The Yehudi Menuhin School

# YMS Mental Health and Wellbeing Policy

## Introduction

## Mental Health and YMS

1. At the Yehudi Menuhin School we aim to promote positive mental health and wellbeing for our whole school community – children, staff, parents and carers – and we recognise that mental health and emotional wellbeing are just as important to our lives as physical health.

2. We recognise that children's mental health is a crucial factor in their overall wellbeing and can affect their learning and achievement. All children go through ups and downs during their school career, while some face more significant events which can drastically affect their mental health.

3. Recent figures show that about 1 in 6 children aged 5 to 18 have a diagnosable mental health need, and these can have an enormous impact on quality of life, relationships and academic achievement. In many cases they are life-limiting. The Department for Education (DfE) recognises that "in order to help their children succeed, schools have a role to play in supporting them to be resilient and mentally healthy".

4. Schools can be a place for children and young people to experience a nurturing and supportive environment that has the potential to develop self-esteem and give positive experiences for overcoming adversity and building resilience. For some, school will be a place of respite from difficult home lives and offer positive role models and relationships, which are critical in promoting children's wellbeing and can help engender a sense of belonging and community.

5. Our role at YMS is to ensure that children and young people are able to manage times of change and stress, and that they are supported to reach their potential or to access help when they need it. We also have a role to ensure that children learn about what they can do to maintain positive mental health, what affects their mental health, how they can help reduce the stigma surrounding mental health issues, and where they can go if they need help and support.

6. Our aim is to help develop the protective factors which build resilience to mental health problems and to be a school where:

- all children are valued
- children have a sense of belonging and feel safe
- children feel able to talk openly with trusted adults about their problems without feeling any stigma
- positive mental health is promoted and valued
- mutual support is promoted; bullying is not tolerated

## Purpose of the policy

7. This policy sets out:

- what mental health and wellbeing mean for us as a school

- the main mental health problems our pupils can face and the factors which may cause poor mental health
- a discussion of mental health in the unique context of a music school
- staff roles and responsibilities, both in proactively supporting good mental health and in reacting to mental health problems which arise
- how we identify and support children with mental health needs
- where we can get outside help to support pupils with mental health needs

8. This policy is divided into two parts: first, it details the school's proactive approach to mental health and wellbeing; second, it describes the steps we take when reacting to mental health concerns we have among our pupils.

9. This policy should be read and applied in conjunction with the School's other policies directly related to the care of children and young people, especially the Safeguarding, PSHE/RSE, and Anti-Bullying Policies.

# Part One: Being Proactive

## A Proactive Approach to Mental Health

10. We use the World Health Organisation's definition of mental health and wellbeing, as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Mental health and wellbeing are not just about the absence of mental health problems. We want all children and young people to:

- feel confident in themselves
- be able to express a range of emotions appropriately
- be able to make and maintain positive relationships with others
- cope with the stresses of everyday life
- manage times of stress and be able to deal with change
- learn and achieve

11. We take a whole school approach to promoting positive mental health that aims to help children become more resilient, happy and successful and to prevent problems before they arise. This encompasses several aspects, including:

- creating an ethos, policies and behaviours that support mental health and resilience, and which everyone understands
- helping children to develop social relationships, support each other and seek help when they need it
- helping children to be resilient learners
- teaching children social and emotional skills and an awareness of mental health
- early identification of children who have mental health needs and planning support to meet their needs, including working with specialist services

- effectively working with parents and carers
- supporting and training staff to develop their skills and their own resilience

13. We also recognise the role that stigma can play in preventing understanding and awareness of mental health issues. We therefore aim to create an open and positive culture that encourages discussion and understanding of these issues.

## Mental Health and Wellbeing in a Specialist Music School

14. The Yehudi Menuhin School is a specialist music school. The pupils are all highly talented, and the musical education they receive is strongly focused towards developing them into young professional musicians.

15. It is axiomatic that music is good for mental health, nevertheless our existence as a music school brings with it several challenges to mental health and wellbeing which would not be present, or at least not present to such an extent, in non-specialist mainstream schools.

16. The first challenge centres on the fact that our pupils are all high achievers. Such high achievers tend to expect a great deal of themselves, be very self-critical, regularly compare their own achievements with those of their peers, and react poorly to failure.

17. In order to address this issue, many talks and discussions throughout the year, in settings such as Morning Meetings (Assemblies) and PSHE lessons, focus on notions of success and failure, humility, resilience, and other elements of our emotional tool-kit which help us to achieve a greater equilibrium and perspective in our lives.

18. The second challenge arises from the fact that the specific arena in which these high achievers are striving to excel is a particularly stressful one: public musical performance. Performance anxiety, stage fright, and stress-related injuries are among the most common occupational hazards of professional performers.

19. The pupils' instrumental teachers, and other music staff such as staff pianists, have a crucial role to play in mitigating the emotional and physical dangers inherent in the life of a performer. They monitor the quality and quantity of practice which the pupils do; they talk through issues relating to performance anxiety with their students; and they communicate constantly with pastoral staff about concerns they have over particular children.

20. The third challenge to mental health and wellbeing consists in the fact that, in order to achieve the levels of musicianship to which they strive, our pupils must give of themselves both emotionally and physically in a way which far exceeds what would be expected of their peers in non-specialist schools. Making music at this level is an emotionally and physically draining experience.

21. It is therefore important that pupils have down-time, when they put their instruments away and switch off. The boarding facilities allow for such periods of relaxation and

diversion, and the School arranges activities throughout the year which help the pupils relax and enjoy themselves.

22. Physical exercise is an important way to counter the challenges to mental health in the life of a musician, and pupils take part in regular sporting activities, including an hour's swimming for all pupils per week.

23. The fourth challenge to mental health derives from the fact that music school pupils commonly exhibit a wide range of neurodiversity, perhaps because the intensity and focus required to achieve excellence on an instrument calls forth skills and characteristics which are particularly prevalent among children with Autism Spectrum Disorder (ASD).

24. Members of the pastoral team therefore endeavour proactively to monitor pupils' social behaviour in order to ensure children with potential ASDs can be formally assessed and the correct support can be given to them.

25. It is the task of the staff at YMS to help the pupils reach the musical heights to which they aspire while preserving their mental health. To this end, good communication between the musical and the pastoral staff is vital.

