Positive Mental Health Policy
HOLLY GROVE SCHOOL

Policy Statement

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

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

In addition to promoting positive mental health, we aim to recognise and respond to mental ill health. In an average mainstream classroom, three children will be suffering from a diagnosable mental health issue. Although it can be challenging to identify mental ill health in children with additional needs, by developing and implementing practical, relevant and effective mental health policies and procedures we can promote a safe and stable environment for children affected both directly and indirectly by mental ill health.

Scope

This document describes the school's approach to promoting positive mental health and wellbeing.
This policy is intended as guidance for all staff including non-teaching staff and governors.
This policy should be read in conjunction with our Behaviour Policy.

The Policy Aims to:

- Promote positive mental health in all staff, children and families
- Increase understanding and awareness of common mental health issues
- Alert staff to early warning signs of mental ill health
- Provide support to staff working with children with mental health issues
- Provide support to children suffering mental ill health and their peers and parents or carers

Lead Members of Staff

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

- Karen Alty (Headteacher), Eve Taylor (Deputy Head), Nick Barrett (Family Support Manager), Danielle Alty (Assistant Headteacher Key Stage 2) - Designated Child Protection / Safeguarding Lead and Deputies.
- Karen Alty (Headteacher) - Mental Health Lead
- Eve Taylor (Deputy Headteacher) - Lead First Aider

 Nick Barrett – Family Support Manager
 Eve Taylor - CPD lead
 Rebecca Taylor – Subject Leader for PSHE
 We also have staff and children who are Well-being Champions.

Any member of staff who is concerned about the mental health or wellbeing of a child should speak to the mental health lead in the first instance. If there is a fear that the child is in danger of immediate harm then the normal child protection procedures should be followed with an immediate referral to the designated child protection lead, the head teacher or the designated governor. If the child presents a medical emergency then the normal procedures for medical emergencies should be followed, including alerting the first aid staff and contacting the emergency services if necessary. Where a referral to CAMHS is appropriate, this will be led and managed by Karen Alty, mental health lead. Guidance about referring to CAMHS is provided in Appendix F.

Individual Care Plans

Initially children will be assessed using the Boxall Profile. Targets will be identified and included in Targeted Learning/Play Plans where appropriate.
It may also be helpful to draw up an individual care plan for pupils causing concern or who receive a diagnosis pertaining to their mental health. This should be drawn up involving the pupil, the parents and the school nurse / any relevant health professionals.

Teaching about Mental Health

The skills, knowledge and understanding needed by our children to keep themselves and others physically and mentally healthy and safe are included as part of our developmental PSHE curriculum. The specific content of lessons will be determined by the specific needs of the cohort we're teaching but there will always be an emphasis on enabling children to develop the skills, knowledge, understanding, language and confidence to seek help, as needed, for themselves or others.
We will follow the PSHE Association Guidance[1] to ensure that we teach mental health and emotional wellbeing issues in a safe and sensitive manner which helps rather than harms.
[1] Teacher Guidance: Preparing to teach about mental health and emotional wellbeing

Signposting

We will ensure that staff, children and parents are aware of sources of support within school and in the local community. What support is available within our school and local community, who it is aimed at and how to access it is outlined in Appendix D.

Whenever we highlight sources of support, we will increase the chance of child help-seeking by ensuring children understand:
 What help is available
 Who it is aimed at
 How to access it
 Why to access it
 What is likely to happen next

Warning Signs

School staff may become aware of warning signs which indicate a child is experiencing mental health or emotional wellbeing issues. These warning signs should **always** be taken seriously and staff observing any of these warning signs should communicate their concerns with Karen Alty, our mental health and emotional wellbeing lead and record on CPOMS.
Possible warning signs include:
 Physical signs of harm that are repeated or appear non-accidental
 Changes in eating or sleeping habits
 Increased isolation from friends or family, becoming socially withdrawn
 Changes in activity and mood
 Lowering of academic achievement
 Talking or joking about self-harm or suicide
 Expressing feelings of failure, uselessness or loss of hope
 Changes in clothing – e.g. long sleeves in warm weather
 Secretive behaviour
 Skipping PE or getting changed secretively
At Holly Grove the above signs could relate to a number of issues due to the additional needs of our children. All concerns should always be recorded on CPOMS.

