Ruthin School

MENTAL WELLBEING POLICY	
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Mental Wellbeing Policy

Background References:

· Wellbeing of Future Generations (Wales) Act 2015.

· Public Health England (March 2015) Promoting children and young people's emotional health and wellbeing; A Whole school and college approach

· WAG (August 2010) Thinking Positively 089/2010

· NAW (April 2018) Mind over Matter- A report on the step change needed in emotional and mental health support for children and young people in Wales.

· British Psychological Society (BPS) (June 2019) Briefing Paper – Promoting mental health & wellbeing in schools

Future guidance is expected from WAG : Framework Guidance on Embedding a Whole School Approach to Emotional Wellbeing and Mental Health

Ruthin School's primary and overriding concern is the welfare of the pupils; all other considerations are subsidiary. Ruthin School is committed to supporting the mental health and emotional wellbeing of our pupils We are a supportive, caring and respectful culture. Positive mental health is everyone's responsibility.

This policy is a guide to all staff; teachers, support and boarding staff and Committee of Management ("COM") trustees. It outlines the School's approach to mental health and wellbeing and should be read in conjunction with all other relevant policies/guidelines and documentation produced by the School.

Aims

The central aims of this policy are:

- to demonstrate commitment to, and promotion of, the positive mental health and emotional wellbeing of our pupils
- to outline how we promote good mental health and welfare
- to promote the welfare of all pupils throughout the curriculum
- to promote School values and a sense of belonging to the School community
- to provide opportunities to enhance self-worth and self-reflection
- to celebrate each pupil as an individual, both academic and non-academic achievement
- to promote "pupil voice"
- to help pupils understand their emotions and experiences better and ensure they are comfortable sharing concerns and worries
- to help pupils form and maintain healthy relationships
- to help pupils develop resilience and positive coping strategies
- to encourage pupil confidence and promote self-esteem
- to outline the services and provision that we offer
- to ensure, as far as is possible, that every pupil is able to benefit from and make his/her full contribution to the life of the School, consistent always with the needs of the school community
- to raise awareness amongst all staff and pupils and facilitate early recognition/warning signs of developing problems
- to ensure that staff are appropriately informed about procedures involving a pupil with mental health difficulties
- to involve parents, School's internal support, and external agencies wherever appropriate
- to ensure that Ruthin School is inclusive
- to ensure that Ruthin School meets all relevant statutory requirements

Parents will be encouraged to:

- Endorse the School's approach to pastoral care through its school policies and its pastoral system of tutors, pastoral leaders, boarding staff and pastoral head.
- Work in partnership with the School in promoting and maintaining the wellbeing of their child
- Respond to the reasonable requests from School for help, assistance, and guidance

Background

Children can: develop psychologically, emotionally, intellectually and spiritually; initiate, develop and sustain mutually satisfying personal relationships; use and enjoy solitude; become aware of others and empathise with them; play and learn; develop a sense of right and wrong; and resolve (face) problems and setbacks and learn from them.

An important key to promoting children's and young people's mental health is therefore an understanding of the protective factors that enable them to be resilient when they encounter problems and challenge. Resilience involves several related elements: firstly, a sense of self-esteem and confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem-solving approaches.

The role that schools play in promoting the resilience of their pupils is important, particularly so for some children where their home life is less supportive. Adverse Childhood Experiences (ACEs) are serious childhood traumas that result in toxic stress that can harm a child's brain. This toxic stress may prevent a child from playing in a healthy way with other children and can result in long term problems. Ruthin School aims to be a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems. The adults will help to guide, signpost and refer issues or problems appropriate to their role.

Principles of a Whole School Approach

A whole school approach seeks to support good mental health by building resilience and focusing on prevention and early intervention. When more targeted approaches are needed, it seeks to tackle existing or developing mental illness, and work together with other services in a timely fashion to provide appropriate interventions.

Everyone involved with the school places *wellbeing* at the heart of all they do. Inclusion is valued, where everybody works together, contributing their skills and resources to the collective good. There is a shared understanding of what constitutes a supporting environment where young people are encouraged to fulfil their personal and academic potential, supported by staff who operate in a culture which values everyone's wellbeing.

In order for leadership and management to be effective, school leaders must be able, and expected, to demonstrate a focus on creating a whole school approach to mental health and psychological wellbeing that is recognised and understood by all staff.

The recognised eight dimensions or principles of a whole school approach are:

- Leadership and management

Support from the senior leadership team is essential to ensure that efforts to promote emotional health and wellbeing are accepted and embedded.

– School ethos and environment

The environment in which staff and pupils spend a high proportion of every week day has been shown to affect their physical, emotional and mental health and wellbeing, as well as impacting on attainment.

– Curriculum, teaching and learning

School-based programmes of social and emotional learning can help young people acquire the skills they need to make good academic progress as well as benefit pupil health and wellbeing.

– pupil voice

Involving pupils in decisions that impact on them can help them to feel part of the school and wider community, and to have some control over their lives.

– Staff development, health and wellbeing

It is important for staff to access training to increase their knowledge of emotional wellbeing and to equip them to be able to identify mental health difficulties in their pupils. Promoting staff health and wellbeing is also an integral principle of the whole-school approach.

– Identifying need and monitoring impact

Education settings can use a variety of tools to understand and plan a response to pupils' emotional health and wellbeing needs. Defining pupil need on a more formal basis can help to inform commissioning decisions at school level, across clusters or at a local authority level. It is also important to record and monitor the impact of any support that is put in place.

– Working with parents/carers

Families play a key role in influencing children and young people's emotional health and wellbeing.

– Targeted support

Some children and young people are at greater risk of experiencing poorer mental health and will need targeted support.

We aim to be a "talking school". Pupils have an opportunity to talk to their peers and the tutor system, which is vertical allowing pupils to talk to older peers in their group. Pupils can talk to whichever member of staff they feel most comfortable doing so, be it personal tutor, member of the Pastoral Team, boarding house staff, nurse etc. If they find it hard to report directly, they can use the reporting boxes around school. These are all checked on a weekly basis by the Designated Safeguarding Person ("DSP") and will be actioned as required.

Ruthin School is a highly academic institution. In a world where children and young people are at growing risk of mental health issues, we acknowledge that the likelihood of these issues occurring amongst our pupils may be increased as perfectionist tendencies can be a common personality trait of our pupils as they seek to do well in this highly competitive environment.

Young people are inclined to compare themselves to their peer group; where this remains balanced and in proportion, this is simply a reflection of life out in the real world and managing it is a good skill for the pupils to learn. Where this results in a pupil judging themselves negatively however, it is detrimental, and staff at Ruthin School are very aware that this is an issue that needs to be monitored, and managed promptly and effectively, otherwise it can become very damaging to that pupil's self-confidence and self-esteem. Staff at Ruthin School are committed to creating and maintaining a culture within the school that values all pupils. This is achieved through

the merit system which allows pupils to gain rewards other than academic, the house activities competitions also reward pupils who do not always get recognised academically. Assemblies are also used to reward pupils in all forms of recognition. This allows them to feel a sense of belonging, and makes it possible to talk about problems in an open and honest way.

