are still concerned, keep exploring why your concerns remain until you are clear that suicide is not part of their thinking. If they are not having thoughts of suicide, nothing is lost by having the conversation: you will have developed suicide-safety for and with that young person now and for the future.

Below are some ways to continue a conversation about suicide in a reassuring, safe way:

- It's hard and scary to talk about suicide but take your time, and I will listen
- Can you tell me more about why you want to die?
- Things must be so painful for you to feel like there is no way out. I want to listen and help.
- It's not uncommon to have thoughts of suicide. With help and support many people can work through these thoughts and stay safe.
- It sounds as though things are really hard at the moment… Can you tell me a bit more?
- There are organisations that offer support. I can give you their contact details.
- There is hope. There is help available and we can find it together.
- Take your time and tell me what's happening for you at the moment.
- I am so sorry you're feeling this way. Can you tell me more about how you are feeling?
- You've shown a lot of strength in telling me this. I want to help you find support.

If a young person indicates that they have been thinking about suicide, listen and allow them to express their feelings. They will likely feel a huge sense of relief that someone is willing to hear their darkest thoughts without judgment. Reassure them that they are not alone, and you can look for support together.

In situations where you feel there is imminent risk of death or harm, call for professional help and stay with the young person. The young person may not want to talk, but you can let them know that you will remain with them in supportive silence.

If the behaviour in question is historical, then the focus will be on what the young person has learned from this behaviour and using that learning to keep the young person safe.

In all events, inform the Director of Pastoral Care / DSL.

Looking after yourself

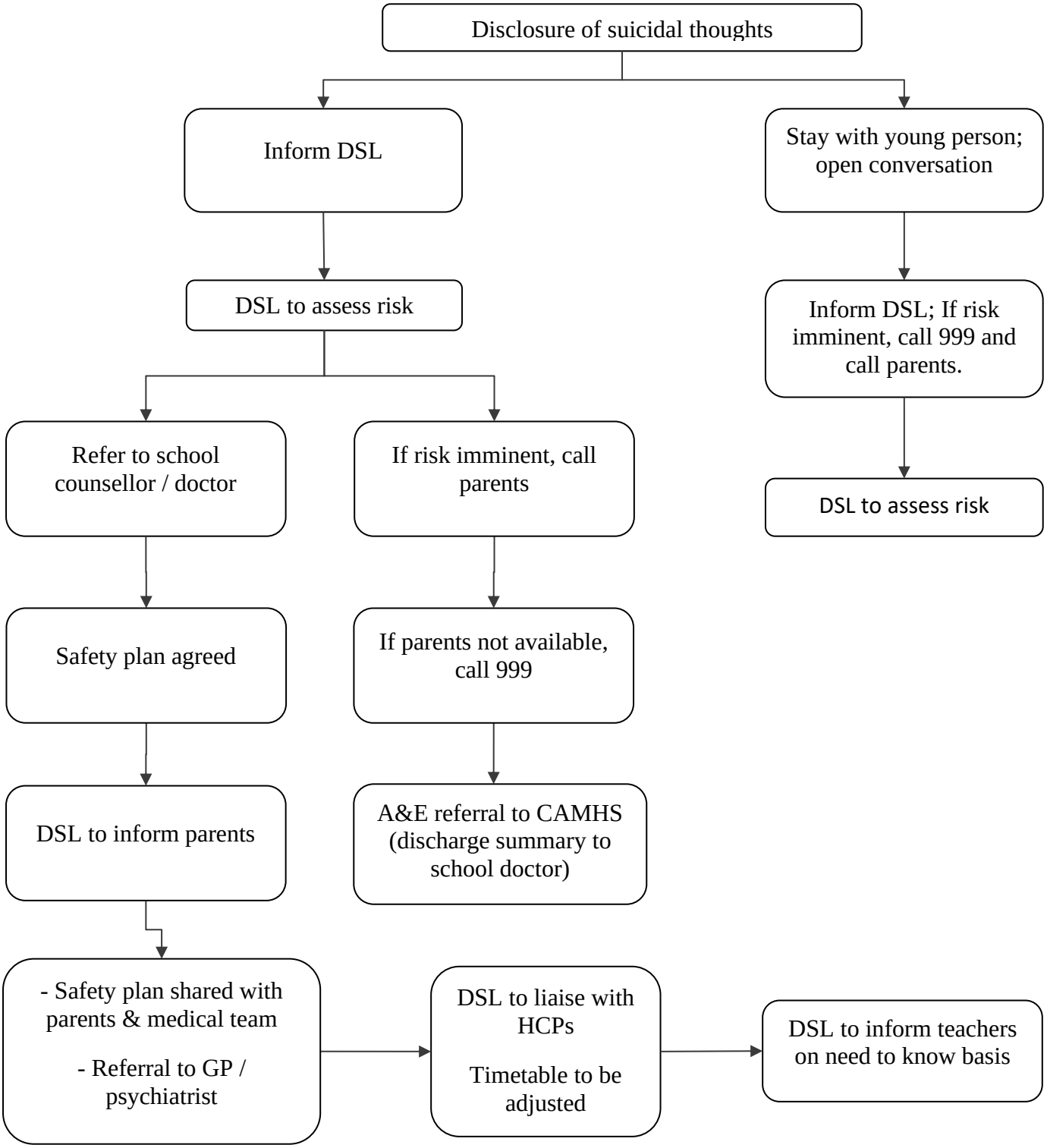
Talking to young people who have suicidal thoughts is challenging and can provoke uncomfortable feelings in ourselves, such as anxiety, fear, confusion, sadness, frustration and powerlessness. You will need to consider how to look after yourself so that you are in the best position to help:

