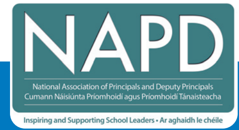

The Very Useful Guide

Policy Guidance – Supporting staff to deal with students experiencing a Mental Health issue

1.0 INTRODUCTION

1.1 THE IMPORTANCE OF STUDENT MENTAL HEALTH PROMOTION

For many students, entry into post primary marks the onset of one of the most challenging periods of adolescence. For this reason, the ability of St Project's School to recognise and plan for these challenges can have a very positive effect on a student's ability to navigate this complex developmental time in a young person's life successfully.

Some students may have experienced mental health difficulties and others may find that they are beginning to have difficulties with things such as concentration, motivation, stamina, creativity, attendance, eating regularly, managing anxiety, or other issues.

Schools have an important role to play in mental health promotion and can act as a protective factor to increase resilience and improve well-being. Within the Irish education system, key guidelines have identified schools as an environment in which to promote the emotional and mental health of students with current thinking focusing on a 'whole school' approach to mental health for all (DES, 2013).

The Department of Education's Wellbeing Policy Statement and Framework for Practice 2018 states that "*Schools play a vital role, in the promotion of children and young people's academic, physical, mental, emotional, social and spiritual development*".

Student mental health issues affect all members of our schools either directly or indirectly. Supporting students with mental health issues is never easy or straightforward and staff often worry that they are '*getting it wrong'* or are fearful that they might make a mistake or err in some way.

This document sets out the parameters for the in-house support on offer and understands the process of 'referring on' to local networks and resources such as counsellors, GPs and local mental health services.

1.2 POLICY STATEMENT

St. Project's is committed to an inclusive education for all, which welcomes diversity and promotes equal opportunities for students to develop to their full potential. To this end, St. Project's student mental health policy:

- enables the school to fulfil its caring, educational and legal responsibilities to students;
- heightens awareness and increases understanding across the college community about mental health issues;
- promotes informed and constructive attitudes to mental health issues;
- follows international best practice guidelines in the area of student mental health, including the provision of appropriate and timely support services for students;
- provides guidance and promotes training to ensure staff are aware of the emergency procedures, the support services available and know how to make appropriate referrals and interventions for students they encounter with mental health difficulties;
- respects the rights of each individual student and of the student body as a whole;
- defines the right to confidentiality within specified guidelines.

By articulating a written policy and providing guidelines on student mental health, St. Project's aims to promote student well-being, to provide a safe and healthy work environment for all students and staff, to ensure that appropriate intervention is taken where needed and which encourages students with mental health difficulties to disclose them so that appropriate arrangements can be made to support them.

This policy will be reviewed and updated on a regular basis.

1.3 RELATIONSHIP TO OTHER SCHOOL POLICIES

St. Project's has a number of other policies, codes and procedures that should be read in conjunction with this policy. These include:

- Code of Behaviour
- Anti-Bullying
- Wellbeing Policy
- Safeguarding and associated policies
- Student support and Critical Incident Policy
- Guidance and Counselling Policy
- Substance Use
- Campus security
- Inclusion
- Acceptable Use IT

Include additional policies as appropriate for your school*. i.e. Pastoral Care Policy, School Tour Policy (if something happens outside normal school day), etc.*

2.0 SCOPE OF THE DOCUMENT

Section 2 briefly outlines the meaning of the term '*mental health*', and explains the distinction between mental health difficulties and mental illness. Section 3 aims to give guidance to members of staff and students on how and where to seek help for students experiencing mental health problems. The important issue of confidentiality is also addressed in this section.

The policy concludes with a list of support services (relating to Sections 2 and 3) and a sample incident recording form.

2.1 WHAT IS MEANT BY THE TERM 'MENTAL HEALTH DIFFICULTY'?

The term '*mental health*' describes a sense of well-being, the capacity to live in a resourceful and fulfilling manner and to have the resilience to deal with the challenges and obstacles which life presents. A mental health problem is one in which a person is distracted from ordinary daily living by upsetting and disturbing thoughts, behaviours and/or feelings. These problems may disorientate a person's view of the world and produce a variety of symptoms and behaviour likely to cause distress and concern. Mental health is a continuum encompassing the mild anxieties and disappointments of daily life, to severe problems affecting mood, perception, behaviour and the ability to think and communicate clearly and rationally.