Key Staff / Wellbeing Team

In addition to the pupil's parents, the main people who are likely be involved in the pupil's care and wellbeing whilst they are at Ruthin School are:

- the pupil's Personal Tutor
- the Pastoral Team
- the Boarding House Staff
- the Nursing Team
- the Headmaster
- the Head of Faculties
- the Designated Safeguarding Person
- the School Counsellor
- the Independent Listener

All staff have a duty of care for any individual pupil and it follows therefore that information generally needs to be shared around the Wellbeing Team which is made up of a team of individuals (listed above) who all play their part in providing the pupil with the care and support that they need. It will be explained to the pupil that some, or in rare occasions, all of these people will know about their situation, on a need to know basis, but that the information will not go beyond the Wellbeing Team if the pupil does not want it to (unless it is in the pupil's best interest for this to happen). The pupil can identify the individual within the Wellbeing Team to whom he/she feels most comfortable talking if appropriate.

The various individuals of the Wellbeing Team will also:

- Inform the pupil's parents if appropriate. The pupil will always be encouraged to keep their parents informed. If however a pupil has strong feelings about this a decision will be made depending on the age and competency of the pupil. Parents will generally be informed unless:
  (i) a pupil is deemed to be (Gillick) competent to make the decision otherwise, or
  (ii) it is deemed to be in the best interests of the pupil for the parents not to know
- Be aware of when it is essential for other professional bodies to be informed, such as social services or the DSP;
- Monitor the help, support and progress of the pupils in their care and maintain communication with them;
- Maintain communication with the parents;
- Liaise with each other to decide if any other members of staff who have contact with the pupil should be made aware of the situation and underlying concerns;
- Hold multi agency meetings in school with the Wellbeing Team if deemed appropriate;
- Observe other pupils that may be affected and ensure that adequate support is given to them;
- Remind friends that they are not responsible for their friend's issues or recovery;
- Be mindful of other pupils' reactions to the situation.

1. **The Personal Tutor**. Each pupil is allocated a personal tutor when he or she arrives at Ruthin School. The pupils meet with their tutor weekly in tutor groups for one hour and as often as necessary thereafter individually. Pupils have the opportunity to go and have time out in the Pastoral Leader's room. The Personal Tutor is the member of staff who has the overview of a pupil workload. It is possible at times for pupils' workloads to become unbalanced and pupils are encouraged to discuss this with their personal tutors if they need support with organising their time and perhaps arranging for their workload to be reduced, either temporarily (e.g. at times of exams, coursework deadlines, etc) or permanently if the pupil has simply too much on.

2. **The Boarding House Staff** is led by the Head of Boarding and House Masters and Mistresses. The House Staff's job is to ensure pupils lives run smoothly. Pupils are encouraged to talk to House staff about any problems or worries at all especially those not involving the curriculum. It is the House Master/Mistress job to help sort these issues out, however small or large.
3. **The Headmaster.** This person leads the overview of the pupils' academic and holistic life. He works closely with the DSP and Pastoral Team.
4. **The Pastoral Team** is led by the DSP, their deputy and nominated members of the teaching staff.
5. **The Nursing Team**. There is a nurse on duty every day with a full day service 7 days a week and pupils often talk to them about issues that they are having trouble resolving. Nurses do not expect to be consulted solely about physical problems; they will discuss and advise upon mental health issues as well. Nurses owe a duty of confidentiality to all those who receive their care unless the pupil is at risk of harm.
6. We also have our own **School Doctors** (from the local GP surgery) who can refer, advise and treat both physical and mental health issues and refer on for specialist help as necessary.

Counselling Services. Pupils can ask to be referred to a counsellor for less severe anxiety, worries, low mood type problems. This offers a fast route into counselling for children needing to talk and or gain additional support. The first consultation is paid by the school and afterwards by parents as and when required.

Designated Safeguarding Person. The DSP and deputy DSP work closely together with the whole of the Wellbeing and Pastoral Teams.

Mental wellbeing. The School recognises that there will be pupils who will need additional support at times. Pupils learn about the importance of wellbeing and resilience through their PSHE lessons and their tutor group. Pupils are encouraged to talk to someone as soon as they feel they are not coping. Early intervention is the key. Pupils are taught that asking for help is positively encouraged.

Physical wellbeing. Physical wellbeing is important to mental wellbeing. Pupils are encouraged to exercise and enjoy the many different activities which the School offers. The gym (for over 16s) and swimming pool are available at the Sports Hall across the road.

Sizing up the problem. Pupils who are experiencing problems with eating, self-harming behaviours, anxiety, stress or depression will be encouraged to see one of the nursing team for an assessment of the extent of the problem. Healthy eating is promoted throughout the school and especially in PSHE lessons and tutor time. The main dining hall experience promotes healthy eating in the menu and with the availability of fruit throughout the day.

Range of mental health problems. From mental health to mental illness, there is a spectrum which can range from initial home sickness through to serious psychiatric disorder, spanning a wide range of emotional, behavioural and psychological problems. The majority of mental health problems originate during childhood through to late adolescence.

The issues:

- Ensuring that pupils understand that asking for help is a sign of strength not weakness
- Developing resilience
- Managing the competitive element
- Managing pupils' expectations of themselves, which are sometimes unrealistic.
- Perfectionist tendencies
- Stress
- Anxiety and depression
- Deliberate Self Injury
- Eating disorders
- Tic disorders
- Obsessive Compulsive Disorder

- More serious mental illness

Procedure for care of a Pupil with a mental health concern:

New Admissions

The admission to Ruthin School is subject to a fully completed medical questionnaire. For overseas pupils the process of issuing a visa will not be started until the completed questionnaire is returned to the Registrar.

For prospective pupils where any mental health concerns are highlighted on the pre-admission Medical Questionnaire, they will be discussed on an individual basis, by the nursing team (+/- the School Doctor) Pastoral Team & DSP, & Head of Boarding/House Master/Mistress. Currently one of the Trustees is a retired child and adolescent psychiatrist and is able to offer input if required.

The School will consider all applications on a case by case basis and consider whether any adjustments are required, and if so, whether they are reasonable for the school to put in place.

Pupils with well-controlled symptoms, and without serious side-effects from medication should be considered for entry to the School, and a Boarding house place. Entry will require a full care plan from the Wellbeing Team (School Nurse, doctor, DSP, Head of Boarding and on advice from the pupil's Consultant/CAMHS team as appropriate). Possible conditions include healthy weight anorexia nervosa, pupils with anxiety and depressive disorders, and tic disorders (Tourette Syndrome) well-controlled on medication and able to function normally in a classroom setting. Any pupil at risk of deliberate self-harm or with suicidal ideation, or serious mental illness would potentially be a safeguarding risk as the School does not have the appropriate resources to support and maintain their safety. If the pupil is acutely unwell with mental illness for example (but not exhaustive); moderate to severe depression, psychosis (Schizophrenia, Bi-polar disorder), the high academic pressure of Ruthin School, and the boarding environment will not be a safe environment. For pupils where there is a lower level of concern referral may be made to the School Doctor and/or the counsellor (currently Senga Shaw). For pupils who are taking medication prescribed by their consultant, but unlicensed in the UK, they will be required to be assessed in the UK before being considered for admission (see Medication Policy for more information).

