**The Mark Way School**
**The Mental Health Policy**

***Intent***

***"At MW we understand the impact of good (strong, positive) and bad (week, negative) MH. It is our aim that all students, staff, parents, and professionals can approach us at any time to talk about MH. We want to work together as a team / family so that we can all Thrive."***

**Introduction**
This policy applies to all members of The Mark Way School community.
As part of our core mission and values, and continued dedication to the health and wellbeing of our students, this policy provides a clear set of protocols for dealing with any issues that may arise, surrounding mental health and the syndrome of self-injury.

In order to help our students to succeed, we have a key role to play in supporting our young people in being resilient and mentally healthy. There are a variety of ways at The Mark Way that we provide support, for all of our students and for those with particular problems.

**Factors that put students at risk**
Typically, certain individuals and groups are more at risk of developing mental health problems than others. These risks can relate to the child themselves, to their family, or to their community or life events. Risk factors are cumulative. Children exposed to multiple risks such as social disadvantage, family adversity and cognitive or attention problems are much more likely to develop behavioural problems. Mental health and issues leading to self-harm/self-injury can however affect anyone during what may be a vulnerable period.

**Factors that make children more resilient**
Seemingly against all the odds, some children exposed to significant risk factors develop into competent, confident and caring adults. An important key to promoting children's mental health is therefore an understanding of the protective factors that enable children to be resilient when they encounter problems and challenges.
The role that The Mark Way plays in promoting the resilience of our students is important, particularly so for some children where their home life is less supportive. The Mark Way School is a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems.

**Difficult events that may have an effect on students**
Teachers and Learning Support Assistants see their students' on a daily basis. They know them well and are well placed to spot changes in behaviour that might indicate a problem. The balance between the risk and protective factors set out above is most likely to be disrupted when difficult events happen in student's lives.

These include:

**Loss or separation** – resulting from death, parental separation, divorce, hospitalisation, loss of friendships (especially in adolescence), family conflict or breakdown that results in the child having to live elsewhere, being taken into care or adopted.

**Life changes** – such as the birth of a sibling, moving house and relationship breakdown or changing schools or during transition from primary to secondary school, secondary school to sixth form and to further education.

**Traumatic events** such as abuse, domestic violence, bullying, violence, accidents, injuries or natural disaster.
The Mark Way School aims to offer support to students at such times, intervening well before mental health problems develop.

**Identifying children with possible mental health problems**

Behavioural difficulties do not necessarily mean that a child or young person has a possible mental health problem or a special educational need (SEN). Consistent disruptive or withdrawn behaviours can, however, be an indication of an underlying problem, and where there are concerns about behaviour there will be a meeting between key staff and the Behaviour Leader of all of the identified factors to determine whether there is a risk of a mental health condition given the students current behaviours and their Special Educational Need.

The Mark Way School is well-placed to observe students day-to-day and identify those whose behaviour suggests that they may be suffering from a mental health problem or be at risk of developing one. This may include withdrawn students whose needs may otherwise go unrecognised.

There are often two key elements that enable schools to reliably identify children at risk of mental health problems:

**Effective use of data** so that changes in students' patterns of attainment, attendance or behaviour are noticed and can be acted upon

**An effective pastoral system** - that knows every student well and can spot where poor or unusual behaviour may be due to life events that needs addressing. Where this is the case, the pastoral system or school policies should provide the structure through which staff can escalate the issue and take decisions about what to do next.

Only medical professionals should make a formal diagnosis of a mental health condition. The Behaviour Leader, Inclusion Leader and the Family Support Worker will refer any students it feels may be at risk of mental health issues to CAMHS and/or advise parents to take their child to their GP or A&E where appropriate.

See appendix 2 for the main types of mental health needs as defined in the DfE Mental Health and Behaviour in Schools Advice 2015

**Self-Harm**
Self-harm encompasses a wide range of issues including eating disorders, self-injury and drug / alcohol misuse. This policy focuses primarily on the cause, effect, preventative measures and supportive steps against self-injury although clearly in some cases issues may be interlinked with behavioural or other aspects covered under the broader definition self - harm.
If you are in any doubt as to your role and responsibilities (see the Safeguarding Policy) or have concerns in respect of any student speak with the DSLs immediately.

**Self-injury**
Self-injury in school aged children and young people, is an issue that The Mark Way School takes very seriously.