26. The Director of Music and team therefore have a crucial role to play in the pastoral life of the School, and contribute fully to meetings at all levels in which the wellbeing of the children and young people at the School is discussed. Equally, pastoral input feeds into all decisions that are made about pupils' participation in musical events, whether they be concerts, tours, or competitions.

27. There are certain pinch-points during the year in a specialist music school, when pupils' mental health and wellbeing can be most severely tested. Among the most stressful of these are the termly pre-assessments and assessments, in which each pupil plays a short programme in front of a panel, including the Director of Music, to assess their progress. The Winter and Summer Festivals are other examples of times of increased stress.

28. These pinch-points are easily predictable, precisely because they are set periods in the school year, and therefore the School seeks proactively to boost pupils' sense of wellbeing at these times by arranging Morning Meetings (Assemblies) and other pastoral activities on the subject of mental health.

29. This holistic approach to mental health and wellbeing, in which all departments in the school participate equally, is a hallmark of our ethos. It underpins everything we stand for as a school.

## Factors Influencing Mental Health

30. Mental health in children and adolescents has become a growing concern. Mental health problems affect around one in six children. These include depression, anxiety, and conduct disorder, and are often a response to what is happening in young people's lives.

31. Most recently, the global COVID-19 pandemic, resulting in national lockdowns leading to isolation from friends and family for so many, has highlighted the increase of poor mental health amongst young people.

32. The dominance of social media in young people's lives has affected peer relationships, peer pressures, and societal expectations amongst young people. 'Sexting' and media exploitation have become commonplace in a world where children and young people are considered less resilient than they once were.

33. We live in a world where children are primed to succeed rather than experiment to find out what they are good at or bad at, and in an environment that is health and safety conscious and generally risk averse. The danger is that young people are not getting the full range of experiences which would enable them to be best equipped for the ups and downs of adult life.

34. As part of the NHS Long Term Plan in 2019, a commitment was made to increase the access that children and young people have to mental health services and support. In addition, the Department of Health and Department of Education Green Paper in 2017, 'Transforming children and young people's mental health provision' encourages schools to build safe mental wellbeing.

35. Traumatic events can often trigger mental health problems in children and young people who are already vulnerable.

36. Teenagers often experience emotional turmoil as their minds and bodies develop. Some young people find it hard to transition into adulthood and may experiment with drugs, alcohol and other substances which can affect mental health.

## Staff roles and responsibilities

37. We believe that all staff have a responsibility to promote positive mental health, and to understand about protective and risk factors for mental health. Some children will require additional help and all staff should have the skills to look out for any early warning signs of mental health problems and ensure that children with mental health needs get early intervention and the support they need.

38. The Deputy Head (Pastoral), who is also the DSL, leads and works with other staff to coordinate whole school activities to promote positive mental health and wellbeing. In collaboration with the Deputy Head (Academic) and Section Heads, she leads on PSHE teaching about mental health and provides advice and support to staff and organises training and updates. She is the first point of contact with mental health services, and makes individual referrals to them.

39. We recognise that many behaviours and emotional problems can be supported within the School environment, or with advice from external professionals. Some children will need more intensive support at times, and there are a range of mental health professionals and organisations that provide support to children with mental health needs and their families.

40. Sources of relevant support within the school include:

- Leadership Team – including the DSL and two Deputy DSLs
- Boarding Team – including the residential Houseparents and their assistants
- DSL Team – the Deputy Head (Pastoral) is the DSL, the Head and the Deputy Head (Academic) are the Deputy DSLs
- Heads of Section – the staff responsible for each year-group and section of the School (As, Bs, Cs)
- Ds Class Teacher – responsible for the Ds
- School Counsellor – pupils can ask to see her themselves or they can be referred by pastoral staff
- SENCO – who helps staff understand their responsibilities to children with special educational needs and disabilities (SEND), including children whose mental health problems mean they need special educational provision
- Independent Listener – an external lay counsellor who is always available to the pupils
- School Nurse – who tends to pupils' medical and emotional needs and liaises with the pastoral staff

## **Traffic Light Criteria** (TLC)

41. The Deputy Head (Pastoral) (also DSL) manages a Traffic-Light system of monitoring pupil mental health and wellbeing, in which GREEN stands for those considered to have a positive state of mental health, AMBER represents those with a heightened need for support, and RED stands for those with an urgent and/or severely heightened need for support.

42. Evidence to support the allocation or changing of traffic-light status of an individual is gathered from Pastoral Meetings, Boarding Meetings, CPOMS entries, conversations with Deputy DSLs, debriefs with the School Counsellor and School Nurse, communications with parents and carers, and any other sources which reveal the mental health and particular domestic and social circumstances of our pupils.

43. Any changes in traffic-light status to or from RED proposed by the Deputy Head (Pastoral) are first approved by the Head before being actioned and communicated to staff.

44. Notwithstanding the traffic-light status of an individual pupil at any one time, all children and young people in our school community are cared for equally, comprehensively, and professionally.

## **Peer Listeners**

45. We are committed to safeguarding and promoting the welfare of children. As part of this commitment, and as a result of discussions within the education sector and in society as a whole about how schools should respond to *Everyone's Invited*, the School has decided to institute a programme of Peer Listeners chosen from among the student body.

46. The School already provides an array of professionals who are well trained and equipped to help pupils with pastoral concerns, including the DSL and Deputy DSLs, Boarding staff, Pastoral staff, the School Nurse, the School Counsellor, and the Independent Listener. *Everyone's Invited* has, however, demonstrated that children are not always willing or able to discuss their experiences relating to safeguarding and child protection matters with adults. The School therefore believes it is desirable and appropriate to institute a scheme whereby older pupils may train to become Peer Listeners.

47. Peer Listeners are not intended to replace any of the adult positions listed above, nor are they to be trained to the same extent as their adult equivalents. The role is designed to provide additional choice to pupils with pastoral needs, and in particular those who prefer, for whatever reason, not to seek help from adults in the first instance.

48. At the start of each school year, the Head and Deputy Head (Pastoral) open applications for Peer Listeners among pupils in A1 to A3 and discuss potential candidates who they consider possess the necessary maturity, compassion and trustworthiness for the position. Peer Listeners from the previous year may apply to continue in their role.

49. Applicants will be asked to fill out a short, written application form and will be interviewed formally by the Head and Deputy Head (Pastoral).

50. Successful candidates will receive training before they commence activity as Peer Listeners and will receive continued assistance and coaching by the Head and Deputy Head (Pastoral) for the duration of their time in the post.

51. The training will consist of general pastoral training from the Head, safeguarding training from either the DSL or one of her deputies, counselling training from the School Counsellor, and medical training from the School Nurse. The training will be appropriate for the Peer Listeners' age and role.

52. The training for prospective Peer Listeners will follow the template provided by the Anna Freud National Centre for Children and Families: https://www.annafreud.org/schools-and-colleges/peer-support/, and will include the following aspects:

- understanding the role and the pupils Peer Listeners are there to support
- appreciating the importance of building a relationship of trust with the pupil(s) being supported
- learning how to make positive changes for these pupil(s)
- understanding the limitations of the role and who Peer Listeners can go to for help
- understanding when to refer cases to the DSL and/or other adults because of urgent concerns a Peer Listener may have as a result of conversations with pupils
- assimilating the crucial ideas of respectful listening and confidentiality, including the occasions in which confidentiality cannot be guaranteed to the pupil being supported
- embedding the principles and practice of safeguarding and child protection in a school setting

- learning how to spot the signs of physical or emotional abuse or neglect

53. In addition to those occasions when Peer Listeners need to contact the DSL or other member of staff immediately as a result of conversations they have had with pupils, the Head will hold Review Meetings with all the Peer Listeners together once every three weeks, and more regularly if the need arises, to discuss the role and any further training they may require.

54. At these Review Meetings, Peer Listeners may share their experiences with each other but must not name the pupils they are supporting, nor reveal indirectly the identities of those pupils by being too specific about particular circumstances they have encountered during their conversations. All pupils receiving peer support have a right to privacy.

55. Individual Peer Listeners may additionally come at any time to the Director of Staff and Boarding to discuss specific pupils whom they are supporting.

# Part Two: Reacting to Pupil Need

## Recognition of pupils at risk of developing emotional health issues

56. Common signs of distress which school staff may notice and which should lead to referral are listed below. The decision to refer a young person is based on the overall severity of the symptoms and intuition about the degree of risk, rather than the number of symptoms. The following behaviours may indicate distress and pupils at risk:

**Unexpected reduction of academic or music performance**
Unusual failure to complete assignments, apathetic in class, has recently received a very much lower than expected grade, poor musical performances, not practising their instrument, extremely disappointed at being rejected for a course or demonstrates abrupt changes in attendance, such as increased absences, tardiness, or truancy.

**Change in mood**
Withdrawal, sudden tearfulness, and remarks, which indicate profound unhappiness, despair, hopelessness, helplessness. Anger at self, increased irritability, moodiness and aggressiveness. Lack of interest in surroundings and activities and marked emotional instability. New involvement in high-risk activities.

**Difficulty concentrating**
Lowered concentration, daydreaming, lack of interest in studies practising or playing their instrument, constant fidgeting and disruptive or avoidant behaviour.

**Grief about a significant loss**
Stress due to the recent disintegration of the family, or a recent death or suicide in the family, a friend lost through death or suicide, or a break-up with a partner.

**Changes in sleep patterns**
Signs of continued physical tiredness, apathetic in class, excessive yawning or falling asleep during the day are all signs of disturbed sleep patterns. Equally other signs include restless behaviour, lack of concentration, irritability and tearfulness.

**Sudden changes in weight**
Gaining or losing weight in a short period of time. Signals to look for include avoidance of mealtimes, loss of appetite, withdrawing socially where food is served. In addition, sudden keen interests in food, overeating, evidence of excessive snacking (such as packets found in rooms) are to be considered and monitored.

**Withdrawal from relationships**
Change in relationships with friends and classmates. Loses interest in extra-curricular activities and may drop out of sports and other clubs. Begins to spend long periods of time alone.

**Physical symptoms with emotional cause**
Eating disturbances or chronic physical complaints, such as headaches, stomach aches, fatigue, body aches, scratching or marking of the body, or other self-destructive acts. Reduced personal hygiene.

**Ideas and themes of depression, death and suicide – preoccupation with morbidity**
Reading selections, written essays, conversation, and artwork contains themes of depression, death and suicide. Statements or suggestions that they would not be missed if they were gone. Appears to collect and discuss information on suicide methods. Begins giving away prized possessions (possibly with some elevation in mood) and has demonstrated previous direct or indirect suicide threats or attempts.

**High-risk behaviours**
Increased use of alcohol and drugs to the point of intoxication. Engages in other risky behaviours.

57. The significance of the risk factors above may be accentuated in young people who lack parental warmth, for example, their parents appear uninvolved, unsupportive, and demonstrate denial of the pupil's problems. They may appear angry, threatened and defensive or there is evidence of a long history of home problems.

58. Once a member of staff has identified a pupil who is considered to have a number of these symptoms, who is likely to be distressed, and where the member of staff judges there to be some risk (no matter how small), then he/she must make a referral to the DSL or a Deputy DSL and make an entry on CPOMS (Child Protection Online Management System). Staff should decide to refer a pupil based on the overall severity of the symptoms and their intuition, rather than the number of symptoms. If a member of staff is concerned that the cause of the distress is abuse, then they should immediately go to the Designated Safeguarding Lead. This includes reports to staff from pupils and/or parents.

59. Involvement of staff and other people:

**Head**

The Head delegates responsibility to the Deputy Head (Pastoral)/DSL who will act on his behalf. She reports directly to the Head and will keep him fully informed.