Managing disclosures

A child may choose to disclose concerns about themselves or a friend to any member of staff so all staff need to know how to respond appropriately to a disclosure.
If a child chooses to disclose concerns about their own mental health or that of a friend to a member of staff, the member of staff's response should always be calm, supportive and non-judgemental. Staff should listen rather than advise and our first thoughts should be of the child's emotional and physical safety rather than of exploring 'Why?' For more information about how to handle mental health disclosures sensitively see appendix E.
All disclosures should be recorded on CPOMS. It should include:

- The name of the member of staff to whom the disclosure was made
- The main points from the conversation
- Agreed next steps

See appendix F for guidance about making a referral to CAMHS.

Confidentiality

We should be honest with regard to the issue of confidentiality. If it is necessary for us to pass our concerns about a child on, then we should discuss with the child:
 Who we are going to talk to
 What we are going to tell them
 Why we need to tell them

We should never share information about a child without first telling them (where appropriate taking into account their level of learning difficulties). Ideally we would receive their consent, though there

are certain situations when information must always be shared with another member of staff and / or a parent, e.g. children who are in danger of harm.
It is always advisable to share disclosures with a colleague, usually the mental health lead, Karen Alty. This helps to safeguard our own emotional wellbeing as we are no longer solely responsible for the child, it ensures continuity of care in our absence; and it provides an extra source of ideas and support. We should explain this to the child and discuss with them who it would be most appropriate and helpful to share this information with.
Parents must always be informed and children may choose to tell their parents themselves. If a child gives us reason to believe that there may be underlying child protection issues, parents should not be informed, but the child protection leads (Karen Alty, Eve Taylor, Nick Barrett and Danielle Alty) must be informed immediately.

Working with Parents

Where it is deemed appropriate to inform parents, we need to be sensitive in our approach. Before disclosing to parents we should consider the following questions (on a case by case basis):

- Can the meeting happen face to face? This is preferable
- Where should the meeting take place? At school, at their home or somewhere neutral?
- Who should be present? Consider parents, the child, other members of staff.
- What are the aims of the meeting?

It can be shocking and upsetting for parents to learn of their child's issues and many may respond with anger, fear or upset during the first conversation. We should be accepting of this (within reason) and give the parent time to reflect.

We should always highlight further sources of information and give them leaflets to take away where possible as they will often find it hard to take much in whilst coming to terms with the news that you're sharing. Sharing sources of further support aimed specifically at parents can also be helpful too, e.g. parent helplines and forums.
We should always provide clear means of contacting us with further questions and consider booking in a follow-up meeting or phone call right away as parents often have many questions as they process the information. Finish each meeting with agreed next steps and always keep a brief record of the meeting on CPOMS.

Working with All Parents

Parents are often very welcoming of support and information from the school about supporting their children's emotional and mental health. In order to support parents, we will:
 Highlight sources of information and support about common mental health issues on our school website
 Ensure that all parents are aware of who to talk to, and how to go about this, if they have concerns about their own child or a friend of their child
 Make our mental health policy easily accessible to parents
 Share ideas about how parents can support positive mental health in their children
 Keep parents informed about the mental health topics their children are learning about in PSHE and share ideas for extending and exploring this learning at home (where appropriate taking into consideration their level of learning difficulties).

Supporting Peers

When a child is suffering from mental health issues, it can be a difficult time for their friends. Friends often want to support but do not know how. In the case of self-harm or eating disorders, it is possible that friends may learn unhealthy coping mechanisms from each other. In order to keep peers safe, we will consider on a case by case basis which friends may need additional support. Support will be provided either in one to one or group settings and will be guided by conversations with the child who is suffering and their parents with whom we will discuss:
 What it is helpful for friends to know and what they should not be told
 How friends can best support
 Things friends should avoid doing or saying which may inadvertently cause upset
 Warning signs that their friend may need help (e.g. signs of relapse)

Additionally, we will want to highlight with peers:
 Where and how to access support for themselves
 Safe sources of further information about their friend's condition (where appropriate)
 Healthy ways of coping with the difficult emotions they may be feeling

Training

As a minimum, all staff will receive regular training about recognising and responding to mental health issues as part of their regular child protection training to enable them to keep children safe. The MindEd learning portal[2] provides free online training suitable for staff wishing to know more about a specific issue.

2 www.minded.org.uk

3 Source: Young Minds

Training opportunities for staff who require more in depth knowledge will be considered as part of our performance management process and additional CPD will be supported throughout the year where it becomes appropriate due to developing situations with one or more children.

Where the need to do so becomes evident, we will host twilight training sessions for all staff to promote learning or understanding about specific issues related to mental health.

Suggestions for individual, group or whole school CPD should be discussed with Eve Taylor, our CPD Subject Leader, who can also highlight sources of relevant training and support for individuals as needed.

Policy Review

This policy will be reviewed every 3 years as a minimum. It is next due for review in Autumn 2021. Additionally, this policy will be reviewed and updated as appropriate on an ad hoc basis. If you have a question or suggestion about improving this policy, this should be addressed to Karen Alty our mental health lead via phone 01282 682278 or email head@holly-grove.sch.uk

This policy will always be immediately updated to reflect personnel changes.

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

Prevalence of Mental Health and Emotional Wellbeing Issues[3]

1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every mainstream class.

 Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.

There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%.

 More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.

 Nearly 80,000 children and young people suffer from severe depression.

 The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.

 Over 8,000 children aged under 10 years old suffer from severe depression.

 3.3% or about 290,000 children and young people have an anxiety disorder.

 72% of children in care have behavioural or emotional problems - these are some of the most vulnerable people in our society.

Below, we have sign-posted information and guidance about the issues most commonly seen in school-aged children. The links will take you through to the most relevant page of the listed website. Some pages are aimed primarily at parents but they are listed here because we think they are useful for school staff too.

Support on all these issues can be accessed via Young Minds (www.youngminds.org.uk), Mind (www.mind.org.uk) and (for e-learning opportunities) Minded (www.minded.org.uk).

Self-harm

Self-harm describes any behaviour where a young person causes harm to themselves in order to cope with thoughts, feelings or experiences they are not able to manage in any other way. It most frequently takes the form of cutting, burning or non-lethal overdoses in adolescents, while younger children and young people with special needs are more likely to pick or scratch at wounds, pull out their hair or bang or bruise themselves.

Online support

SelfHarm.co.uk: www.selfharm.co.uk

National Self-Harm Network: www.nshn.co.uk

Books

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2012) *A Short Introduction to Understanding and Supporting Children and Young People Who Self-Harm*. London: Jessica Kingsley Publishers

Depression

Ups and downs are a normal part of life for all of us, but for someone who is suffering from depression these ups and downs may be more extreme. Feelings of failure, hopelessness, numbness or sadness may invade their day-to-day life over an extended period of weeks or months, and have a significant impact on their behaviour and ability and motivation to engage in day-to-day activities.

Online support

Depression Alliance: www.depressionalliance.org/information/what-depression

Books

Christopher Dowrick and Susan Martin (2015) *Can I Tell you about Depression?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Anxiety, panic attacks and phobias

Anxiety can take many forms in children and young people, and it is something that each of us experiences at low levels as part of normal life. When thoughts of anxiety, fear or panic are repeatedly present over several weeks or months and/or they are beginning to impact on a young person's ability to access or enjoy day-to-day life, intervention is needed.

Online support

Anxiety UK: www.anxietyuk.org.uk

Books

Lucy Willetts and Polly Waite (2014) *Can I Tell you about Anxiety?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2015) *A Short Introduction to Helping Young People Manage Anxiety*. London: Jessica Kingsley Publishers

Obsessions and compulsions

Obsessions describe intrusive thoughts or feelings that enter our minds which are disturbing or upsetting; compulsions are the behaviours we carry out in order to manage those thoughts or feelings. For example, a young person may be constantly worried that their house will burn down if they don't turn off all switches before leaving the house. They may respond to these thoughts by repeatedly checking switches, perhaps returning home several times to do so. Obsessive compulsive disorder (OCD) can take many forms – it is not just about cleaning and checking.