- Reflective practice: it supports us to value and build on prior learning and experience, and allows for a better understanding of how to work safely and effectively with young people
- Training: consider whether you need to seek additional training to improve your skills, knowledge and confidence in helping young people who experience suicidal feelings.

- Be honest about your limits: if supporting the young person becomes too much of a burden, it may affect your relationship with them.

Talk to the Director of Pastoral Care, the Director of People and Diversity, a counsellor, and/or the Chaplain.

Suicidal Thoughts Pathway



For young people at risk, the following procedure will be followed at School

- Their teachers will be alerted to the presenting risk on a need-to-know basis
- The Designated Safeguarding Lead will arrange for the young person to be seen by the School doctor (or a nurse) and a counsellor at the earliest opportunity
- The counsellor will further assess the risk and discuss a safety plan with the young person, which will then be shared with the parents and the wellbeing team
- The medical team will carry out a full nursing assessment, including a screening for depression or contributing factors
- After discussion with the counsellor and medical team, the Designated Safeguarding Lead will contact the student's parents or guardian and, when appropriate, assist the family with urgent referral
- Where high risk has been identified and the parents cannot be reached, the DSL may call the emergency services or bring the student to the nearest A&E

Levels of risk and intervention

Risk level	Presentation	Initial Actions	Service Options
Low	Self-harm as coping mechanism; Fleeting thoughts of suicide but no intent or plan; Protective factors evident including support network, hope of recovery seeking help.	Acknowledge distress, identify options to address underlying difficulties and agree a plan with the young person; Clarify confidentiality and issues of consent Encourage young person to tell parents; Parents to be informed within a reasonable timeframe if risk remains.	School counsellor; Self-help resources and online information; In-school monitoring (DSL – weekly)
Medium	Suicidal thoughts frequently but no specific plan or immediate intent; Evidence of persistent symptoms of mental ill health in particular depression, anxiety, or psychosis; Significant alcohol and/or substance abuse; Previous suicide attempts; Current self-harm;	Acknowledge distress, identify options to address underlying difficulties and agree a plan with the young person, including clear plan for follow-up; Plan must include actions to be taken if distress increases or suicidal thoughts become more persistent of difficult to resist i.e. a safety plan;	In-school counselling; In-school medical team; Self-help resources and online information; Referral to GP; Consider professional consultation with CAMHS;

	Reluctance to share with support network or withdrawal from peers and/or family.	Clarify confidentiality and inform parents. Think about phrasing again	In-school monitoring (DSL – weekly)
High	Frequent suicidal thoughts with increased intensity which are difficult to ignore; Some planning / intent or ambivalence; Research of potential lethal means; Access to means; Previous suicide attempts; Significant alcohol and/or substance use; Withdrawal from support network; Evidence of persistent symptoms of mental ill health, especially depression, anxiety or psychosis; Family history of, or peer suicide.	Acknowledge distress, identify options to address underlying difficulties and agree a plan with young person to include a clear plan for follow up – this will include immediate actions to be taken i.e. GP appointment, urgent referral to CAMHS, A&E; Clarify confidentiality and inform parents and GP	GP; CAMHS; Increased support from existing network; Increased monitoring and review (DSL – daily)

Suicide-Safety plan

A good suicide-safety plan always includes the following:

- Why do I want to stay safe?
- Making my environment safe
- Helpline numbers that are available and appropriate, including 24-hour helplines.
- Safety contacts: people and organisations that the young person can contact when they feel they cannot keep themselves safe, including a safety contact for when they are at school
- Professional support from a counsellor or therapist

Below is an example from Papyrus

https://papyrus-uk.org/wp-content/uploads/2018/10/Suicide-Safety-Plan-Template-1.pdf

Appendix V

Bereavement

Every 22 minutes in the UK, a parent of dependent children dies, leaving about 41,000 bereaved children each year. Many more are bereaved of a grandparent, sibling, friend or a significant other, and, sadly, around 12,000 children die in the UK each year.