**What is self-injury?**
Self-injury is a coping mechanism. An individual harms their physical self to deal with emotional pain, or to break feelings of numbness by arousing sensation. Self-injury is defined as any deliberate, non-suicidal behaviour that inflicts physical harm on your body and is aimed at relieving emotional distress. Physical pain is often easier to deal with than emotional pain, because it causes 'real' feelings. Injuries can prove to an individual that their emotional pain is real and valid. Self-injurious behaviour may calm or awaken a person. Self-injury only provides temporary relief; it does not deal with the underlying issues. Self-injury can become a natural response to the stresses of day to-day life and can escalate in frequency and severity. Self-injury can include but is not limited to, cutting, burning, banging and bruising, non-suicidal overdosing and even deliberate bone-breaking. Self-injury is often habitual, chronic and repetitive; self-injury tends to affect people for months and years.

People who self-injure usually make a great effort to hide their injuries and scars, and are often uncomfortable about discussing their emotional inner or physical outer pain. It can be difficult for young people to seek help from the NHS or from those in positions of authority, perhaps due to the stigma associated with seeking help for mental health issues. Self-injury is usually private and personal, and it is often hidden from family and friends. People who do show their scars may do so as a reaction to the incredible secrecy, and one should not assume that they are ‘inflicting’ their scars on others to seek attention, although attention may well be needed.

Risk factors include, but are not limited to:

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

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

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

- Drug and / or alcohol misuse or risk taking behaviour
- Negativity and lack of self-esteem
- Out of character behaviour
- Bullying other students
- A sudden change in friends or withdrawal from a group
- Physical signs that self-injury may be occurring
- Obvious cuts, scratches or burns that do not appear of an accidental nature
- Frequent 'accidents' that cause physical injury
- Regularly bandaged arms and / or wrists
- Reluctance to take part in physical exercise or other activities that require a change of clothes
- Wearing long sleeves and trousers even during hot weather

**Self-injury is not:**

Like any behaviour, self-injury may be used to attract attention, but this is not usually the focus of chronic, repetitive self-injury. If self-injury is being used in order to gain attention, one must look to find the reasons as to why someone is in such dire need of attention. It could be there is a problem at home, or issues of bullying, and they feel that no one is listening or hearing them.

Self-injury is not about seeking attention, a way of fitting in or a response to music, films or the emo or gothic culture. Prejudices and perceptions may lead people to believe they 'know' that self-injury is linked to a certain demographic or background, but each person is unique and will have found self-injury by their own route, and rely on it at times of stress due to the release and relief it offers them.

**Suicide**

Although self-injury is non-suicidal behaviour and relied on as an attempt to cope and manage, it must be recognised that the emotional distress that leads to self-injury can also lead to suicidal thoughts and actions. It is therefore of the utmost importance that any concerns or particular incidents of self-injury are taken seriously and reported in accordance with the Safeguarding Policy to allow for the underlying issues to be thoroughly investigated and the necessary emotional support given, in order to minimise any greater risk. Any

mention of suicidal intent should be reported via the reporting system immediately to one of the DSLs and the Family Support Worker who is ASIST trained.

**Roles and Responsibilities of All Staff**

The Mark Way will, where appropriate, make a referral to Children's Services and CAMHS where it has concerns regarding a child's well-being/mental health. All members of staff should be familiar with the following information to support the identification of potential self-harm/injury issues and the necessary steps to take where there are concerns:

- The Mark Way School ensure that all staff, including teaching assistants, lab technicians and other nonteaching staff are made aware of, and understand, the self-injury policy.
- All staff must make records of students experiencing self-injury, incidents of self-injury and all other concerns surrounding the issue and report to DSL.
- All staff must ensure they are fully confident in your understanding of self-injury and seek additional information and / or training if you feel it necessary
- Follow The Mark Way School safeguarding procedures (see Safeguarding Policy)
- Be aware of communication processes with the DSL in the safeguarding policy.
- Remain calm and non-judgemental
- Avoid dismissing a students' reasons for distress as invalid
- Encourage students to be open with you and reassure them that they can get the help they need if they are willing to talk
- Don't make promises that can't keep regarding confidentiality
- Avoid asking a student to show you their scars or describe their self- injury
- Avoid asking a student to stop self- harming - you may be removing the only coping mechanism they currently have
- Report the matter to a DSL as soon as you become aware of the problem, and inform the student that you are doing this
- If a student discloses self-harm, report it immediately to a DSL.