**The Deputy Head (Pastoral)/DSL and the Care Team**

The Deputy Head (Pastoral)/DSL leads the Care Team, which includes the School Nurse, the Director of Staff and Boarding, the Deputy Designated Safeguarding Leads (DDSL) and the School Counsellor. House staff are invited to attend meetings as appropriate. The team will:

i. Refer to appropriate professional support e.g. psychologist, psychiatrist, health agency
ii. Co-ordinate communication within school and with the family
iii. Update CPOMS and amend the Traffic Light Criteria system (TLC)
iv. Provide counselling and ongoing support to pupils “at risk” as appropriate
v. Manage follow-up support and monitoring for “at risk” pupils returning to school settings
vi. Keep records and action points of all meetings

**Doctor’s Appointment**

All boarders are expected to be registered with the local GP surgery: Cobham Health Centre. Any pupil causing concern will have an appointment made for them at the Cobham Health Centre to see a Doctor or, if not registered there, a pupil’s family will be asked to make an appointment with the family Doctor who will:

i. Assess their emotional state and judge whether they should be considered ‘at risk’.
i. The Doctor may refer the pupil for counselling within school
ii. Refer and oversee further medical intervention, if appropriate, such as child & adolescent mental health services (CAMHS) and/or child & adolescent Psychiatric services
iii. Review care at regular intervals.

**The Health Centre**

The nurse who assesses a pupil as 'at risk' will also assess to what degree of risk. Depending on the pupil's needs, a Risk Assessment/Safety Plan will be written. If a pupil is deemed to be at immediate risk to themselves or others then prompt referral is made, in all cases, for a clinical assessment, followed by the School's Designated Safeguarding Lead (DSL). The DSL will ensure that the Head is informed as necessary/appropriate, update CPOMS[1] and the TLC register. The pupil of concern will remain under the care of the Health Centre until the Doctor has reviewed them and a decision made on their mental state.

60. If a pupil is struggling emotionally and recognises the need to seek further support, their consent is sought and a referral can be made directly to the School Counsellor. Pupils are always encouraged to discuss problems, worries or concerns with their housemistress/master, personal tutor, Director of Pastoral Care, Director of Boarding, the Independent Listener, nurse and/or parents.

See also the First Aid, Health Care and Medicines Policy.

**School Counsellor**

i. Provides regular counselling/psychotherapy in a safe environment.
ii. Reviews and monitor client's wellbeing.
iii. Works on behalf of the pupil to maintain autonomy.
iv. Liaises with Deputy Head (Pastoral) and the Care Team whilst observing confidentiality.

**House staff**

i. Hold weekly pastoral/boarding meetings to keep house team informed as appropriate.
ii. Conduct regular monitoring and observation.
iii. Administer any medicines as per school protocol.
iv. Encourage vigilance within the House, being sensitive to any changes of behaviour amongst the pupils in their care. Domestic staff often have a role to play in this.
v. Update CPOMS.

**Staff/tutors**

i. Provide assistance in recognition of "emotional distress" and "at risk" factors alerting Housemistress/master and other staff as appropriate.
ii. Refer "at risk" students immediately to the Deputy Head Pastoral/DSL, either in person if urgent or via CPOMS, at which point the TLC register may be amended to reflect escalating concerns.

[1] CPOMS – Child Protection Online Management System: the software used for pastoral record-keeping

iii. Provide ongoing support and assistance to pupils as directed.

**Other pupils and friends**

The Yehudi Menuhin School encourages its pupils to look out for one another. Sometimes friends and peers will be the first to notice a pupil's low mood. They are frequently encouraged to bring any concerns to the attention of their House Staff.

**Parents and family**

Parents and family are integral to any Risk Assessment. It is important that the school maintain close liaison with the family, via co-ordination from the Care Team.

## Communication and Confidentiality

i.

## Guidelines Regarding Confidentiality and Communication with Family, Pupils and Staff

61. Confidentiality issues arise when the trust relationship between a pupil and school staff comes into conflict with the need to ensure the safety of the young person and/or others.

62. Parents have a contract with the school and have a right to know should their child be unwell. However, pupils may not wish parents to be informed and it is the duty of Health Centre Staff to respect Medical Confidentiality. Medical confidentiality applies if the information was shared only with medical professionals, but in all matters, the wellbeing of the pupil will be the primary influence in matters of communication. (see Guidelines on Medical Confidentiality below).

63. A pupil should be encouraged to communicate problems to parents, preferably with the support of a member of the school community, but may consider that parents may not need to know the full personal details. Ideally, every effort should be made to encourage them to share their concerns with others. However, decisions must be made in terms of the best interest of the young person, e.g. individual rights/privacy vs immediate risk/safety.

64. Ideally, every effort should be made to encourage them to share their concerns with others. However, decisions must be made in terms of the best interest of the young person, e.g. individual rights/privacy vs immediate risk/safety.

65. Clear communication is vital when dealing with a young person at risk. Communications of initial information must be immediate, accurate and sensitive to the needs of family and friends. Consideration to be given to what communications must be given to which staff, and any other pupils involved.

66. While it is recognised that most staff have a desire to be informed and to assist, the sensitivity of the situation, and recognition of confidentiality and respect for those most vulnerable in the situation (the pupil) – may mean that not all staff will be briefed, and/or that briefing information will be minimal (e.g. particular noting of absenteeism). Co-operation from staff, even if not given confidential personal information and/or involved, is critical. Our main concern is the wellbeing of the pupil.

67. The following people will either need to be informed, or will consider they need to be informed. The Headmaster and the Care Team have the role of deciding who needs to be informed at what level.

**Within the school**

i. Head
ii. Deputy Head Pastoral/DSL
iii. Deputy Designated Safeguarding Leads
iv. Health Centre
v. Houseparent and House staff
vi. Teachers and general staff
vii. Friends of the pupil at risk, who are impacted by the situation

**Outside of school**

i. Family
ii. External specialists

68. The Deputy Head (Pastoral)/DSL should be central to communication with parents. Parents and family should be contacted at regular intervals and/or if anything changes. Further decisions should be made in consultation with the family.

69. Guidelines for staff about how to respond to other pupils will be provided by members of the Care Team.

i. Staff should maintain awareness of any other pupils that may be aware and affected by event (including siblings, friends, classmates etc.).
ii. Pastoral staff should identify any other pupils who have knowledge and/or may be affected.
iii. House staff should remind pupils that the problem is not theirs to solve, and that although they are not the focus, they are still eligible for support.

iv. Necessary staff will be informed and/or involved, and will have input into decision-making process as appropriate.
v. It is critical that co-ordination of response and care of the student be actioned through the Care Team.
vi. Suitable documentation and records must be maintained at all stages.
vii. Staff working intensively with students will be provided with support (individual or group) throughout the critical time, and debriefing should take place afterwards.