The role of the pastoral staff

- To have bereavement support training and cascade learning to other staff
- To establish and co-ordinate links with external agencies where necessary
- To support the bereaved student

Procedures

- Contact with the deceased's family should be established by the High Mistress, and the family's wishes in communicating with others.
- Head of Year / Director of Pastoral care will meet with the bereaved student and offer support; counselling will be offered.
- Staff should be informed before pupils and be prepared to share information in age-appropriate ways, as agreed for each individual circumstance.
- Where appropriate, pupils should be informed, preferably in small groups, by their form tutor. A decision should be made as to whether this information should be given as part of a whole-school approach or if only certain groups of pupils need to be informed.
- In the situation of the death of the parent or sibling of a student, the deceased's family may decide that the school contact their daughters' friends' parents.
- The school should be aware that the school timetable may need a degree of flexibility to accommodate the needs and wellbeing of children affected by the situation. However, minimal disruption to the timetable also offers a sense of security and familiarity.
- In consultation with the bereaved family, arrangements for funeral attendance may be clarified.
- School should be aware that the impact of bereavement follows a child through their school life, so information should be recorded and shared with relevant people, particularly at transition points. The pastoral team should be aware of anniversaries where possible.
- The form tutor / Head of Year should have regular contact with the bereaved student; conversations need not always focus on grief.

Helpful resources:

- Griefcast: funny people talking about death and grief. Hosted by Cariad Lloyd.
- Child Bereavement UK
- Rainbows for all Children
- Cruse Bereavement Care
- Samaritans 116 123
- Childline 0800 1111
- The Mix 0808 808 4994
- 10 ways to support a bereaved friend
- Help2makesense
- R. Abrams (1995) When Parents Die. Routledge: London

Appendix VI

Youth Mental Health First Aiders

Name	Location	Tel:
Sophie Corthine	PE Office	020 7605 4829
Kate Frank	Lower School Office	020 7605 4803
Anna Foster	Staffroom	020 7605 1128
Sydne Derbyshire	Middle School Office	020 7605 4893
Kaarin Scanlan	Middle School Office	020 7605 4859
Emilie Eymin	Senior School Office	020 7605 1106
Linda Kelley	Library	020 7605 4809
Tom Peck	Staffroom	020 7605 4806

If a member of staff is unavailable on their departmental number, please try the staff room on 020 7605 4806

St. Paul's Girls' School, Brook Green, London, W6 7BS – updated April 2019

Appendix VII

Further Reading and Useful Links

HM Government (2011), *No Health Without Mental Health*, Department of Health

Websites

b-eat: http://www.b-eat.co.uk/

Childline: http://www.childline.org.uk

Mind: http://www.mind.org.uk/

NHS: http://www.nhs.uk/livewell/mentalhealth/Pages/Mentalhealthhome.aspx

Mental Health Foundation: http://www.mentalhealth.org.uk/

Stem4: http://www.stem4.org.uk/

Royal College of Psychiatrists: http://www.rcpsych.ac.uk/expertadvice/youthinfo/parentscarers.aspx

Eating Disorders Support: http://www.eatingdisorderssupport.co.uk/help/links-resources

Beat Eating Disorders: https://www.beateatingdisorders.org.uk/

Anorexia Bulimia Care: http://www.anorexiabulimiacare.org.uk/family-and-friends/parents

Anna Freud - self-harm: https://soundcloud.com/anna-freud-centre/why-do-some-people-self-harm

Harmless: http://www.harmless.org.uk/

Young Minds https://youngminds.org.uk/find-help/for-parents/parents-helpline/

National Self Harm Network: http://www.nshn.co.uk/

Youth wellbeing directory: https://www.annafreud.org/on-my-mind/youth-wellbeing/

Useful contacts

Papyrus – HOPEline UK	HOPELineUK offers support and advice: To children and young people under the age of 35 having thoughts of suicide To anyone who is concerned about a child or young person Call: 0800 068 41 41 Text: 07786 209 697 Email: pat@papyrus-uk.org Monday – Friday 10am – 10pm Weekends 2pm – 10pm Bank Holidays 2pm – 5pm

National Suicide Prevention Alliance	http://nspa.org.uk
Support after Suicide Partnership	http://supportaftersuicide.org.uk
Child Bereavement UK	Child Bereavement UK provides support to families grieving the loss of a child, and advice for professionals working with bereaved families Phone: 01494 568 900 www.childbereavement.org.uk
Crisis / Mental Health Crisis	West London Mental Health Trust 24-hour phone line: 0300 1234 244
ChildLine	Phone: 0800 11 11 Counselling chat https://www.childline.org.uk/get-support/1-2-1-counsellor-chat/ Email https://www.childline.org.uk/get-support/
Samaritans	Phone: 116 123 Email: jo@samaritans.org
Young Minds	Young Mind offers advice and support to parents worried about their children's emotional or mental wellbeing Phone 0808 802 5544 www.youngminds.org.uk
Emergency Services	999
Child and Adolescent Mental Health Clinic	Hammersmith & Fulham CAMHS 48 Glenthorne Road, W6 0LS Phone: 020 8483 1979 Ealing CAMHS 1 Armstrong Way UB2 4SA Phone: 020 8354 8160 Hounslow CAMHS Heart of Hounslow Centre for Health 92 Bath Road TW3 3EL Phone: 020 8483 2050
Other resources	www.verywellmind.com

	https://www.mind.org.uk/information-support/types-of-mental-health-problems/suicidal-feelings https://www.samaritans.org/sites/default/files/kcfinder/files/SbS%20information_for_staff.pdf https://www.samaritans.org/sites/default/files/kcfinder/files/SbS%20information_for_students.pdf https://afsp.org/