**Roles and responsibilities of Designated Safeguarding Lead**

- The DSL and DDSLs are responsible for dealing with and keeping an up to date record of all incidents relating to self-injury/mental health.
- They report to other professional bodies to be informed such as Children's services.
- Contact other organisations and external agencies including CAMHS,
- Inform the student's parents/carers if appropriate and liaise with them as to how best manage the situation including advice on self-injury and wound control
- Review personalised provision for students who self-injure, for example time out of the classroom during emotional distress with the support of a member of staff and permission to wear long sleeves for sports.
- Be clear with students and parents about what behaviour will not be tolerated (for example, self- injuring in front of other or using it as a threat)
- Escalate any reports of suicidal feelings or behaviour as a matter of urgency to Children's Services

**Roles and Responsibilities of the Governing Body**

- Provide students with open access to information about self-injury and details of who to go to for help and support
- Decide whether self-injury should be covered in the school curriculum or as an extracurricular presentation
- Consider parental consent and whether parents/carers should be invited to learn more about self-injury for themselves

**Roles and Responsibilities of Parents**

- Understand and endorse the school's Young Minds Mental Health Policy
- Educate themselves regarding self-injury and discuss the subject with their child
- If your child is self-injuring, work closely with the school and take an active role in deciding the best course of action for your child, including taking their child to the GP
- Keep the school informed of any incidents outside of school that you feel they should know about
- Take care of yourself and seek any emotional support you may need in dealing with your child's self-injury

**Supporting Students with Mental Health at The Mark Way School**

There are a variety of ways that The Mark Way School support students, these include:

- Thrive to promote well-being.
- School based counselling through FIEPS, ELSA, Play Therapy and Andover Mind.
- Strengths and Difficulties Questionnaire (SDQ) to help judge whether individual students might be suffering from a diagnosable mental health problem as per DFE Mental Health and Behaviour in Schools guidance 2015
- Referral to Child and Adolescent Mental Health Services (CAMHS) and attendance at meetings with the family as appropriate and requested.
- Half-termly meetings with CAMHS practitioner in school.
- Weekly Vulnerable student meetings between the ELSA, FIEPS and Family Support Worker, to identify support strategies for students.
- Early intervention, for students showing early signs of problems
- Continuous professional development for all staff
- Clear policies on behaviour and bullying
- Culture within the school that values all students, allows them a sense of belonging and makes it possible to talk about problems in a non-stigmatising way
- Working with outside agencies to provide interventions for students with mental health problems
- A whole school approach to promoting the health and wellbeing of all students
- Peer mentoring.

See appendix 1 for Sources of Support and Information

**Reviewing this policy**

This policy was reviewed by the Headteacher in Autumn 2024.

It will be reviewed in Autumn 2026 or earlier if required.

Headteacher: ……..……. Date: ……..……..

**Appendix 1**

## Sources of Support and Information

Childline - A confidential service provided by NSPCC
www.childline.org.uk

Samaritans - Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair or suicidal thoughts.
www.samaritans.org

MindEd - Provide mental health advice
www.minded.org.uk

HeadMeds - Developed by the charity
young minds to provide
mental health advice
www.headmeds.org.uk

Mental Health and Bullying - A guide for teachers and other children's workforce staff
http://www.antibullyingalliance.org.uk/media/5436/Mentalhealth- and-bullying-module FINAL.pdf

National Institute for Care Excellence (NICE) - To improve outcomes for people using the NHS
https://www.nice.org.uk

Place2BE Charity working in schools providing early intervention and mental health support
www.place2be.org.uk

Relate Offers advice and relationship counselling
www.relate.org.uk

School Nursing - Public Health Service Supporting students at school with medical conditions - statutory advice for schools
https://www.gov.uk/government/publications/school-nursing-public-health-services

Women's Aid - National Domestic Violence Charity
www.womensaid.org.uk

Young Minds - Charity to improve emotional wellbeing and mental health in schools up to the age of 25
www.youngminds.org.uk

Mental Health and Departmental advice for Behaviour in Schools
https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2

Catch22 – Charity to support young people who are involved or at risk of solvent misuse.

Andover Mind – Local charity that provide counselling to adults and young people.

Andover Crisis Centre – For adults and young people to access support when they are in crisis.

**Appendix 2**

**Main types of mental health needs as defined in the DfE Mental Health and Behaviour in Schools Advice 2015**

The full document can be found at

https://www.gov.uk/government/publications/mentalhealth-and-behaviour-in-schools--2

This appendix provides a brief description of the main types of mental health needs and summarises which approaches other professionals **MIGHT** use if a mental health problem is diagnosed.

**Conduct disorders**
**(E.g. defiance, aggression, anti-social behaviour, stealing and fire setting)**

Overt behaviour problems often pose the greatest concern for practitioners and parents, because of the level of disruption that can be created in the home, school and community. These problems may manifest themselves as verbal or physical aggression, defiance or Anti-social behaviour. In the clinical field, depending on the severity and intensity of the behaviours they may be categorised as Oppositional Defiant Disorder (a pattern of behavioural problems characterised chiefly by tantrums and defiance which are largely confined to family, school and peer group) or Conduct Disorder (a persistent pattern of antisocial behaviour which extends into the community and involves serious violation of rules).

Around 4-14% of the child and adolescent population may experience behaviour problems. Many children with attention deficit hyperactivity disorder (ADHD) will also exhibit behaviour problems. Such problems are the most common reason for referral to mental health services for boys, and the earlier the problems start, the more serious the outcome. There is, however, evidence to support the effectiveness of early intervention.

**Intervention for Secondary School Students**

**The strongest evidence supports prevention/early intervention approaches that include a focus on:**

- Multi-component school-based prevention programmes for older children – targeted at students at high risk – though their impact is greater with younger children. There are targeted universal US programmes (e.g. 'The Family Check Up' targets adolescents and their families) which have had some successes but these have not yet been introduced in the UK. Where particular problems have been identified the strongest evidence supports.
- Working with the family is preferable as therapeutic approaches are most effective when they look at the young person in the context of their family structure and work with all family members, even while intervening in the school. Where this is impossible, individual work focusing on thoughts and behaviour can also be helpful.

- For more severe and entrenched problems, a range of tailored, multi component interventions. In multi-systemic therapy, therapists have multiple contacts each week and deliver a range of different evidence-based services according to each family's individual needs. While effective, this approach involves high levels of professional resources.
- For chronic and enduring problems, specialist foster placement with professional support, within the context of an integrated multi agency intervention. Multicomponent interventions without integration by an overarching organisational focus and shared set of principles are ineffective.

**Anxiety**

Anxiety problems can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but they tend not to impact on their environment. Children and young people may feel anxious for a number of reasons – for example because of worries about things that are happening at home or school, or because of worries about things that are happening at home or school, or because of a traumatic event. Symptoms of anxiety include feeling fearful or panicky, breathless, tense, fidgety, sick, irritable, tearful, or having difficulty sleeping. If they become persistent or exaggerated, then specialist help and support will be required.

**Clinical professionals make reference to a number of diagnostic categories:**

- Generalised anxiety disorder (GAD) – a long term condition which causes people to feel anxious about a wide range of situations and issues, rather than one specific event.
- Panic disorder – a condition in which people have recurring and regular panic attacks, often for no obvious reason.
- Obsessive-compulsive disorder (OCD) – a mental health condition where a person has obsessive thoughts (unwanted, unpleasant thoughts, images or urges that repeatedly enter their mind, causing them anxiety) and compulsions (repetitive behaviour or mental acts that they feel they must carry out to try to prevent an obsession coming true).
- Specific phobias – the excessive fear of an object or a situation, to the extent that it causes an anxious response, such as panic attack (e.g. school phobia).
- Separation anxiety disorder– worry about being away from home or about being far away from parents, at a level that is much more than normal for the child's age
- Social phobia – intense fear of social or performance situations.
- Agoraphobia – a fear of being in situations where escape might be difficult, or help wouldn't be available if things go wrong.

While the majority of referrals to specialist services are made for difficulties and behaviours which are more immediately apparent and more disruptive (externalising difficulties), there are increasing levels of concern about the problems facing more withdrawn and anxious children, given the likelihood of poor outcomes in later life.

**The strongest evidence supports prevention/early intervention approaches that include a focus on:**

- Regular targeted work with small groups of children exhibiting early signs of anxiety, to develop problem-solving and other skills associated with a cognitive behavioural approach.

- Additional work with parents to help them support their children and reinforce small group work. Such work is likely to be especially effective when the parents are themselves anxious and the children are younger.

**Where particular problems have been identified the strongest evidence supports:**

- Therapeutic approaches focusing on cognition and behaviour for children with specific phobias, generalised anxiety and obsessive compulsive disorder (in some cases doctors may consider using medicines alongside therapy if therapy alone is not working but this does not include anxiety related to traumatic experiences). This should include parents where the child is under 11 or where there is high parental anxiety.
- Specific individual child focused programmes which show recovery in 50-60% of C & YP include Coping Cat and FRIENDS. On the other hand, group based interventions are likely to be almost as effective. The programmes have been shown to be effective when delivered by different professionals, including teachers.
- Education support, training in social skills and some behaviour focused interventions are highly effective for social phobia (e.g. Social Effectiveness Therapy).
- For obsessive compulsive disorders professionally administered Exposure and Response Prevention (ERP) and cognition focused interventions are most effective.
- Trauma related problems require special adaptations of therapy (e.g. Trauma – focused CBT) including sexual trauma. Trauma and grief component therapy is effective for trauma and can be delivered in school (e.g. Cognitive Behavioural Intervention for Trauma in Schools).