70. This policy serves as guidelines for best practice. In all cases, the safety and wellbeing of the pupil is of foremost importance: if there is concern that communication will put a pupil at risk, the decision to communicate must be discussed with the Deputy Head (Pastoral)/DSL, who may seek further guidance from the Head and/or the Care Team.

## Mental Health

71. Mental health affects all aspects of a child's development, including their cognitive abilities and their emotional wellbeing. Childhood and teenage years are when mental health is developed and patterns are set for the future. For most children, the opportunities for learning and personal development during adolescence are exciting and challenging and an intrinsic part of their school experience. However, they can also give rise to anxiety and stress. Children may also suffer anxiety or stress owing to circumstances outside schools.

72. All Yehudi Menuhin staff are responsible for fostering a culture which encourages pupils to openly discuss their problems, including any mental health concerns. See also the Bereavement Policy (Appendix 1).

73. The School may become aware of concerns over a pupil's mental health in a variety of different ways, including where:

- A pupil acknowledges that they have a problem and seeks help
- A pupil exhibits consistent disruptive, unusual or withdrawn behavior which may be indicative of an underlying problem and/or indicates that a pupil could be at risk of developing mental health problems
- A member of staff, parent or another adult reports concerns about, or issues relating to a pupil's mental health or behavior
- Where another pupil or child reports concerns about or issues relating to a pupil's metal health or behavior

74. The staff at the Yehudi Menuhin School will take all reports of concerns over the mental health and wellbeing of its pupils seriously and not delay in investigating and if appropriate, in putting support in place including where necessary taking immediate steps to safeguard a pupil.

## Anxiety

75. All children and young people get anxious at times; this is a normal part of their development. Welfare concerns are raised when anxiety is impairing their development, or having a significant effect on their schooling or relationships. Anxiety disorders include:

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

76. Symptoms of an anxiety disorder can include:

i. <u>Physical effects</u>

- 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

ii. <u>Psychological effects</u>

- 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

iii. <u>Behavioural effects</u>

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

77. 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.
78. Members of staff will respond in accordance with the following protocol:

- In the first instance any concerns should be reported immediately to Houseparents, the DSL, a CPOMS referral made and the School nurse informed.
- The School nurse will assess the pupil to establish the level of need and if deemed necessary refer pupils to the School counsellor and/or outside agencies whichever is appropriate.
- The DSL will notify the Head of all pupils who are of cause for concern.
- Families will be contacted by the DSL as per our guidance on Communication and Confidentiality procedures set out above (P.61)
- Depending on the outcome of level of need required pupils will be supported by the relevant members of staff and if appropriate outside agencies.
- If the level of need indicates the necessity for additional awareness and support the TLC register will be amended to reflect on-going concerns and will be discussed with pastoral staff, whilst observing appropriate levels of confidentiality.
- Should symptoms escalate to a point where pupils are struggling to be part of the school community the Head will be consulted regarding the pupil's suitability to remain in school.

## Depression

78. Some people will develop depression in a distressing situation, whereas others in the same situation may not. Risk Factors (in no particular order):

- 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
- Substance misuse
- Adverse Childhood Experiences (ACEs)
- Head injury

79. Symptoms include:

- 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, confusion and a 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.

80. Members of staff will respond in accordance with the following protocol:

- In the first instance any concerns should be reported immediately to Houseparents, the DSL, a CPOMS referral made and the School nurse informed.
- The School nurse will assess the pupil to establish the level of need and if deemed necessary refer pupils to the School counsellor and/or outside agencies whichever is appropriate.
- The DSL will notify the Head of all pupils who are of cause for concern.
- Families will be contacted by the DSL as per our guidance on Communication and Confidentiality procedures set out above (P.61)
- Depending on the outcome of level of need required pupils will be supported by the relevant members of staff and if appropriate outside agencies.
- If the level of need indicates the necessity for additional awareness and support the TLC register will be amended to reflect on-going concerns and will be discussed with pastoral staff, whilst observing appropriate levels of confidentiality.
- Should symptoms escalate to a point where pupils are struggling to be part of the school community the Head will be consulted regarding the pupil's suitability to remain in school.

## Suicidal ideation (thoughts and feelings)

80. Any suggestion that a pupil may be considering suicide should always be taken very seriously.

81. Members of staff will respond in accordance with the following protocol:

i. Find a member of the pastoral team (preferably associated with that boarding house) to locate and stay with the pupil immediately. The pupil should not be left alone until further notice.

ii. Assess the immediate risk and take whatever urgent action is necessary, which may include immediately calling 999 in an emergency.

iii. Notify the School Nurse and the Deputy Head (Pastoral)/DSL, or the Deputy Designated Safeguarding Lead (DDSL). The Director of Pastoral Care is responsible for informing the Head.

iv. A full assessment will be undertaken by the Deputy Head (Pastoral)/DSL and the School nurse. The assessment will include a decision as to whether further medical intervention or a CAMHS/psychiatric referral is needed.

v. The pupil may be asked to undertake counselling, and to that end, professional advice concerning the management of, and support for, the pupil will be sought. This will include assessing the feasibility of the pupil's continued presence at the School. Consideration will be given as to whether or not the pupil may benefit from a period at home/away from school.

vi. Parents will be informed at the earliest opportunity.

## Self-harm

82. The Yehudi Menuhin School acknowledges that self-harming is a growing phenomenon in our society, particularly, but not exclusively, amongst young women. Our approach is essentially a pro-active one in that we endeavour to promote pupils' mental health in the same way as their physical health and we aim to educate pupils against such behaviour. Nonetheless we recognise that a number of factors may lead to a pupil wanting to harm themselves and we need to be prepared to deal with this when the situation arises. Pastoral and nursing staff have training in dealing with such behaviour. In all cases the safety and welfare of the individual pupil is the most important consideration.