Online support

OCD UK: www.ocduk.org/ocd

Books

Amita Jassi and Sarah Hull (2013) *Can I Tell you about OCD?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Susan Conners (2011) *The Tourette Syndrome & OCD Checklist: A practical reference for parents and teachers*. San Francisco: Jossey-Bass

Suicidal feelings

Young people may experience complicated thoughts and feelings about wanting to end their own lives. Some young people never act on these feelings though they may openly discuss and explore them, while other young people die suddenly from suicide apparently out of the blue.

Online support

Prevention of young suicide UK – PAPYRUS: www.papyrus-uk.org

On the edge: ChildLine spotlight report on suicide: www.nspcc.org.uk/preventing-abuse/research-and-resources/on-the-edge-childline-spotlight/

Books

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Terri A.Erbacher, Jonathan B. Singer and Scott Poland (2015) *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention*. New York: Routledge

Eating problems

Food, weight and shape may be used as a way of coping with, or communicating about, difficult thoughts, feelings and behaviours that a young person experiences day to day. Some young people develop eating disorders such as anorexia (where food intake is restricted), binge eating disorder and bulimia nervosa (a cycle of bingeing and purging). Other young people, particularly those of primary or preschool age, may develop problematic behaviours around food including refusing to eat in certain situations or with certain people. This can be a way of communicating messages the child does not have the words to convey.

Online support

Beat – the eating disorders charity: www.b-eat.co.uk/about-eating-disorders

Eating Difficulties in Younger Children and when to worry: www.inourhands.com/eating-difficulties-in-younger-children

Books

Bryan Lask and Lucy Watson (2014) *Can I tell you about Eating Disorders?: A Guide for Friends, Family and Professionals*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2012) *Eating Disorders Pocketbook*. Teachers' Pocketbooks

Appendix B: Guidance and advice documents

Mental health and behaviour in schools - departmental advice for school staff. Department for Education (2014)

Counselling in schools: a blueprint for the future - departmental advice for school staff and counsellors. Department for Education (2015)

Teacher Guidance: Preparing to teach about mental health and emotional wellbeing (2015). PSHE Association. Funded by the Department for Education (2015)

Keeping children safe in education - statutory guidance for schools and colleges. Department for Education (2014)

Supporting pupils at school with medical conditions - statutory guidance for governing bodies of maintained schools and proprietors of academies in England. Department for Education (2014)

Healthy child programme from 5 to 19 years old is a recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. Department of Health (2009)

Future in mind – promoting, protecting and improving our children and young people's mental health and wellbeing - a report produced by the Children and Young People's Mental Health and Wellbeing Taskforce to examine how to improve mental health services for children and young people. Department of Health (2015)

NICE guidance on social and emotional wellbeing in primary education

NICE guidance on social and emotional wellbeing in secondary education

What works in promoting social and emotional wellbeing and responding to mental health problems in schools? Advice for schools and framework document written by Professor Katherine Weare. National Children's Bureau (2015)

Appendix C: Data Sources

Children and young people's mental health and wellbeing profiling tool collates and analyses a wide range of publically available data on risk, prevalence and detail (including cost data) on those services that support children with, or vulnerable to, mental illness. It enables benchmarking of data between areas.

ChiMat school health hub provides access to resources relating to the commissioning and delivery of health services for school children and young people and its associated good practice, including the new service offer for school nursing.

Health behaviour of school age children is an international cross-sectional study that takes place in 43 countries and is concerned with the determinants of young people's health and wellbeing.

Appendix D: Sources or support at school and in the local community

School Based Support

List the full range of support available to childs. For each include:

- First Aid Mental Health Lead
- Trained Mental Health First Aiders
- Well-being Champions both children and staff
- Well-being Change Team
- Boxall Profiles
- Supervision – is provided by Listening Tree for Senior Members of staff. Provided by Supervision Facilitators Eve Taylor, Rebecca Taylor, Angie Henney and Nick Barrett on a half termly basis or when required by completing a request form in the Deputies Office.