**There is also evidence to support:**

- For anxiety, the use of play-based approaches to develop more positive child/parent relationships or to enable the child to express themselves
- Psychoanalytic family psychotherapy (focusing on the 'internal' world of family members and their unconscious processes) has reported some positive outcomes especially when trauma is involved.

**Depression**

Feeling low or sad is a common feeling for children and adults, and a normal reaction to experiences that are stressful or upsetting. When these feeling dominate and interfere with a person's life, it can become an illness. According to the Royal College of Psychiatrists, depression affects 2% of children under 12 years old, and 5% of teenagers.
Depression can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but tends not to impact on their environment. There is some degree of overlap between depression and other problems. For example, around 10% to 17% of children who are depressed are also likely to exhibit behaviour problems.

Clinicians making a diagnosis of depression will generally use the categories major depressive disorder (MDD – where the person will show a number of depressive symptoms

to the extent that they impair work, social or personal functioning) or dysthymic disorder (DD – less severe than MDD but characterised by a daily depressed mood for at least two years).

**The strongest evidence supports prevention/early intervention approaches that include a focus on:**

- Regular work with small groups of children focusing on cognition and behaviour – for example changing thinking patterns and developing problem – solving skills – to relieve and prevent depressive symptoms.

**Where particular problems have been identified the strongest evidence supports:**

- Therapeutic approaches focusing on cognition and behaviour, family therapy or interpersonal therapy lasting for up to three months (in severe cases these interventions are more effective when combined with medication)
- Psychoanalytic child psychotherapy may also be helpful for children whose depression is associated with anxiety
- Family therapy for children whose depression is associated with behavioural problems or suicidal ideation
- For mild depression, non-directive supportive counselling.

**Hyperkinetic Disorders**
(**e.g. disturbance of activity and attention)**
Although many children are inattentive, easily distracted or impulsive, in some children these behaviours are exaggerated and persistent, compared with other children of a similar age and stage of development. When these behaviours interfere with a child's family and social functioning and with progress at school, they become a matter for professional concern.

Attention Deficit Hyperactivity Disorder (ADHD) is a diagnosis used by clinicians. It involves three characteristic types of behaviour – inattention, hyperactivity and impulsivity. Whereas some children show signs of all three types of behaviour (this is called 'combined type' ADHD), other children diagnosed show signs only of inattention or hyperactivity/impulsiveness.

Hyperkinetic disorder is another diagnosis used by clinicians. It is a more restrictive diagnosis but is broadly similar to severe combined type ADHD, in that signs of inattention, hyperactivity and impulsiveness must all be present. These core symptoms must also have been present before the age of seven, and must be evident in two or more settings.

**The strongest evidence supports:**

- Use of medication, where ADHD is diagnosed and other reasons for the behaviour have been excluded. These treatments have few side effects and are effective in 75% of cases when there is no depression or anxiety accompanying ADHD. High doses can be avoided if behavioural treatments accompany medication.

- Introduction of parent education programme and individual behavioural therapy where there is insufficient response to medication. These need to be provided in the school as well as home, as they do not appear to generalise across settings
- For children also experiencing anxiety, behavioural interventions may be considered alongside medication.
- For children also presenting with behavioural problems (conduct disorder, Tourette's Syndrome, social communication disorders), appropriate psychosocial treatments may also be considered by medical professionals.

**Evidence also supports:**

- Making advice about how to teach children with ADHD-like behaviour in their first two years of schooling widely available to teachers, and encouraging them to use this advice.

**Attachment Disorders**

Attachment is the affectionate bond children have with special people in their lives that lead them to feel pleasure when they interact with them and be comforted by their nearness during times of stress. Researchers generally agree that there are four main factors that influence attachment security; opportunity to establish a close relationship with a primary caregiver; the quality of caregiving; the child's characteristics and the family context. Secure attachment is an important protective factor or mental health later in childhood, while attachment insecurity is widely recognised as a risk factor for the development of behaviour problems.