83. A pupil found to be self-harming will be referred initially to the School Nurse for appropriate treatment. They will then be referred to the School Counsellor. The Deputy Head (Pastoral)/DSL must also be informed. The content of the meeting with the Counsellor is strictly confidential but the Deputy Head (Pastoral)/DSL will be informed whether or not the pupil attends. At the stage of arranging counselling, parents will be informed. The pupil will be encouraged to tell their parents themselves and will be provided with support to do so. If the pupil is not prepared to tell their parents, their Housemistress/master or another appropriate representative of the School will do so. A Risk Assessment would normally be put in place.

84. Cases of pupils referring themselves to the Heath Centre or to the Counsellor for self-harm will be treated, where appropriate, confidentially. However, should a pupil's wellbeing be in jeopardy then pupil wellbeing takes priority over confidentiality and a referral would be made to the DSL.

85. Whilst self-harming will not normally be regarded as a disciplinary issue, the School considers such behaviour as detrimental to the community and thereby unacceptable. Pupils who have self-harmed will be counselled with the aim of addressing underlying issues and finding alternative strategies for the release of emotional pain. A pupil who persists in self-harming; or who refuses to acknowledge they have a problem; or, whose behaviour, in the judgement of the Head is having a serious negative impact on other pupils; is likely to be sent home until a resolution can be found. In the event of a pupil being required to go home on their return there will be a meeting of the Houseparent, Deputy Head (Pastoral)/DSL, the parents and possibly others in the Care Team to ensure that future expectations and support are agreed and understood.

86. Other pupils who have witnessed a self-harming incident or are fearful of one occurring, will be given appropriate support in House. Maintaining a calm atmosphere is essential in such situations. Pupils are encouraged to report concerns about self-harming to House or Health Centre staff.

87. Any deliberate harm, regardless of how minor it may outwardly seem, will be regarded as self-harming and dealt with as outlined above. Examples may include:

- Deliberate scratching
- Cutting
- Burning
- Drinking poisons
- Regular alcohol or substance misuse
- Risky sexual behaviour
- Eating disorders are included within the overall category of self-harm. This is addressed separately below.

## Eating Disorders

95. Eating disorders are not primarily about food; starving or binge eating are symptoms of underlying emotional and psychological disorders. For some people, an eating disorder becomes a means of coping with life when they are faced with seemingly insoluble problems or overwhelming distress. The two most common eating disorders are:

i. **Anorexia Nervosa** - a condition of weight loss with a body-mass index (BMI) below 17.5 in an adult caused by food avoidance secondary to psychosocial conflict and when in adolescents there are a variety of considerations to bear in mind:

ii. **Low Risk** – above the 9th percentile with no weight loss over the past two weeks

iii. **Moderate Risk** – 9th – 2nd BMI centile with recent weight loss of up to 500g/week for two consecutive weeks

iv. **Alert to High concern** – between 2nd and 0.4th BMI centile with a recent loss of weight of 500g -999g/week for 2 consecutive weeks

**v.** **High Risk** – below 0.4th BMI centile with recent loss of weight of 1 kg or more/week for two consecutive weeks

vi. **Bulimia Nervosa** - a condition of over-eating associated with the use of laxatives, vomiting or over-exercise to control weight.

96. It is estimated that about 725,000 people in the U.K. have anorexia or bulimia nervosa at any one time; bulimia is more common. Both conditions usually start during adolescence.

97. Other eating disorders exist; these include Binge-eating disorder, ARFID (Avoidant/restrictive food intake disorder), OSFED (Other specified feeding or eating disorder).

98. These guidelines are to assist staff in the recognition and management of pupils who may be suspected of or diagnosed as suffering from an eating disorder.

**Weighing**

To monitor pupils boarding at school, the following is advised:

i. When joining the school, all pupils will be weighed and measured, and Body Mass Index (BMI) calculated with reference to age using The Department of Health's RCPCH growth charts (Royal College of Paediatrics and Child Health).

ii. Weighing may be undertaken more frequently at the discretion of the School nurse should there be concerns about a pupil's weight.

**iii.** Pupils are to be weighed ONLY by the School nurse, in the Health Centre, in a discreet and sensitive manner. The results are to be kept as confidential medical records**.**

**Initial Assessment**

i. Concerns regarding pupils must be expressed to the School Nurse in the Health Centre, who will arrange an initial assessment.

ii. If deemed necessary by the School nurse, an appointment with a Doctor will be made. The Doctor will consult the pupil to exclude underlying physical disorders or other mental illness. A CAHMS referral will be made by the School nurse or the pupils Doctor should the pupil meet the threshold for referral.

**Confidentiality and Communication with parents/family**

See above section on confidentiality.

**Core Group**

With respect to the details of individual pupils, ideally a Core Group of people should meet to discuss Eating Disorder cases. The purpose of such meeting may involve treatment assessment and plans, support of pupil and parents, and support for involved carers. Such a group may consist of:

i. Parents
ii. Pupil
iii. Nurse
iv. Deputy Head (Pastoral)/DSL
v. Deputy Designated Safeguarding Leads (DDSL)
vi. Counsellor
vii. Houseparent
viii. Doctor
ix. CAHMS/Social Services

**Management**

i. Early recognition is vital; listen to concerns from staff and other pupils.
ii. After initial assessment by the School Nurse and a Doctor there will be an early referral to the School Counsellor and CAHMS.
iii. Pastoral Staff, Counsellor and the School nurse may manage cases in co-operation with pupil and parents.
iv. Be realistic - none of us are experts at managing eating disorders and referral to Specialist Centres may be appropriate such as the Eating Disorder Team at CAHMS

**Referral**

Referral should be made, after discussion with parents, to an appropriate Specialist (Psychiatrist/ Psychologist with expertise in this field) either privately or on the NHS.

**Boarding**

The decision as to whether a pupil with disordered eating should remain in boarding rests with the Head and the Deputy Head (Pastoral)/DSL, who must consider the impact that the pupil may have on other boarders, in addition to the pupil's own wellbeing. In making this decision, the pupils Doctor and Counsellor will be consulted, and the following considered:

i. A BMI below the 2$^{nd}$ centile is unusual and may reflect undernutrition but may simply reflect a small build.
ii. A BMI which is below the 0.4th centile on the RCPCH BMI chart would be considered to have additional problems and if not already receiving medical or dietetic attention should be referred.

iii. If there is a rapid weight loss and /or concerns regarding a pupil's relationship with food and there are concerns regarding their emotional/psychological/physiological state this will be discussed by appropriate members of the Core Group. Parents may be asked to withdraw their child from boarding.

iv. A pupil may return to boarding after an appropriate and negotiated weight gain as discussed with the Eating Disorder Team CAHMS or private provider)

v. After consensus decision from the Core Group, an Eating Disordered pupil may not remain in House if their behaviour causes significant disturbance or upset to other pupils.

99. Research suggests 'copycat' behaviour is unlikely to be a serious risk for an individual unless they are already predisposed to an Eating Disorder through personality traits, emotional restraint and low self-esteem, or abnormal family function.

100. Day pupils are encouraged to be weighed and measured in the same way as boarders.

101. If a problem is detected, the pupil (and parents) should be advised to consult their own GP, if not registered with the School Doctor.

102. If a pupil or parents are un-cooperative in a case of suspected eating disorder, then the Core Group will meet to discuss future action.

103. The Head, the Deputy Head (Pastoral)/DSL and DDSL should be informed of all eating disorder cases within the terms of Medical Confidentiality already mentioned.

104. The Head should make the final decision regarding removing pupils from the boarding environment or from the school itself, after consideration of Core Group consensus.
105. The Head must be informed if the pupil is a danger to themselves, if their behaviour is affecting others, or if they are not complying with management plans. These considerations over-ride the normal requirement for Confidentiality.

106. The following is advice for parents and carers:

**DO**

- Express love and support
- Try to understand, however difficult
- Discretely monitor food intake (without comment)
- Listen and talk, even if the content seems trivial and insignificant to you
- Try to see how the individual and other family members perceive the situation

- If the pupil is open to discussion, help to identify food types they consider acceptable.
- Realise that they are terrified of gaining weight and being fat although they may actually be underweight. These irrational fears are real to the individual.
- Emphasise the positive and all their good characteristics, and compliment on all the things they do well.
- Encourage them to accept support, and to honestly express their feelings
- Recognise that non-food factors are at the heart of the problem, e.g. losing control over certain aspects of their life, food and weight being the only thing they can control.
- Do all you can to encourage them to help themselves and to boost their self-esteem.
- **DON'T**
- Try to force them to eat or stop exercising.
- Comment on their appearance (positively or negatively) as it will be unlikely to be correctly interpreted.
- Get angry or punish them.
- Be impatient.
- Lecture, patronise or judge them.
- Be too busy, even if this means giving up 'important' things.
- Spy on them.
- Make them feel bad or guilty.
- Blame anybody for their problems.
- Pretend it will just go away.
- Be afraid to talk about and confront problems.
- Take it personally if they do not want to talk to you. Help them to find someone they want to talk to.

# Appendix 1

## Bereavement Policy

1. The aim of this policy is to facilitate the provision of a considered, planned and organised response to a pupil's experience of bereavement.

2. Parents are encouraged to inform the Houseparent of all situations of bereavement and, if at all possible, to come to see their child to impart distressing news.

3. Bereavement may apply to the loss of a close member of the family, a friend or a pet. Indeed, many pupils' first experience of bereavement may be the loss of a much-loved pet. Bereavement is included in the School's PSHE programme. In some circumstances, the nature of the death or deaths may necessitate the implementation of the **School's Emergency Plan**. That plan should be considered alongside this policy.

4. While every situation that surrounds a death is unique, there are similar implications and outcomes to most.

5. We recognise that the way in which young people are treated when someone important in their lives dies has a profound effect on their future ability to manage their own lives.

6. Most children and young people affected by a death just need adults who care about them. If the pupil was not close to the person who died, they may be relatively unaffected. However, it is best not to make any assumptions. Any death may make young people anxious, as they become more aware of their own mortality and that of those around them. Teenagers may become withdrawn and difficult to engage with. We need to respect their need for personal space whilst gently reminding them that we are there if they need us.

7. A team approach to handling a bereavement will be employed, to ensure that the pupil has a choice of mentors or support persons and that there is no danger of different members of staff thinking that others are dealing with this issue and nobody in fact doing so. We should be aware of our own, often English cultural, unwillingness or discomfort in talking about death.

8. The team should consist of the Head, Deputy Head (Pastoral)/DSL, Tutor, Counsellor/s and, possibly, any other member of staff considered particularly appropriate. The support of pupils in the House and peer group should be encouraged within the bounds of reasonable expectations. Some pupils may have experiences which enable them to be particularly empathetic, but they will need support and guidelines, as they are obviously not professionally trained.

9. The key people in the team are the pupil's Tutor and Houseparent, although s/he may not be the one with the greatest role once a support programme is established. S/he should liaise with the family, acquire the relevant facts and inform other members of the team and Head and other colleagues as appropriate. Most situations of bereavement will need to be known by all who teach the pupils concerned, as well as the Health Centre and in the case of a parent or guardian, the School Office staff. Basic facts should be entered onto CPOMS and TLC updated. The Houseparent should liaise with the Deputy Head (Pastoral)/DSL to discuss the most appropriate form of support and who will provide it. The likely forum for this would be a meeting.

10. Counselling should normally be offered, whether by the School Counsellor, Independent Listener or an outside agency.

11. The permission of the bereaved pupil should be gained before other pupils in the House are informed. They may or may not wish to be present.

12. What happened should be explained to the other pupils in a sensitive way to avoid rumours and whispers. The correct words such as 'death' and 'dead' should be used, rather than euphemisms such as 'passed away'.

13. Boarding staff should try to explain to other pupils how the bereaved pupil may be feeling and encourage them to be openly supportive.

14. In the case of a death of a pupil, whether at home or at school, the Housemaster/Housemistress, after first consulting with the Head and the deceased child's family or relatives, would then inform close friends and acquaintances. A general staff meeting might then be called to allow private grief before announcing the news to the rest of the school.

15. Confidentiality is paramount. To avoid rumours, it is important to be open and honest, not to make any assumptions about the cause of death unless:

- the deceased's next-of-kin has given consent;
- there has been an official determination.

16. It is essential that all staff and pupils, who are acquainted with the deceased, be informed as quickly as possible.

17. Staff should allow pupils to express their emotions, allowing them to show their feelings and thoughts in a safe environment with a member of staff with whom they feel at ease. However, the Head or Deputy Head (Pastoral)/DSL would discuss with staff how they feel about this.

18. It is essential to allow pupils to articulate their thoughts and feelings, to support them and not to let them feel in any way inhibited. Sharing their grief in a supportive environment can help facilitate the grieving process. It should also be remembered that as people react to such news in very different ways, some pupils might not want to share their feelings at an early stage. Sensitivity must always be shown, respecting the pupils' choice as to when they are ready to explore their feelings about what has happened.

19. For pupils or staff who are particularly affected, the school may wish to enlist the appropriate outside agencies, e.g. Cruse, Child Bereavement Trust, Mosaic.

20. The advent of death brings with it unforeseeable situations and circumstances that the team should consider and address. Once these have been identified a specified member of staff should assume responsibility and should deal with them.

21. In the event of multiple deaths, the School's Emergency Response Plan would be used.

22. It may be necessary to retrieve the personal belongings of the deceased for their return to the next-of-kin. Information on the school's database, including references and

addresses, will probably need to be amended and updated. This also applies to notice boards etc. The school may decide to write letters to parents to allow them to explain to their children the meaning and implications of an event. It is important for the school and parents to maintain a consistency in account and to deal with the effects of the situation similarly.

23. Before the bereaved pupil returns to school, there is likely to be a funeral. It is probable that pupils and staff will express a wish to attend, or take part in the service, but they should only do so with the agreement of the deceased's family or relatives' prior agreement, as well as the agreement of their own parents/guardians.

24. If the bereaved family wish pupils and staff to attend, the team should be available to offer support before and after the service. If they do not wish the school to attend, their wishes should be respected and the school should consider arranging an alternative.

25. This is a period when the bereaved, both family and close friends, try to come to terms with the situation. They may feel helpless yet wish in some way to express their sorrow. Planning a Memorial service, reading lessons, poems, playing music with a special meaning, can all assist in the grieving process.

26. When discussing cultural and religious beliefs, it is helpful to distinguish the terms of grief and mourning, as they are often used interchangeably and can cause confusion. **Grief** describes the emotional and psychological response to loss and is experienced by people of all cultures, whereas **mourning** denotes the actions and manner of portraying such grief and its expression is found to vary between cultures and religions.

27. Mourning practices reinforce societal norms by assisting the bereaved person to assign meaning to his/her loss, realign his/her role within society and to gain support from the family and community. Such mourning practices are denoted by the person's culture and are typically related to religious or political beliefs. According to many researchers, mourning practices are essential in enabling the bereaved to accept and come to terms with the loss – emotionally, cognitively and physically.

28. Worden (1984) identifies several reasons why we mourn. These include accepting the reality of the loss, to express grief, to adjust to the environment in which the deceased is no longer present and to re-invest in new relationships.

29. Differing cultures will determine to a large extent the involvement or otherwise of children in the traditions and rituals which surround death. It is clear that children involved in such ceremonies tend to deal with later life events with much less stress than those who are excluded. It has been observed that even children who have experienced a death of a pet are more prepared and have a better understanding of the physical characteristics of death, its permanency and the behaviours of grief and mourning than those who have not experienced such events.

30. Attending funerals or ceremonies of death therefore should, if the pupil feels they are able, be encouraged. Allowing pupils to attend such events gives them the opportunity to

express their grief, allowing them to accept the reality of their loss, to say good-bye as well as to allow the grieving process to begin. Without this opportunity they may well feel excluded later, developing feelings of anger, guilt and resentment as they gradually come to realise the significance of the events in which they did not participate.

31. Difficulties can also arise if a pupil is unable, or prevented from, expressing their grief in a way that is acceptable the pupil's culture. For example, a long mourning period can make it difficult to continue with activities outside the immediate family.

32. For the bereaved pupil or member of staff, returning to school will be traumatic. It is essential to pave the way for their return. In most cases it is advisable (providing the parents/guardians of the bereaved pupil agree) that everyone (teaching, ancillary staff and pupils) is aware of the situation before the pupil returns.

33. The pupil returning to school may well be worried how their friends will react, and what s/he should say to them. If everybody knows, and the bereaved person is aware of this, then it should make the situation more bearable. It is also important for everyone to be aware so that they can appreciate and make allowances for uncharacteristic behaviour. If staff find a pupil in a distressed state, they will at least be prepared in their own minds as how best to deal with it.

34. Staff should be aware of the need for quiet places.

35. A pupil experiencing bereavement will find school very tiring. They will find it difficult to concentrate, may think more slowly, lack initiative and need more help than usual. They may feel different and not 'normal'.

36. Staff should look for changes in behaviour, which may surface many months later. Aggression may be a way of letting out feelings of anger or anxiety. Be equally alert for a pupil who is uncharacteristically quiet.

37. Following the death of a member of the School, a book of condolence may be an invaluable vehicle for expression of feelings, as well as an appropriate symbol of remembrance. Other appropriate forms of tribute or memorial may be considered.

38. Awareness of and sensitivity to significant anniversaries is important – the Housemaster/Housemistress should make a discreet note of anniversaries.

39. The following are key points for counselling the bereaved:

- Offer to support, but don't be obtrusive.
- Share grief.
- Allow discussion.
- Allow expression.
- Talk openly but honestly about the person who has died.
- Be aware of other peoples' beliefs and values.
- Reassure those who feel that they are in some way to blame.

- Be honest with explanations.
- Be compassionate but firm.
- Be prepared to ask for additional help if needed.
- Expect regression.
- Never avoid the bereaved.
- Never pretend life will be the same.
- Never put a time limit on how long you expect the grieving period to last.
- Be honest at all times.

## Useful Resources

**The Child Bereavement Charity** - http://childbereavementuk.org/for-schools/secondary-schools/

**Cruse Bereavement Care Youth Involvement Project** http://www.cruse.org.uk/children
**Mosaic** http://www.mosaicfamilysupport.org.uk/

**Winston's Wish -** http://www.winstonswish.org.uk/

**http://hopeagain.org.uk/** - a website for children and young people who have been bereaved and want news and information designed for them. Also has details of a confidential telephone number and private email service to contact a counsellor. Also has a message board.

**Childline** - http://www.childline.org.uk/talk/Pages/Talk.aspx