Current Pupils

Where a pupil is observed to be experiencing difficulties, the School will consider all instances of mental health issues experienced by a current pupil on a case by case basis and consider whether any adjustments are required to and if so, whether they are reasonable for the school to put in place.

If a current pupil of the School experiences mental ill health, the pupil will be asked to talk to one of the pastoral team (as appropriate). If the pupil is not willing to accept support at this stage, the Pastoral Team will liaise as to the appropriateness or otherwise of monitoring from a distance or more directly. If the suggestion of extra support is accepted the nurse will make an assessment & will ascertain the extent of the problem, discuss any underlying issues, liaise with other relevant staff and assess whether the pupil should be referred for internal support (from the school counsellor) or referred via the School Doctor to CAMHS. The school nurse can also make a referral in some cases.

If the pupil is being treated and is well and maintained, whether on medication or not, the School will consider whether any reasonable adjustments can be made to enable them to remain at School.

If any current pupil experiences serious mental illness, the same safeguarding risk detailed above may apply. If a current pupil is undergoing psychiatric treatment but is unstable, the Boarding house and School may not be appropriate and safe environments for them. For pupils who are acutely unwell, planned arrangement for safe return home (as with physically unwell pupils) may be made.

Remaining in School

For pupils with mental health problems who remain in school it is expected:

- That where it is felt that intervention is needed, the pupil is willing to accept a referral for support to address the underlying issues that are causing the problems;
- That the professional to whom the referral is made confirms that it is appropriate for the pupil to be in school;
- That the pupil complies with specific expectations and care plans;
- That the pupil talks to the appropriate staff member (rather than other pupils) if he/she is in emotional distress;
- That we work together to keep the child safe from harm.

A Key worker will oversee and be the point of all contact for every pupil with a mental health concern. In most cases this will be a member of the Pastoral Team.

If academic work restriction is recommended by professionals in order to aid recovery, then a period of absence from School may be recommended. This would always be decided in conjunction with the specialist health care agencies, the School and parents and would be part of the support plan.

NB In some situations, the School may not be able to implement the necessary care. Some pupils will be better managed at home or in an in-patient situation. Again, this decision will be made in conjunction with the relevant professionals involved.

For pupils who are required to take medication – please refer to the medication policy.

Advice for Staff if a mental health problem is suspected.

- make it known to the pupil that you are available to listen;
- never promise confidentiality;
- remain calm and non-judgemental at all times;
- don't dismiss a pupil's reasons for distress as invalid or trivial;
- encourage the pupil to be open with you and reassure them that they can get the help they need if they are willing to talk;
- try and enable the pupil to feel in control by asking, for example, what help they feel they need;
- report the matter to the appropriate member of the Pastoral Team, and to the nurse on duty, inform the pupil that you are doing this. If they are not happy about this explain to them carefully and clearly that in your position as a member of staff, you have to follow the designated procedure. Reassure them that the nurses and Pastoral Team have lots of experience dealing with such situations and the matter will be dealt with sympathetically and discreetly and they, the pupil, will be consulted at all times;

The Grey Area

There is a fine line between vigilance and intervention.

It is vital that staff be vigilant and look out for any possible warning signs (see separate appendices) and report those concerns to the Pastoral Leads, DSP, School Nurses or on 'my concern'.

Recognising the Risks and Symptoms

Please see appendices for details of the separate issues.

The PSE Programme. This is timetabled into the curriculum as a separate lesson. The syllabus is balanced and appropriate following the government guidelines for PHE.

Parents will be encouraged to endorse the school's approach to the management of pupils' wellbeing and to work in partnership with the school. Parents are welcome to discuss their concerns or queries with the nursing or Pastoral Team at any time.

Other sources of support and information:

- Young Minds is a charity committed to improving the emotional wellbeing and mental health of children and young people. They undertake campaigns and research, make resources available to professionals (including teachers) and run a helpline for adults worried about the emotional problems, behaviour or mental health of anyone up to the age of 25. www.youngminds.org.uk
- CAMHS is the NHS referral service to which pupils can be referred for diagnosis and treatment.
- Anna Freud resources. The Anna Freud Centre is committed to empowering and enabling other organisations to support the mental health and wellbeing of children and young people wherever they may be. They provide resources for school and individuals.
- Mind Cymru Tel: 02920 395123 www.mind.org.uk/about-us/mind-cymru

- Moodjuice
- NHS website
- NSPCC

APPENDICES

Appendix A **Risk and protective factors for child and adolescent mental health**

Appendix B **Dealing with Anxiety, Stress and Depression**

Appendix C **Dealing with Eating Disorders**

Appendix D **Deliberate Self Injury (DSI)**

Appendix E **Dealing with Tic Disorders**

Appendix F **Dealing with Obsessive Compulsive Disorder (OCD)**

Appendix G **Dealing with Attention Deficit Hyperactivity Disorder (ADHD)**

Appendix H **Autistic Spectrum Disorder**

Appendix I **Individual Healthcare Plan**

Appendix A Risk and protective factors for child and adolescent mental health

	Risk factors	**Protective factors**
In the child	• Genetic influences • Low IQ and learning disabilities • Specific developmental delay or neuro-diversity • Communication difficulties • Difficult temperament • Physical illness • Academic failure • Low self-esteem	• Being female (in younger children) • 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 or rejecting relationships • Failure to adapt to a child's changing needs • Physical, sexual 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 pupil 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 events	• 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

Appendix B Dealing with Anxiety, Stress and Depression

Anxiety. Anxiety problems can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but they tend not to impact on their environment.

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 these symptoms become persistent or exaggerated, then specialist help and support will be required.

Stress. A small amount of stress is a positive force as it drives us on to achieve. When this gets out of balance however, it will have a negative impact and the pupil will start to feel overwhelmed and unable to cope.

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.