**The strongest evidence supports:**

- Video feedback based interventions with the mothers of pre-school children with attachment problems, with a focus on enhancing maternal sensitivity.

**Evidence also supports:**

- Use of approaches which use play as the basis for developing more positive child/parent relationships.
- Use of the Thrive Approach.

**Eating Disorders**

The most common eating disorders are anorexia nervosa and bulimia nervosa. Eating disorders can emerge when worries about weight begin to dominate a person's life. Someone with anorexia nervosa worries persistently about being fat and eats very little. They lose a lot of weight and if female, their periods may stop. Someone with bulimia nervosa also worries persistently about weight. They alternate between eating very little, and then binging. They vomit or take laxatives to control their weight. Both of these eating disorders affect girls and boys but are more common in girls.

**The strongest evidence supports:**

- The primary aim of intervention is restoration of weight and in many cases impatient treatment might be necessary

- For young people with anorexia nervosa, therapeutic work with the family, taking either a structural systemic or behavioural approach may be helpful even when there is family conflict
- For young people with bulimia nervosa, individual therapeutic work focusing on cognition and behaviour, for example to change thinking patterns and responses.

Evidence also supports:

- Early intervention because of the significant risk of ill-health and even death among sufferers of anorexia
- School-based peer support groups as a preventive measure (i.e. before any disordered eating patterns become evident) may help improve body esteem and self-esteem
- When family interventions are impracticable, cognitive-behavioural therapy may be effective.

**Substance Misuse**

Substance misuse can result in physical or emotional harm. It can lead to problems in relationships, at home and at work. In the clinical field, a distinction is made between substance abuse (where use leads to personal harm) and substance dependence (where there is compulsive pattern of use that takes precedence over other activities). It is important to distinguish between young people who are at high risk of long-term dependency. The first group will benefit from a brief, recovery oriented programme focusing in cognitions and behaviour to prevent them to move into more serious use. The second group will require on-going support and assessment, with careful consideration of other concurrent mental health issues.

**The strongest evidence supports:**

- Therapeutic approaches which involve the family rather than just the individual; this assists communication, problem-solving, becoming drug-free and planning for relapse prevention. These approaches are especially helpful with low-level substance users, and when combined with cognitive-behavioural therapy or treatments focusing on motivation
- A variation of family therapy known as ‘one-person family therapy’ , where families cannot be engaged in treatment; and
- Multi-Systemic Therapy, Multidimensional Family Therapy and the Adolescent Community Reinforcement Approach and other similar approaches (which consider wider factors such as school and peer group), where substance misuse is more severe, and part of a wider pattern of problems.

**Evidence also supports:**

- The introduction of programmes, delivered in community settings or schools and which focus on developing skills that enhance resilience, as a preventative measure as substance abuse is connected to other problems that can be addressed within these settings.

**Deliberate self-harm**
Common examples of deliberate self-harm include 'overdosing' (self-poisoning), hitting, cutting or burning oneself, pulling hair or picking skin, or self-strangulation. The clinical definition includes attempted suicide, though some argue that self-harm only includes actions, which are not intended to be fatal. It can also include taking illegal drugs and excessive amounts of alcohol. It can be a coping mechanism, a way of inflicting punishment on oneself and a way of validating the self or influencing others.

**The strongest evidence supports:**

- Brief interventions engaging the child and involving the family, following a suicide attempt by a child or young person
- Assessment of the child for psychological disturbance or mental health problems which, if present, should be treated as appropriate. At times, brief hospitalisation may be necessary
- Some individual psychodynamic therapies (Mentalisation Based Treatment) and behavioural treatments (Diabetic Behaviour Therapy).

**Post-traumatic Stress**
If a child experiences or witnesses something deeply shocking or disturbing they may have a traumatic stress reaction. This is a normal way of dealing with shocking events and it may affect the way the child thinks, feels and behaves. If these symptoms and behaviours persist, and the child is unable to come to terms with what has happened, then clinicians may make a diagnosis of posttraumatic stress disorder (PTSD).

**The strongest evidence supports:**

- Therapeutic support which is focused on the trauma and which addresses cognition and behaviour especially regarding sexual trauma and some can be delivered in schools such as Trauma and grief component therapy and Cognitive Behavioural Intervention for Trauma in schools (CBITS). Trauma focused CBT should be adapted appropriately to suit age, circumstances and level of development.

**The evidence specifically does NOT support:**

- Prescription of drug treatments for children and young people with PTSD; or
- The routine practice of 'debriefing' immediately following a trauma.