3.0 GUIDANCE WHEN DEALING WITH STUDENTS WHO ARE EXPERIENCING MENTAL HEALTH DIFFICULTIES

3.1 DEALING WITH STUDENTS EXPERIENCING MENTAL HEALTH DIFFICULTIES?

The following section outlines how to deal with the situation if you are concerned that a student is showing signs of distress. Staff should be ready to offer support to students but are not expected to assume responsibilities outside the parameters of their role. Staff should be aware of their personal and professional limitations. The appropriate course of action for staff members who become concerned about a student's mental health depends on the urgency of the situation. Staff may need to make an assessment and a judgement if the situation is an emergency and a student should be referred if there is a concern. If you are uncertain about what action is required you should consult with any of the following staff (*sample list that will need to be adjusted to reflect each individual school)*:

Guidance Counsellor	Tutor
Care Team member	Chaplain
Principal	Deputy Principal

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3.2 HOW URGENT IS THE SITUATION?

Staff member concerned about mental health of student

If the student is very threatening or very aggressive
Call Gardaí 112 or 999

Life Threatening Emergency
Overdose Definite or Possible
Call Ambulence 112 or 999

Non-urgent

If the student seeks help or:

- Is withdrawn, low in mood, tearful.
- Is unduly anxious.
- Shows unusual academic deterioration.

and

- Does not display features considered as Urgent/Emergency.

Urgent/Emergency

If the student is or appears:

- Suicidal or is wishing they were dead.
- Reporting or threatening to self-harm or harm others.
- Disclosed a recent sexual assault/abuse
- Expressing bizarre thoughts or ideas which are out of reality.
- Unduly agitated or behaving in a bizarre manner.

Response (Non-urgent)

- Explain your concerns to student.
- Advise and encourage the students to talk to their parent or talk to school's Guidance Counsellor.
- Ask the student do they want you to talk to their parent.
- Arrange a follow up appointment to talk to the student.
- You may wish to discuss your concerns at this stage with the Tutor/Year Head/ Guidance Counsellor or request the student be brought up at the Care Team meeting.
- Further action is appropriate at any stage where their condition or situation deteriorates to become Urgent or an Emergency.
- Keep a record of the incident(s) and response(s).

Response (Urgent/Emergency)

- Send for help.
- If possible, consult a colleague – do not act alone.
- Inform Principal, Deputy Principal/Guidance Counsellor.
- Explain concerns to student, unless you judge this will inflame the situation.
- Seek consent to contact parent/guardian of student (beyond consent if a treat to life).
- Remove other students from the room if there is a danger of aggression. In the case of violence/armed assault implement the evacuation or lock down procedures.
- Does the school need to contact A&E/ D-Doc/An Garda Siochána?
- Keep a record of the incident(s) and response(s).

** Schools should have clear referral procedures and only trained and qualified staff should work with students experiencing mental health issues.*

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SUGGESTED TEMPLATE WHICH TAKES ACCOUNT OF SAFEGUARDING AND SUICIDE THREAT

The following outlines the actions to be followed when students are identified at risk of significant mental health issues. If the student discusses any alleged abuse, then the Principal will firstly seek advice from Túsla, Child & Family Agency as an appropriate step to take before contacting the parents/guardians.

Student tell staff of attempt or thoughts of suicide and plans in relation to self/others.

Students or staff members learn of attempt.

Staff member believes that a student is at risk.

...makes a referral to the Student Support Team (SST) and/or Guidance Counsellor.

Guidance Counsellor meets with student to explore concerns.

May talk with key staff members who know the student well.

Completes a "Risk Assessment" if appropriate with SST members.

STUDENT NOT CONSIDERED AT HIGH RISK

Parents are informed. Feedback is provided to original source of referral, with plan for monitoring.

The Guidance Counsellor documents the process and schedules a review.

CONCERNS CONFIRMED

As appropriate, the Guidance Counsellor informs the Principal /consults with NEPS (if deemed necessary).

Safeguarding: Disclosure of alleged abuse: Principal follows advice from TUSLA.

Mental Health Issue: The Principals informs parents regarding immediate action e.g. seek GP advice, etc.

Devises on-going plan.

Informs relevant staff.

Contacts NEPS.

The school decides on a management plan for the student/s while at the school.

Parents make contact with GP.

The first thing to try to establish is how urgent and serious the situation is:

- Is the student at risk of immediately hurting her/himself or others?
- Is there an immediate risk of suicide?
- Is the student confused, drowsy or ill?
- Is the student acting "*out of sorts*"?
- Has the student's behaviour, mood or personality suddenly changed?

If the above questions do not apply, see section 3.4 below (Non- Emergency Situation) as you may be concerned about a student because of his or her:

- lack of interaction, isolation or withdrawal from staff or peers;
- difficulties with daily functioning (eating, sleeping, mood, physical activity, personal appearance);
- attendance problems;
- changed academic performance;
- lack of attention/involvement.