This information is communicated to children:

- See above for key members of staff
- Angie Henney and Class Teacher/Key Worker will complete Boxall Profiles.
- Well-Being Champions (displayed on well-being board) offer 1:1 Interventions which include sensory processing, Lego therapy, art therapy, nurture/containment time with their trusted adult of choice.

Local Support

Information is available in the Family Support Team Office.

Appendix E: Talking to children when they make mental health disclosures

The advice below is from children themselves, in their own words, together with some additional ideas to help you in initial conversations with children when they disclose mental health concerns. This advice should be considered alongside relevant school policies on pastoral care and child protection and discussed with relevant colleagues as appropriate.

Focus on listening

"She listened, and I mean REALLY listened. She didn't interrupt me or ask me to explain myself or anything, she just let me talk and talk and talk. I had been unsure about talking to anyone but I knew quite quickly that I'd chosen the right person to talk to and that it would be a turning point."

If a child has come to you, it's because they trust you and feel a need to share their difficulties with someone. Let them talk. Ask occasional open questions if you need to in order to encourage them to keep exploring their feelings and opening up to you. Just letting them pour out what they're thinking will make a huge difference and marks a huge first step in recovery. Up until now they may not have admitted even to themselves that there is a problem.

Don't talk too much

"Sometimes it's hard to explain what's going on in my head – it doesn't make a lot of sense and I've kind of gotten used to keeping myself to myself. But just 'cos I'm struggling to find the right words doesn't mean you should help me. Just keep quiet, I'll get there in the end."

The child should be talking at least three quarters of the time. If that's not the case then you need to redress the balance. You are here to listen, not to talk. Sometimes the conversation may lapse into silence. Try not to give in to the urge to fill the gap, but rather wait until the child does so. This can often lead to them exploring their feelings more deeply. Of course, you should interject occasionally, perhaps with questions to the child to explore certain topics they've touched on more deeply, or to show that you understand and are supportive. Don't feel an urge to over-analyse the situation or try to offer answers. This all comes later. For now your role is simply one of supportive listener. So make sure you're listening!

Don't pretend to understand

"I think that all teachers got taught on some course somewhere to say 'I understand how that must feel' the moment you open up. YOU DON'T – don't even pretend to, it's not helpful, it's insulting."
The concept of a mental health difficulty such as an eating disorder or obsessive compulsive disorder (OCD) can seem completely alien if you've never experienced these difficulties first hand. You may find yourself wondering why on earth someone would do these things to themselves, but don't explore those feelings with the sufferer. Instead listen hard to what they're saying and encourage them to talk and you'll slowly start to understand what steps they might be ready to take in order to start making some changes.

Don't be afraid to make eye contact

"She was so disgusted by what I told her that she couldn't bear to look at me."
It's important to try to maintain a natural level of eye contact (even if you have to think very hard about doing so and it doesn't feel natural to you at all). If you make too much eye contact, the child may interpret this as you staring at them. They may think that you are horrified about what they are saying or think they are a 'freak'. On the other hand, if you don't make eye contact at all then a child may interpret this as you being disgusted by them – to the extent that you can't bring yourself to look at them. Making an effort to maintain natural eye contact will convey a very positive message to the child.

Offer support

"I was worried how she'd react, but my Mum just listened then said 'How can I support you?' – no one had asked me that before and it made me realise that she cared. Between us we thought of some really practical things she could do to help me stop self-harming."
Never leave this kind of conversation without agreeing next steps. These will be informed by your conversations with appropriate colleagues and the schools' policies on such issues. Whatever happens, you should have some form of next steps to carry out after the conversation because this will help the child to realise that you're working with them to move things forward.

Acknowledge how hard it is to discuss these issues

"Talking about my bingeing for the first time was the hardest thing I ever did. When I was done talking, my teacher looked me in the eye and said 'That must have been really tough' – he was right, it was, but it meant so much that he realised what a big deal it was for me."