1. Recognizing the warning signs

Children who are anxious, stressed or depressed can become lethargic, unable to concentrate, and their school work is likely to degenerate. The main warning signs are:

- Persistent sadness, anxiety or generally low mood
- Loss of interest
- Lethargy or decreased energy
- Irregular sleep or change in sleep pattern
- Appetite or weight changes
- Increased tearfulness
- Restlessness
- Poor concentration and difficulty making decisions
- Hopelessness and pessimism
- Feelings of helplessness
- Feelings of worthlessness or guilt
- Thoughts of death or suicide

Appendix C Dealing with Eating Disorders

1. 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 bingeing. They vomit or take laxatives to control their weight. Both of these eating disorders affect girls and boys but are more common in girls. **Follow Advice for Staff and Teachers if a problem is suspected**

1. What are eating disorders?

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

2. What eating disorders are not

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

3. Risk factors associated with eating disorders

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

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

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

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

4. Recognizing the Warning Signs

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

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

6. Anorexia Nervosa

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

- Rapid weight loss or, failure to develop and gain expected weight during a growth spurt.
- Hormone disturbance – shows as an absence of periods in females and affects sperm development in males but may only become evident as a lack of interest in sex in late teenage years.
- Loss of calcium from bones means that bones may break more easily than would be expected in someone young.
- Other physical effects of starvation and dehydration may include constipation, swollen stomach and ankles, dizziness, poor circulation shown in coldness, blue fingers and toes, and growth of fine downy hair on the face and body.
- Fears around being 'fat' and overweight, and being weighed.
- Fears around shape - the mind of an anorexic shows them as 'fat' when they look in the mirror when others see them as a virtual skeleton.
- A belief that the more weight they lose the closer they come to being worthwhile.
- Feelings of paranoia that people are staring at them because they are fat and 'ugly'.
- If challenged, they deny that have a problem and refuse to believe they are dangerously thin.
- They are unable to accept rational argument around their eating habits and weight.
- Personality changes may include violence, mood swings and depression.
- Sufferers become secretive around food, their body and their eating habits. They may claim to have eaten when they have not.
- Rituals and superstition may build up around food and drink: specific times when 'meals' may be eaten, precise measurements of portions and the way food is prepared and presented. Being faced with the need to eat outside of these conditions may lead to panic.
- Excessive exercise is often linked to eating disorders as is inappropriate use of large numbers of laxatives or diuretics.
- Panic attacks.

7. Bulimia

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

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

8. Binge Eating Disorder

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

- There may be steady or sudden weight gain or marked fluctuation in weight if yoyo dieting is involved.

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

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

9. The Grey Area

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

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

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

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

As Eating Disorders can often start in early teenage years, staff at Ruthin School may encounter pupils that could be a) prior to the start of an eating disorder, b) in the early stages of an eating disorder or c) perhaps more established eating disorders when pupils enter a Sixth Form.

It is vital that staff be vigilant and look out for any possible warning signs and report those concerns on to the Pastoral Team and nurses, Head of House and/or the School Nursing Team.

1. Procedure for Care of a pupil with a suspected eating disorder:

A pupil who has a suspected eating disorder will be asked to see the School Nurse about receiving support.

The nurse will ascertain the extent of the problem and will refer to the School Doctor, and from there to external organisations for support. The School will support a pupil with an eating disorder to continue with their studies and life in school provided;

- the pupil is willing to address the underlying issues that are causing the problems and therefore will accept a referral for support;
- the pupil cooperates with treatment and care plans and maintains the agreed BMI
- the pupil to the appropriate staff member (rather than other pupils) if he/she is in emotional distress;
- That the appropriate staff, day & boarding, Pastoral Team, nurses, School Doctor, &/or external organisations are in agreement that the School (& Boarding House environment) is the appropriate environment for the pupil.

Physical movement restriction may be imposed until target weight is gained (in anorexia). This would always be decided in conjunction with the specialist health care agencies and would form part of any care plan.

11. Strategy to prevent the spread of eating disorders within the School

- Close monitoring of pupils who have been in contact with another pupil with an eating disorder.
- Informal discussion groups within School & the boarding house, led by the Pastoral Team and/or medical staff.
- Information about Eating Disorders is delivered as part of PSHE, ensuring raised awareness and understanding within the pupil body.
- Encouraging an open attitude to eating disorders, where pupils and staff feel comfortable to discuss and raise concerns where necessary.
- Training opportunities are offered to staff who have a particular interest in the subject. This will be refreshed at regular intervals to keep knowledge up to date.
- Eating disorders will periodically feature in mental health \& wellbeing training for staff.

Appendix D Deliberate Self Injury (DSI)

1. What is DSI?

DSI is a coping mechanism. An individual causes harm to their physical self to deal with emotional pain, or to break feelings of numbness by arousing sensation.

Self-injury is any deliberate, non-suicidal behaviour that inflicts physical harm on the body and is aimed at relieving emotional distress. It can become a natural response to the stresses of day-to-day life and can escalate in frequency and severity.

DSI can include, but is not limited to, scratching, cutting, burning, banging and bruising, non-suicidal overdosing and even deliberate bone-breaking.

People who self-injure usually make a great effort to hide their injuries and scars, and they are often uncomfortable about discussing their emotional inner or physical outer pain. It can be difficult for young people to seek help perhaps due to the stigma associated with seeking help for mental health issues.

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

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

3. What self-injury is not

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

4. Risk factors associated with self-injury

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

Risk factors include, but are not limited to:

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

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

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

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

- Drug and/or alcohol misuse or risk-taking behaviour;
- Negativity and lack of self-esteem;
- Out of character behaviour;
- Bullying other pupils;

- A sudden change in friends or withdrawal from a group.

6. Suicide

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

7. Physical signs that self-injury may be occurring

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

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

- make it known to the pupil that you are available to listen;
- never promise confidentiality;
- remain calm and non-judgemental at all times;
- don't dismiss a pupil's reasons for distress as invalid or trivial;
- don't ask a pupil to show you their scars or describe their self-injury;
- never ask a pupil to stop self-injuring - you may be removing the only coping mechanism they have;
- encourage the pupil to be open with you and reassure them that they can get the help they need if they are willing to talk;
- report the matter to the DSP and Nurses and tell the pupil that you are doing this. If they are not happy about this explain to them carefully and clearly that in your position as a member of staff, you have to follow the designated procedure. Reassure them that the nurses and DSP have lots of experience dealing with such situations and the matter will be dealt with sympathetically and discreetly and they, the pupil, will be consulted at all times;
- a pupil's biggest worry is often that they will be sent home if it is known that they self-injure. Reassure the pupil that this is not the case as long as they comply with certain conditions (outlined below at para 10).

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

- Remain calm
- Ascertain the extent of the injury (in this situation you can ask to see the injury)
- Contact the nursing staff immediately for **all** suspected overdoses and severe bleeding. Alternatively ring 999 for an ambulance and then let the Head of Boarding and DSP know.
- For less severe injuries explain to the pupil that they must attend the nurse to have their cuts assessed and dressed properly. Contact the nurse to let her know you are on your way up and then escort the pupil up there.
- Report any mention of suicidal feelings or behaviour as a matter of urgency to the nurse;

10. Procedure

A pupil who is self-injuring will be asked to talk to the nurse about receiving support. The nurse will discuss the underlying reasons for the self-injury and, in conjunction with the appropriate members of the Pastoral Team the pupil is referred to external organisations for support namely CAMHS via the School Doctor. The School will support a pupil who is self-injuring to continue with their studies and

life in school provided

- the pupil is willing to address the underlying issues that are causing the pupil to self-injure and therefore will accept a referral for support;
- the pupil is open and honest with the nurse about the extent of the injuries and will attend as appropriate for injuries to be assessed, treated and dressed;
- the pupil does not display open wounds/injuries;
- the pupil talks to the appropriate staff member (rather than other pupils) if he/she is in emotional distress;
- that the School can keep the child safe from significant harm

Appendix E Dealing with Tic Disorders

1. Overview

Tics are fast, repetitive muscle movements that result in sudden and difficult to control body jolts or sounds.

They're fairly common in childhood and typically first appear at around 5 years of age. Very occasionally they can start in adulthood.

Tics are not usually serious and normally improve over time. But they can be frustrating and interfere with everyday activities.

Tourette's syndrome is a term that's used when tics have lasted for more than a year, is covered separately. **Types of tics**

There are many types of tic. Some affect body movement (motor tics) and others result in a sound (vocal or phonic tics).

Examples of tics include:

- blinking, wrinkling the nose or grimacing
- jerking or banging the head
- clicking the fingers
- touching other people or things
- coughing, grunting or sniffing
- repeating a sound or phrase – in a small number of cases, this may be something obscene or offensive

Tics can happen randomly, and they may be associated with something such as stress anxiety, tiredness as excitement or happiness. They tend to get worse if they're talked about or focused on.

They often start with an unpleasant sensation that builds up in the body until relieved by the tic – known as an urge – although they can sometimes be partly suppressed.

Tics are not usually serious, and they do not damage the brain.

A referral to the GP is not usually necessary if they're mild and not causing problems. Sometimes they can disappear as quickly as they appear.

Referral to a GP if there is concern about the child's tics, for support or advice, or the tics:

- occur very regularly, or become more frequent or severe
- cause emotional or social problems, such as embarrassment, bullying, or social isolation
- cause pain or discomfort (some tics can cause the person to accidentally hurt themselves)
- interfere with daily activities, school or work
- are accompanied by anger, depression or self-harm

A GP should be able to diagnose a tic from a description of it and, if possible, seeing it. Recording a short video can be helpful but be careful not to draw too much attention to the tic while filming as this can make it worse.

Treatments for tics

Treatment is not always needed if a tic is mild and is not causing any other problems. Self-help tips such as avoiding stress or tiredness, are often very helpful for the majority of people. If a tic is

more severe and is affecting everyday activities, therapies that aim to reduce how often tics occur may be recommended.

The main therapies for tics are:

- Habit reversal therapy – this aims to help a child learn intentional movements that "compete" with tics, so the tic cannot happen at the same time
- Comprehensive behavioural intervention for tics (CBIT) – a set of behavioural techniques to help learn skills to reduce tics
- Exposure with response prevention (ERP) – this aims to help a child get used to the unpleasant sensations that are often felt just before a tic, which can stop the tic occurring

There are also medicines that can help reduce tics. These may be used alongside psychological therapies or after trying these therapies unsuccessfully.

How long do tics last?

In most cases, tics improve over time or stop completely.

Sometimes they may just last a few months, but often they come and go over several years.

They are normally most severe from around 8 years of age until teenage years, and usually start to improve after puberty.

Causes of tics

It's not clear what causes tics. They're thought to be due to changes in the parts of the brain that control movement.

They can run in families, and there's likely to be a genetic cause in many cases. They also often happen alongside other conditions, such as:

- Attention Deficit Hyperactivity Disorder
- Obsessive Compulsive Disorder

Tics can sometimes be triggered by taking illegal drugs, such as cocaine or amphetamines, and are occasionally caused by more serious health conditions such as cerebral palsy or metabolic diseases.

Tourette's syndrome is a condition that causes a person to make involuntary sounds and movements called tics

It usually starts during childhood, but the tics and other symptoms usually improve after several years and sometimes go away completely. There's no cure for Tourette's syndrome, but treatment can help manage symptoms.

People with Tourette's syndrome may also have

- Attention Deficit Hyperactivity Disorder
- Obsessive Compulsive Disorder

Symptoms of Tourette's

Tics are the main symptom of Tourette's syndrome. They usually appear in childhood between the age of 5 and 9.

People with Tourette's syndrome might have both physical and vocal tics.

Examples of physical tics:

- blinking
- eye rolling
- grimacing
- shoulder shrugging
- jerking of the head or other limbs
- jumping
- twirling
- touching objects and other people

Examples of vocal tics:

- grunting
- throat clearing
- whistling
- coughing
- tongue clicking
- animal sounds
- saying random words and phrases
- repeating a sound, word or phrase
- swearing

Swearing is rare and affects only about 1 in 10 people with Tourette's syndrome.

Tics aren't usually harmful to a person's overall health, but physical tics, such as jerking of the head, can be painful.

Tics can be worse on some days than others.

They may be worse during periods of stress, anxiety and tiredness

People with Tourette's syndrome can have behavioural problems, such as:

- antisocial behaviour
- flying into sudden rages
- inappropriate behavior

Children with Tourette's syndrome may be at risk of bullying because their tics might single them out. **Premonitory sensations**

Most people with Tourette's syndrome experience a strong urge before a tic, which has been compared to the feeling you get before needing to itch or sneeze. These feelings are known as premonitory sensations. Premonitory sensations are only relieved after the tic has been carried out. Examples of premonitory sensations include:

- a burning feeling in the eyes before blinking
- a dry or sore throat before grunting
- an itchy joint or muscle before jerking

Controlling tics

Some people can control their tics for a short while in certain social situations, like in a classroom. It requires concentration but gets easier with practice.

Controlling tics can be tiring. A person may have a sudden release of tics after a day trying to control them, like after returning home from school.

Tics may be less noticeable during activities involving a high level of concentration, such as reading an interesting book or playing sports.

When to get medical advice

Many children have tics for several months before growing out of them, so a tic doesn't necessarily mean your child has Tourette's syndrome.

Diagnosing Tourette's

There's no single test for Tourette's syndrome. Tests and scans, such as an MRI, may be used to rule out other conditions. Tourette's syndrome can be diagnosed if an individual has had several tics for at least a year. Getting a firm diagnosis can help the individual and others understand the problems better, and help access to the right kind of treatment and support. To get a diagnosis, a GP may refer to different specialists, such as a neurologist (a brain and nervous system specialist).

Treating Tourette's

There's no cure for Tourette's syndrome and most children with tics don't need treatment for them. In some cases, treatment may be recommended to help you control your tics.

Treatment, usually available on the NHS, can involve:

- behavioural therapy
- medication

Behavioural therapy

Behavioural therapy is usually provided by a psychologist or a specially trained therapist.

Two types of behavioural therapy have been shown to reduce tics.

Habit reversal training

This approach involves working out the feelings that trigger tics. The next stage is to find an alternative, less noticeable way of relieving the urge to tic.

Exposure with response prevention (ERP)

This method trains you to better control your urge to tic. Techniques are used to recreate the urge to tic to train you to tolerate the feeling, without doing the tic, until the urge passes.

Medication

Some people's tics are helped with medicines, but this is usually only recommended if the tics are more severe or affecting daily activities.

Medicines for Tourette's syndrome can have side effects and they won't work for

everyone. **Causes of Tourette's**

The cause of Tourette's syndrome is unknown. It's thought to be linked to a part of the brain that helps regulate body movements.

For unknown reasons, boys are more likely to be affected by Tourette's syndrome than girls. For more information on treatment and support, contact the charity Tourette's Action.

Appendix F Dealing with Obsessive Compulsive Disorder (OCD)

The word 'obsessive' gets used commonly. This can mean different things to different people. Obsessive compulsive disorder (OCD) is a type of anxiety disorder. In this condition, the person suffers from obsessions and/or compulsions that affects their everyday life, like going to school on time, finishing homework or being out with friends**.**

What are the symptoms?

An **obsession** is a thought, image or urge that keeps coming into your mind even though you may not want it to. An obsession can be annoying, unpleasant or distressing and you may want it to go away. An example of an obsession is the thought that your hands are dirty even though they are not. Different people have different obsessions. Some examples:

- fears about dirt and spreading disease
- worrying about harm happening to you or someone else
- fearing that something 'bad' may happen
- worrying about things being tidy
- worrying about having an illness.

Having an obsession often leads to anxiety or feeling uncomfortable and you may then have the urge to 'put it right'. This is where compulsions come in.

Compulsions are things you feel you need to do usually to control your 'obsessions', even though you may not want to. You might even try to stop doing them, but this might not be possible. Often a compulsion means doing something again and again, as a 'ritual'. By doing the compulsion you feel you can prevent or reduce your anxiety about what you fear may happen if you don't do it. For example, turning the light on and off 20 times because you worry something bad may happen if you don't. Different people have different compulsions. Some examples include:

- washing
- checking
- thinking certain thoughts
- touching
- ordering/arranging things or lining things up
- counting.

Individuals who have these problems often try to avoid any situation that might set off obsessive thoughts (e.g. not using hands to open doors).

When obsessions and compulsions take up a lot of your time, interfere with your life and cause you distress, it becomes obsessive-compulsive disorder (OCD).

Who does OCD affect?

OCD is common and can affect people of all ages irrespective of their class, religion or gender.

What causes OCD?

We do not know the cause of OCD for certain. However, research suggests that OCD may be due to an imbalance of a brain chemical called 'serotonin'. It is likely that there may be a genetic link and to

similar tic disorder). Sometimes the symptoms seem to start after a specific type of infection (cough and cold). It can also occur after a difficult life event.

How is it treated?

It is important to seek help early.

Referral for specialist help from the child and adolescent mental health service (CAMHS) maybe required.

There are psychological treatments and medications available to treat OCD. One of the helpful psychological or talking treatments for OCD is cognitive behavioural therapy (CBT) that includes exposure and response prevention (ERP). CBT is a psychological approach that is effective in treating young people with OCD. In OCD people often think that by avoiding a certain situation or doing the ritual/compulsion helps to keep the worry (obsession) away or come true. However, this does not help the worry to go away. In the treatment for OCD, the therapist would help to understand this reality and also teach ways to face the worry rather than running away from it. Eventually this helps to get rid of obsessions and the compulsions. In ERP the therapist helps to face the things that are feared and have been avoided They then help to stop the usual response e.g. handwashing. To help fight OCD, a wide range of skills to manage the anxiety that OCD creates would be taught. This helps to learn strategies to control the OCD rather than the OCD doing the controlling.

When OCD is severe medication may be needed. This is usually given to help alongside trying CBT. Medication can help get the most out of the psychological treatment.

Further information

Epic friends - Mental health problems are common. This website is all about helping you to help your friends who might be struggling emotionally.
OCD Action - National charity for people with OCD.
OCD Youth - A website written by and for young people with OCD, giving information on the disorder and its treatments.
OCD UK - OCD-UK is the charity dedicated to improving the mental health and well-being of almost one million people in the UK whose lives are affected by Obsessive-Compulsive Disorder.
YoungMinds have also developed **HeadMeds** which gives young people in England general information about medication. HeadMeds does **not** give you medical advice. Please talk to your Doctor or anyone else who is supporting you about your own situation because everyone is different.

Appendix G Dealing with Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness.

Symptoms of ADHD tend to be noticed at an early age and may become more noticeable when a child's circumstances change, such as when they start school.

Most cases are diagnosed when children are 6 to 12 years old.

The symptoms of ADHD usually improve with age, but many adults who were diagnosed with the condition at a young age continue to experience problems.

People with ADHD may also have additional problems, such as sleep and anxiety disorders.

What causes ADHD?

The exact cause of ADHD is unknown, but the condition has been shown to run in families.

Research has also identified a number of possible differences in the brains of people with ADHD when compared with those without the condition.

Other factors suggested as potentially having a role in ADHD include:

- being born prematurely (before the 37th week of pregnancy)
- having a low birth weight
- smoking or alcohol or drug abuse during pregnancy
- ADHD can occur in people of any intellectual ability, although it's more common in people with learning difficulties.

How ADHD is treated?

Although there's no cure for ADHD, it can be managed with appropriate educational support, advice and support for parents and affected children, alongside medication, if necessary.

Living with ADHD

Looking after a child with ADHD can be challenging, but it's important to remember that they cannot help their behaviour.

Some issues that may arise in day-to-day life include:

- getting a child to sleep at night
- getting ready for school on time
- listening to and carrying out instructions
- being organised
- social occasions
- shopping

Symptoms of ADHD

The symptoms of attention deficit hyperactivity disorder (ADHD) can be categorised into 2 types of behavioural problems: inattentiveness, and hyperactivity and impulsiveness.

Most people with ADHD have problems that fall into both these categories, but this is not always the case. For example, some people with the condition may have problems with inattentiveness, but not with hyperactivity or impulsiveness.

This form of ADHD is also known as attention deficit disorder (ADD). ADD can sometimes go unnoticed because the symptoms may be less obvious.

Symptoms in children and teenagers

The symptoms of ADHD in children and teenagers are well defined, and they're usually noticeable before the age of 6. They occur in more than 1 situation, such as at home and at school.

Inattentiveness

The main signs of inattentiveness are:

- having a short attention span and being easily distracted
- making careless mistakes – for example, in schoolwork
- appearing forgetful or losing things
- being unable to stick to tasks that are tedious or time-consuming
- appearing to be unable to listen to or carry out instructions
- constantly changing activity or task
- having difficulty organising tasks

Hyperactivity and impulsiveness

The main signs of hyperactivity and impulsiveness are:

- being unable to sit still, especially in calm or quiet surroundings
- constantly fidgeting
- being unable to concentrate on tasks
- excessive physical movement
- excessive talking
- being unable to wait their turn
- acting without thinking
- interrupting conversations
- little or no sense of danger
- These symptoms can cause significant problems in a child's life, such as underachievement at school, poor social interaction with other children and adults, and problems with discipline.

Related conditions in children and teenagers with ADHD

Although not always the case, some children may also have signs of other problems or conditions alongside ADHD, such as:

- **Anxiety disorder** which causes your child to worry and be nervous much of the time; it may also cause physical symptoms, such as a rapid heartbeat, sweating and dizziness

- **Oppositional defiant disorder (ODD)** – this is defined by negative and disruptive behaviour, particularly towards authority figures, such as parents and teachers
- **Conduct disorder** – this often involves a tendency towards highly antisocial behaviour, such as stealing, fighting, vandalism and harming people or animals
- **Depression**
- **Sleep problems** – finding it difficult to get to sleep at night, and having irregular sleeping patterns
- **Autistic Spectrum Disorder (ASD)** – this affects social interaction, communication, interests and behaviour
- **Epilepsy**– a condition that affects the brain and causes repeated fits or seizures
- **Tourette's Syndrome** – See Above
- **Learning difficulties** – such as dyslexia

Causes

The exact cause of attention deficit hyperactivity disorder (ADHD) is not fully understood, although a combination of factors is thought to be responsible.

Genetics

ADHD tends to run in families, and, in most cases, it's thought the genes you inherit from your parents are a significant factor in developing the condition.

Research shows that parents and siblings of a child with ADHD are more likely to have ADHD themselves.

However, the way ADHD is inherited is likely to be complex and is not thought to be related to a single genetic fault.

Brain function and structure

Research has identified a number of possible differences in the brains of people with ADHD from those without the condition, although the exact significance of these is not clear.

For example, studies involving brain scans have suggested that certain areas of the brain may be smaller in people with ADHD, whereas other areas may be larger.
Other studies have suggested that people with ADHD may have an imbalance in the level of neurotransmitters in the brain, or that these chemicals may not work properly.

Groups at risk

Certain groups are also believed to be more at risk of ADHD, including people:

- who were born prematurely (before the 37th week of pregnancy) or with a low birth-weight
- with epilepsy
- with brain damage – which happened either in the womb or after a severe head injury later in life

Assessment

There are a number of different specialists for a formal assessment, including:

- a child psychiatrist

- a paediatrician – a specialist in children's health
- There's no simple test to determine if a child has ADHD. The assessment may include:
- a physical examination, which can help rule out other possible causes for the symptoms
- a series of interviews
- interviews or reports from other significant people, such as partners, parents and teachers
- The criteria for making a diagnosis of ADHD in children, teenagers are outlined below.

Diagnosis in children and teenagers

Diagnosing ADHD in children depends on a set of strict criteria. To be diagnosed with ADHD, a child must have 6 or more symptoms of inattentiveness, or 6 or more symptoms of hyperactivity and impulsiveness.

To be diagnosed with ADHD, a child must also have:

- been displaying symptoms continuously for at least 6 months
- started to show symptoms before the age of 12
- been showing symptoms in at least 2 different settings – for example, at home and at school, to rule out the possibility that the behaviour is just a reaction to certain teachers or to parental control
- symptoms that make their lives considerably more difficult on a social, academic or occupational level
- symptoms that are not just part of a developmental disorder or difficult phase, and are not better accounted for by another condition

Treatment for attention deficit hyperactivity disorder (ADHD) can help relieve the symptoms and make the condition much less of a problem in day-to-day life.

ADHD can be treated using medication or therapy, but a combination of both is often best. Treatment is usually arranged by a specialist, such as a paediatrician or psychiatrist, although the condition may be monitored by the GP.

Medication

There are 5 types of medication licensed for the treatment of ADHD:

- methylphenidate
- dexamfetamine
- lisdexamfetamine
- atomoxetine
- guanfacine

These medications are not a permanent cure for ADHD but may help someone with the condition concentrate better, be less impulsive, feel calmer, and learn and practise new skills.

Some medications need to be taken every day, but some can be taken just on school days. Treatment breaks are occasionally recommended to assess whether the medication is still needed.

Methylphenidate is the most commonly used medication for ADHD. It belongs to a group of medicines called stimulants, which work by increasing activity in the brain, particularly in areas that play a part in controlling attention and behaviour.

Methylphenidate may be offered to teenagers and children over the age of 5 with ADHD.

The medication can be taken as either immediate-release tablets (small doses taken 2 to 3 times a day) or as modified-release tablets (taken once a day in the morning, with the dose released throughout the day).

Common side effects of methylphenidate include:

- a small increase in blood pressure and heart rate
- loss of appetite, which can lead to weight loss or poor weight gain
- trouble sleeping
- headaches
- stomach aches
- mood swings

Lisdexamfetamine is a similar medication to dexamfetamine and works in the same way.

It may be offered to teenagers and children over the age of 5 with ADHD if at least 6 weeks of treatment with methylphenidate has not helped.

Lisdexamfetamine comes in capsule form, taken once a day.

Common side effects of lisdexamfetamine include:

- decreased appetite, which can lead to weight loss or poor weight gain
- aggression
- drowsiness
- dizziness
- headaches
- diarrhoea
- nausea and vomiting

Dexamfetamine is similar to lisdexamfetamine and works in the same way. It may be offered to adults, teenagers and children over the age of 5 with ADHD.

Dexamfetamine is usually taken as a tablet once or twice a day, although an oral solution is also available. Common side effects of dexamfetamine include:

- decreased appetite
- mood swings
- agitation and aggression
- dizziness
- headaches
- diarrhoea
- nausea and vomiting

Atomoxetine works differently from other ADHD medications.

It's a selective noradrenaline reuptake inhibitor (SNRI), which means it increases the amount of a chemical in the brain called noradrenaline.

This chemical passes messages between brain cells and increasing it can aid concentration and help control impulses.

Atomoxetine may be offered to teenagers and children over the age of 5 if it's not possible to use methylphenidate or lisdexamfetamine.

Atomoxetine comes in capsule form, usually taken once or twice a day.

Common side effects of atomoxetine include:

- a small increase in blood pressure and heart rate
- nausea and vomiting
- stomach aches
- trouble sleeping
- dizziness
- headaches
- irritability

Atomoxetine has also been linked to some more serious side effects that are important to look out for, including suicidal thoughts and liver damage.
Guanfacine acts on part of the brain to improve attention, and it also reduces blood pressure.

It may be offered to teenagers and children over the age of 5 if it's not possible to use methylphenidate or lisdexamfetamine.

Guanfacine is usually taken as a tablet once a day, in the morning or evening.

Common side effects include:

- tiredness or fatigue
- headache
- abdominal pain
- dry mouth

Therapy

As well as taking medication, different therapies can be useful in treating ADHD in children, teenagers and adults. Therapy is also effective in treating additional problems, such as conduct or anxiety disorders, that may appear with ADHD.

Psychoeducation means being encouraged to discuss ADHD and its effects. It can help children, teenagers and adults make sense of being diagnosed with ADHD and can help you to cope and live with the condition.

Behaviour therapy provides support for carers of children with ADHD and may involve teachers as well as parents. Behaviour therapy usually involves behaviour management, which uses a system of

rewards to encourage your child to try to control their ADHD.

Social skills training involves your child taking part in role-play situations and aims to teach them how to behave in social situations by learning how their behaviour affects others.

CBT is a talking therapy that can help manage problems by changing the way you think and behave.

For information on local support groups, contact Attention Deficit Disorder Information and Support Service (ADDISS) or call 020 8952 2800.

Appendix H Dealing with Autistic Spectrum Disorder

Autism is the central condition in the group of difficulties known as Autism Spectrum Disorders (ASD) or Autism Spectrum Conditions (ASC). They are **neurodevelopmental** disorders – which means they are caused by abnormalities in the way the brain develops and works. They affect approximately 1 in 100 children and young people. Children and young people with ASD have particular difficulties:

- in communicating
- being around people socially and with their
- behaviour

They have a range of intellectual ability from having severe learning disabilities, to being more academically able and in mainstream education. About 10% of people with autism may also have some special skills and abilities.For a diagnosis of autism, there must be evidence of unusual development in the first 3 years of life. Asperger's syndrome is a term used for some higher functioning people on the autism spectrum who have intellectual ability in the average range and no delays in learning to talk. Many often have intense interests such as train timetables, buses or dinosaurs.

What are the causes of Autism Spectrum Disorders?

The exact cause of ASD is still unknown, although research shows that a combination of genetic and environmental factors may account for changes in brain development. There is an increased risk of ASD and other developmental difficulties in the brothers and sisters of children with ASD.

What are the characteristics of Autism Spectrum Disorders?

The characteristics of children and young people with ASD will vary depending upon their age, developmental level and how severely they are affected.

The difficulties are also likely to change over time. Parents are usually (but not always) the first to have some concerns about their child's development, and difficulties may be noticed from as early as infancy. Overall, the problems and behaviours can be divided into three main areas:

Difficulties with communication

Children and young people with ASD have difficulties with both verbal communication (speaking) and non-verbal communication (eye contact, expressions and gestures). Some children may not be able to talk at all or have very limited speech.

Some have good speech and language skills, but still have difficulty using their speech socially or to sustain a conversation. Their use of language may be overly formal or 'adult-like'. They may talk at length about their own topics of interest, but find it hard to understand the back and forth nature of two-way conversations.

Difficulties with social interaction

Children and young people with ASD have difficulty understanding the 'social world', for example, they often have difficulty recognising and understanding their feelings and those of people around them. This in turn can make it difficult for them to make friends. They may prefer to spend time alone, or appear insensitive to others because of their difficulties understanding social rules and expectations.

Difficulties with behaviour, interests and activities

Children and young people with ASD often prefer familiar routines (e.g. taking the same route to school every day, putting their clothes on in a particular order), and tend to have difficulties dealing with change, which they find difficult and distressing.

They may also have unusual intense and specific interests, such as in electronic gadgets or lists of dates. They might use toys more like 'objects' to line up, for example. They may have unusual responses to particular experiences from their environment such as tastes, smells, sounds and textures. For example, they could be very sensitive to the sound of a hair dryer, or the feel of certain materials against their skin.

Some children show unusual repetitive movements such as hand or finger flapping or twisting, or complicated whole body movements.

Where can I get help?

If you are worried about your child's development, or their school or nursery has contacted you about their worries, the first step is to speak to your GP or health visitor who will advise you and make a referral if necessary to the local Child Development Team or Child and Adolescent Mental Health Service (CAMHS).

Making the correct diagnosis requires a detailed discussion about your child's early development, medical and psychological assessment, and a comprehensive assessment of your child's social and communication skills and intellectual abilities. Some of this will be done by watching your child in different settings e.g. school. There is no single test (eg blood test or brain scan) for ASD. However, several different tests may be carried out to exclude other conditions (e.g. hearing tests and blood tests).

Learning difficulties

Children with ASD can have general or specific learning disabilities which may range from mild to severe. They will have their own strengths and difficulties, both with their learning and their abilities, like all children.

What can be done to help?

There are no known cures for ASD, but children and families can be helped in many ways. Help includes:

- being given information about the condition
- managing behavioural difficulties
- developing social communication and emotional skills
- medication in some cases.

There are various approaches available to help with communication and learning, and for children with ASD, it is often better to intervene as early as possible.

Usually, there will be several people involved in the care of a child with ASD, such as a speech and language therapist, psychologist, occupational therapist and a medical doctor (paedicatrician or child psychiatrist).

There might also be specialist courses on parenting, parent support groups, advice on how to help the wider family and more general advice about benefits, for example, from local child health services and independent organisations such as the **National Autistic Society**.

What are the education needs of children with Autism Spectrum Disorders?

Children and young people with ASD often need some special educational support.

This may be in a special school, or in a mainstream school with extra help to manage conflict and upset feelings, and to get on with other people, for example.

Unstructured situations, such as break and lunch-times, can be very difficult for some children with ASD, who may be vulnerable to bullying or exploitation, particularly in secondary schools.

The future

Most children and young people with ASD continue to experience similar difficulties throughout life, although generally they become less severe over time. Getting help as early as possible for children and young people with ASD can make a real difference.

Further help

Social services can have a role to play in providing practical support and help for the young person and their family. They can provide help in accessing local services and resources, such as respite care, and advice on disability allowances. Many families also value support from their local autism parent and carer support group.

Further reading

The Complete Guide to Asperger's Syndrome (2006). Tony Attwood. Jessica Kingsley Publishers: London.

Finding Out About Asperger's Syndrome, High-Functioning Autism and PDD. Author Gunilla Gerland. Jessica Kingsley Publishers: London

Parenting a child with Asperger Syndrome – 200 tips & strategies. B Boyd (Jessica Kingsley)

It can get better. Paul Dickinson & Liz Hannah

The ASD Workbook: Understanding your Autism Spectrum Disorder. Penny Kershaw.

Further support

- The National Autistic Society champions the rights and interests of all people with autism and aim to provide individuals with autism and their families with help, support and services that they can access, trust and rely upon and which can make a positive difference to their lives.
- Contact a Family. UK-wide charity providing advice, information and support to the parents of all disabled children. Free helpline 0808 808 3555.
- Research Autism is a UK charity dedicated to research into interventions in autism.

Appendix H Individual Healthcare Plan

To be used in conjunction with:

- parental agreement for setting to administer medicine
- record of medicine administered to an individual child

Individual Healthcare Plan Template

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

Who is responsible for providing support in school	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

Describe what constitutes an emergency, and the action to take if this occurs

Who is responsible in an emergency *(state if different for off-site activities)*

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to