3.3 EMERGENCY SITUATION

If you are teaching/supervising/ co teaching/ or you are an SNA in a class the following applies to you:

If an individual i.e. student has overdosed or requires assistance for self-harm or has exhibited aggressive behaviour

1. Ask a student to go get another member of staff for help
2. Move all the other students out of the room to General Purpose area or the closest vacant room
3. Contact Emergency services

Once help is on its way, if it is safe to do so, reassure the student and wait with him/her until help arrives.

After the incident:

1. Type up a full account of what happened keeping the account factual and non-emotive (see appendix for template) and forward (in line with school procedure) to a member of the Senior Management Team
2. Offer to debrief staff following the incident • Consider contacting Employee Assistance and Wellbeing Programme (EAWP). Phone: Inspire Workplace (CareCall) – 1800 411 057.

Violence or a student being armed may require a different response in order to protect the immediate safety of the student/s and staff. Schools need to have both an evacuation policy and a lock down for such threats.

3.4 NON-EMERGENCY SITUATION

This section provides advice for staff when dealing with a non-emergency situation with a student. The student themselves may approach the staff member seeking help and may

- appear withdrawn
- be in a low mood, tearful or unduly anxious
- have deterioration in attendance at class or in academic performance.

The following outlines the steps that staff should take if a student wishes to discuss an issue with them or in cases where they initiate a conversation with a student.

1. When discussing sensitive issues, you should arrange to speak to the student in a setting where s/he can feel safe. Do not promise confidentiality as you may need to report the matter to your DLP.

2. If you have concerns about the student and their wellbeing, discuss with the student your concerns and reasons for them.
3. Listen to the student, try not to make judgements and keep an open mind. The process of listening itself might be helpful to the student.
4. Encourage the student to avail of support at home or through the guidance office
5. Offer to communicate your/their concern to home or the guidance office.
6. Keep a record of the incident and responses. Inform the student that you are doing so, unless you judge that in might inflame the situation.
7. If during the conversation the student expresses suicidal ideation, wishes they were dead, threatens self-harm, discloses sexual abuse, expresses bizarre thoughts or ideas or becomes unduly agitated, then you should contact the Principal, Deputy Principal or Guidance Counsellor for further advice and after the incident complete a Student Incident Record Form (see appendix). A copy of this form is kept in the main office. The completed form should be given to the Guidance Counsellor. In addition, you should follow the guidelines indicated above for Emergency Situation.

** Schools might consider having an in-house protocol for contacting the emergency services – possibly an identified code word which would inform staff that the emergency services have been contacted.*

TERMS OF REFERENCE FOR MOST COMMON MENTAL HEALTH DISORDERS AT POST-PRIMARY LEVEL

1. DEPRESSION
Depression is a normal emotion that can affect a person at any stage of life. It can vary from short-lived feelings of sadness to severe depressive disorders that require medical treatment.

Major Depressive Disorder presents with a number of the following symptoms: low mood, loss of interest and pleasure in activities, weight loss, sleep difficulties, agitation, fatigue, feelings of worthlessness, diminished ability to think or concentrate and recurrent thoughts of death or suicidal ideation.

There are various subtypes of depression including:

- *Minor Depressive Disorder:* presents as a discrete episode of depressed mood lasting at least 2 weeks accompanied by some of the symptoms of Major Depressive Disorder.
- *Dysthymic Disorder:* a more long-standing condition characterised by subjective or observed low mood that lasts most of the day but not every day. It is accompanied by some of the symptoms of Major Depressive Disorder.

2: BIPOLAR MOOD DISORDER
The term Bipolar Disorder is sometimes referred to as Manic Depression. A person with Bipolar Disorder may experience extreme mood swings lasting days, weeks or months. These mood swings will vary between periods of high (mania or hypomania) and low (depression).

The term Mania applies to a distinct period of abnormally and persistently elevated, expansive, or irritable mood. In addition to the elevated mood, a sufferer may experience a significant degree of inflated self-esteem or grandiosity, decreased need for sleep, overtalkativeness, flight of ideas, distractibility, increased goal- directed activity and overspending.

Dysphoric Elation, a subtype of Mania, describes a combination of mania / hypomania occurring concurrently with symptoms of depression (See Section 1 above).