It can take a young person weeks or even months to admit to themselves they have a problem, themselves, let alone share that with anyone else. If a child chooses to confide in you, you should feel proud and privileged that they have such a high level of trust in you. Acknowledging both how brave they have been, and how glad you are they chose to speak to you, conveys positive messages of support to the child.

Don't assume that an apparently negative response is actually a negative response

"The anorexic voice in my head was telling me to push help away so I was saying no. But there was a tiny part of me that wanted to get better. I just couldn't say it out loud or else I'd have to punish myself."

Despite the fact that a child has confided in you, and may even have expressed a desire to get on top of their illness, that doesn't mean they'll readily accept help. The illness may ensure they resist any form of help for as long as they possibly can. Don't be offended or upset if your offers of help are met with anger, indifference or insolence; it's the illness talking, not the child.

Never break your promises

"Whatever you say you'll do you have to do or else the trust we've built in you will be smashed to smithereens. And never lie. Just be honest. If you're going to tell someone just be upfront about it, we can handle that, what we can't handle is having our trust broken."

Above all else, a child wants to know they can trust you. That means if they want you to keep their issues confidential and you can't then you must be honest. Explain that, whilst you can't keep it a secret, you can ensure that it is handled within the school's policy of confidentiality and that only those who need to know about it in order to help will know about the situation. You can also be honest about the fact you don't have all the answers or aren't exactly sure what will happen next. Consider yourself the child's ally rather than their saviour and think about which next steps you can take together, always ensuring you follow relevant policies and consult appropriate colleagues.

Appendix F: What makes a good CAMHS referral?

Adapted from Surrey and Border NHS Trust

If the referral is urgent it should be initiated by phone so that CAMHS can advise of best next steps

Before making the referral, have a clear outcome in mind. What do you want CAMHS to do? You might be looking for advice, strategies, support or a diagnosis, for instance. You must also be able to provide evidence to CAMHS about what intervention and support has been offered to the pupil by the school and the impact of this. CAMHS will always ask 'What have you tried?' so be prepared to supply relevant evidence, reports and records.

General considerations

- Have you met with the parent(s) or carer(s) and the referred child or children?
- Has the referral to CMHS been discussed with a parent or carer and the referred pupil?
- Has the pupil given consent for the referral?
- Has a parent or carer given consent for the referral?
- What are the parent or carer pupil's attitudes to the referral?

Basic information

- Is there a child protection plan in place?
- Is the child looked after?
- Name and date of birth of referred child/children
- Address and telephone number
- Who has parental responsibility?
- Surnames if different to child's

GP details

- What is the ethnicity of the pupil / family?
- Will an interpreter be needed?
- Are there other agencies involved?

Reason for referral

- What are the specific difficulties that you want CAMHS to address?
- How long has this been a problem and why is the family seeking help now?
- Is the problem situation-specific or more generalised?
- Your understanding of the problem or issues involved.

Further helpful information

- Who else is living at home and details of separated parents if appropriate
- Name of school
- Who else has been or is professionally involved and in what capacity?
- Has there been any previous contact with our department?
- Has there been any previous contact with social services?
- Details of any known protective factors

Any relevant history i.e. family, life events and/or developmental factors

- Are there any recent changes in the pupil's or family's life?
- Are there any known risks, to self, to others or to professionals?
- Is there a history of developmental delay e.g. speech and language delay
- Are there any symptoms of ADHD/ASD and if so have you talked to the educational psychologist?

The screening tool on the following page will help guide you as to whether or not a CAMHS referral is appropriate.
For further support and advice, our primary contacts are:
Professional's advisory line 123456789 email@email.com
Primary Mental Health worker team 123456789 email@email.com
Name, Role: 123456789 email@email.com

INVOLVEMENT WITH CAMHS	**DURATION OF DIFFICULTIES**
Current CAMHS involvement – **END OF SCREEN***	1-2 weeks
Previous history of CAMHS involvement	Less than a month
Previous history of medication for mental health issues	1-3 months
Any current medication for mental health issues	More than 3 months
Developmental issues e.g. ADHD, ASD, LD	More than 6 months