3: SCHIZOPHRENIA
Schizophrenia is a serious mental illness characterised by disturbances in a person's thoughts, perceptions, emotions and behaviour. The first onset of schizophrenia commonly occurs in adolescence or early adulthood. There are a number of signs and symptoms that are characteristic of schizophrenia. The expression of these symptoms varies greatly from one individual to another. No one symptom is common to all people, and not everyone who displays these symptoms has schizophrenia. Symptoms are divided into two groups:

(A) Active symptoms (also referred to as 'positive' or psychotic symptoms) reflect new or unusual forms of thought and behaviour, e.g.

- Delusions: false personal beliefs held with conviction in spite of what others believe and in spite of proof or evidence to the contrary.
- Hallucinations: unusual or unexplained sensations, which are most commonly heard but can also be seen, touched, tasted or smelled.
- Disorganised thinking and behaviour.

(B) Passive symptoms (also referred to as 'negative' symptoms) reflect a loss of previous feelings and abilities, e.g. social withdrawal and loss of motivation, loss of feeling, poverty of speech and flat affect.

Cognitive impairments such as difficulty with attention, concentration and memory may also occur.

4: ANXIETY DISORDERS

Anxiety is a normal emotion. It is experienced by most people when faced with situations perceived as threatening. When anxiety becomes severe, pervasive or sustained, it is described as a disorder. The categories of Anxiety Disorders are:

- *Generalised Anxiety Disorder:* In this condition, a person experiences excessive worry which may be associated with restlessness, feeling 'keyed up' or 'on edge'; fatigue; concentration difficulties; irritability; muscle tension or sleep disturbance. 24 Mental Health Policy and Guidelines 2008
- *Panic Disorder:* describes the abrupt development of a discrete period of intense fear or discomfort in conjunction with uncomfortable symptoms such as: palpitations, sweating, trembling or shaking, sensations of shortness of breath, choking sensation, chest pain or discomfort, nausea, feeling of dizziness or unreality. Panic disorder may occur with or without agoraphobia. Agoraphobia describes anxiety about being in places or situatio*ns from which escape might be difficult.*
- *Simple Phobia: describes* marked and persistent fear that is excessive or unreasonable, and prompted by the presence or anticipation of a specific object or situation e.g. flying, heights, etc. Exposure to the phobic stimulus provokes an immediate anxiety response. The phobic situation is avoided or endured with intense anxiety or distress.
- *Social Phobia (Social Anxiety Disorder):* describes a marked and persistent fear of one or more social or performance situations where a person is exposed to (a) unfamiliar people or scrutiny and (b) fears that he/she will act in a way (or show anxiety symptoms) that will be humiliating.
- *Obsessive-Compulsive Disorder (OCD):* this disorder is characterised by recurrent, unwanted thoughts, impulses or images (obsessions) and/or repetitive behaviours or mental acts (compulsions). The person recognizes that the obsessions and/or compulsions are excessive or unreasonable.

5: EATING DISORDERS

(A) Anorexia Nervosa

This condition is manifest where a person is unable/unwilling to maintain body weight at or above a minimally normal weight for age and height. The following symptoms may be present: an intense fear of gaining weight or becoming fat; a disturbance in the perception of body weight or shape and a denial of the seriousness of the current low body weight. Two forms of Anorexia Nervosa are described:

- *Restricting Type: where the person has not regularly engaged in binge-eating or purging behaviour;*
- *Binge-Eating/Purging Type: where the person has regularly engaged in binge-eating or purging behaviour*

(B) Bulimia Nervosa
This is a disorder in which a person experiences recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

Eating in a discrete period of time an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances; a sense of lack of control over eating during the episode.

Recurrent inappropriate compensatory behaviour may occur to prevent weight gain, e.g. self-induced vomiting, misuse of laxatives, fasting or excessive exercise.

There are two types of Bulimia Nervosa:

- *Purging Type: where the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.*
- *Non purging Type: where the person has used other inappropriate compensatory behaviours, e.g. fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.*

6: SUBSTANCE RELATED DISORDERS

(A) Substance Use Disorders

(i) Substance Dependence; describes a maladaptive pattern of substance use, leading to clinically significant impairment or distress involving:

- *Tolerance: (i) a need for increased amounts of the substance to achieve intoxication or desired effect, (ii) diminished effect with continued use of the same amount of the substance.*
- *Withdrawal: (i) the characteristic withdrawal syndrome for the substance; (ii) the same substance is taken to relieve or avoid withdrawal symptoms.*
- *intake of larger amounts or over a longer period than was intended;*
- *persistent desire for or unsuccessful efforts to cut down on the substance; extraordinary efforts to obtain the substance.*

(ii) Substance Abuse: A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by at least one of the following:

- *failure to fulfil major role obligations at work, school or home;*
- *use of substance in physically hazardous situations;*
- *recurrent substance-related legal problems.*

(B) Substance Induced Disorders

The most common Substance Induced Disorders are:

- *Substance Intoxication: the development of a reversible, substance-specific syndrome due to ingestion of a substance. In association, there are clinically significant maladaptive behavioural or psychological changes due to the effect of the substance on the central nervous system.*
- *Substance Withdrawal: the development of a substance specific syndrome due to the cessation of substance use that has been heavy and prolonged. Clinically significant distress or impairment in functioning may occur, e.g. social or occupational.*

7: ATTENTION DEFICIT AND HYPERACTIVITY DISORDER

This is a disorder of developmental impairment. AD/HD symptoms affect the brain's 'executive functions' which manage learning, perception, judgement etc. AD/HD may present with symptoms of either 'Inattention' or 'Hyperactivity/Impulsivity', or both. The following may occur with:

Inattention:

- *Failure to give close attention to detail resulting in careless mistakes in schoolwork, work etc;*
- *Difficulty sustaining attention;*
- *Failure to listen when spoken to directly;*
- *Inability to follow through on instructions and failure in completing tasks;*
- *Difficulty organizing tasks and activities;*
- *Avoidance, dislike, or reluctance to engage in tasks that require sustained mental effort; Distraction by extraneous stimuli;*
- *Forgetful in daily activities.*

Hyperactivity:

- *Fidgeting;*
- *Difficulty remaining seated;*
- *Subjective or objective restlessness;*
- *Difficulty playing or engaging in leisure activities;*
- *Acts as if 'driven' or 'on the go';*
- *Excessive talking.*

Impulsivity:

- *Blurting out of answers before questions have been completed;*
- *Difficulty awaiting turn;*
- *Tendency towards interrupting.*

Impairment of an Inattentive or Hyperactive/Impulsive type Disorder is (a) present from an early age and (b) in two or more life settings. There will be clear evidence of clinically significant impairment in social, academic or occupational functioning.

SUPPORT SERVICES – LOCAL NUMBERS

Túsla (local and national)

CAMHS (local)

An Garda Siochána (insert local number)

Hospital (insert local number)

A&E Crumlin Children's Hospital –
Tel: (01) 409 6100

NEPS

ADVOCACY SERVICES

- Mental Health Ireland. Mensana House, 6 Adelaide Street, Dun Laoghaire, Co. Dublin. Contact person Ted Tierney, Tel: 01 284 1166www.mentalhealthireland.ie
- Irish Advocacy Network, Tel: 047 38918

MEDIATION

- Mediation Service (*insert local numbers*)

DOMESTIC VIOLENCE SUPPORT SERVICES

- Saoirse Women's refuge and helpline, Tel: 01 463 0000
- W.O.V.E (Women Overcoming Violent Experiences), Tel: 085 162 0257
- Dublin 12, Domestic Violence Service, Tel: 01 456 3126
- Women's Aid (Helpline & one to one support), 1800 341 900
- Amen (male victims of domestic violence), Tel: 046 23718 www.amen.ie
- Rape Crisis Centre, Tel: 1800 77 88 88

HELPLINES

- H.S.E information line 1800 520 520
- The Samaritans
  Tel: 1850 60 90 90
  www.samaritans.org

COUNSELLING SERVICES

- National Counselling Service (specifically for adults who experienced abuse in their childhood), Tel: 1800 234 112.
- Teen counselling (12-18-year olds), Tel: 01 462 3083
- Accord (marriage counselling), Tel: 01 459 0337
- Jigsaw
- Pieta House Pieta House specializes in helping those who are involved in active self-harm or who have suicidal ideation. Pieta House, Lucan Road, Lucan, Co. Dublin. Tel: (01) 601 0000

**** List any additional counselling services or supports available to the school in this section***

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St. Project's School

Student Incident Recording Form

Observer:

Observation Date:

Observation Time:

Student Name:

Location/Setting:

Is this an Emergency or Non-Emergency *(Circle)?*

Description of the location/setting:

Description of the incident:

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Others involved:

Received by:

Date:

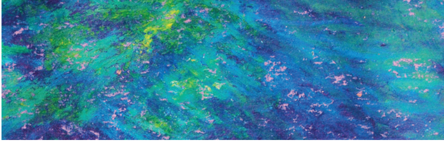
Follow Up

Parents/Guardians contact:

By:

Date:

Recorded note:



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Follow up with student

By:

Date:

Recorded note:

Additional comments/notes: