SUPPORTING PUPILS WITH MENTAL HEALTH PROBLEMS AT SCHOOL POLICY

Policy statement

1.1 This policy applies to all pupils at Malvern College.

1.2 This policy is addressed to all staff and is available to parents and pupils.

1.3 This policy is drafted pursuant to the DofE departmental advice on Mental health and behaviour in schools.

2 Aims

2.1 The College is committed to ensuring that the mental health and wellbeing of pupils is promoted and that all pupils with mental health and behavioural conditions are supported and can access and enjoy the same opportunities at the College as any other pupil and are able to play a full and active role in school life, remain healthy and achieve their academic potential.

3 Responsibilities

3.1 All College staff are responsible for fostering a culture at the College which encourages pupils to openly discuss their problems, including any mental health concerns.

3.2 The Head of Safeguarding and Pupil Wellbeing has overall responsibility for pupil mental health and wellbeing and for co-ordinating and monitoring mental health issues at the College. The SENCO will ensure that all staff understand their responsibilities to children with Special Educational Needs and Disabilities (SEND) and provide advice and support to colleagues as necessary.

3.3 Where a concern about a pupil's mental health is identified, the Head of Safeguarding and Pupil Wellbeing will assess the risks to that pupil's welfare and will consult with the pupil, his or her parents (where appropriate) and other members of staff and the Medical Centre (as necessary) to determine appropriate action to be taken to safeguard, support and monitor that pupil.

3.4 Those with day to day contact with pupils are likely to be best placed to spot any changes in behaviour which may indicate that a pupil is at risk of a mental health problem. They should report any concerns to the Head of Safeguarding and Pupil Wellbeing in accordance with the terms of this policy.

4 Staff Training

4.1 All staff should be made aware of the terms of this policy and how to deal with suspected mental health problems in pupils.

4.2 Appropriate training is provided to staff and this is refreshed at regular intervals to ensure that knowledge is kept up to date, for example how to deal with eating disorders features in INSET for teaching and non-teaching staff.

5 Mental health problems

5.1 The College recognises that mental health problems can take a variety of forms which include:

5.1.1 anxiety disorders including; generalised anxiety disorder (GAD), panic disorder, obsessive compulsive disorder (OCD), separation anxiety disorder (SAD);

5.1.2 phobias;

5.1.3 psychological disorders e.g. post-traumatic stress disorder (PTSD);

5.1.4 depression and suicidal ideation;

5.1.5 eating disorders, including anorexia nervosa and bulimia nervosa;

5.1.6 self-harm;

5.1.7 substance misuse;

5.1.8 hyperkinetic disorders e.g. disturbance of activity and attention;

5.1.9 conduct disorders e.g. stealing, defiance, aggression and anti-social behaviour.

5.2 The College understands the vital role it can play in identifying and supporting pupils with mental health, or suspected mental health, problems.

6 Identifying pupils with possible mental health problems

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

6.1.1 a pupil acknowledges that they have a problem and seeks help;

6.1.2 a pupil exhibits consistent disruptive, unusual or withdrawn behaviour which may be indicative of an underlying problem and/or indicates that a pupil could be at risk of developing mental health problems;

6.1.3 a member of staff, parent or another adult (such as a Police officer) reports concerns about, or issues relating to, a pupil's mental health or behaviour;

6.1.4 where another pupil or child reports concerns about, or issues relating to, a pupil's mental health or behaviour.

6.2 The College will take all reports of concerns over the mental health and wellbeing of its pupils seriously and not delay in investigating and, if appropriate, in putting support in place, including where necessary, taking immediate steps to safeguard that pupil.

7 Action where a mental health problem is suspected

7.1 If a pupil is concerned about another pupil's mental health and wellbeing, he or she should contact a member of staff to report those concerns. That member of staff will then implement the terms of this policy.

7.2 If any member of staff is concerned for a pupil's immediate health, safety and welfare, he or she should take immediate steps to safeguard that pupil, which could include calling 999 and/or seeking assistance from the College Doctor and/or Medical Centre. Once the pupil's immediate needs are protected, the member of staff must contact the DSL without delay.

7.3 Where there is no immediate threat to a pupil's health, safety and welfare, the member of staff concerned should report any concerns to the Designated Safeguarding Lead, as soon as reasonably practicable. The Designated Safeguarding Lead will then consider the position and if necessary arrange for an investigation, and then coordinate an appropriate response.

7.4 The member of staff and the Designated Safeguarding Lead should keep a record of what happened, what was said, his or her concerns regarding the pupil, together with any risk assessment undertaken, and any action taken to address those concerns.

7.5 An assessment of immediate risk will be made (in consultation with the Pastoral team and Housem. where appropriate) and recorded and a decision taken as to whether any further action is required, including whether;

7.5.1 support and intervention is required;

7.5.2 immediate medical assistance is required; and/or

7.5.3 whether parents need to be informed.

7.6 Where it is considered necessary and appropriate, the Designated Safeguarding Lead will then discuss the matter with the pupil concerned and work with him or her to develop a strategy to support and assist that pupil.

7.7 Where appropriate, the Designated Safeguarding Lead may also identify a trusted adult to talk regularly to the pupil, and if relevant, to friends who are aware. The trusted adult will be supported and advised by the Designated Safeguarding Lead.

7.8 Where it is decided that support and/or intervention is required, the Designated Safeguarding Lead will ensure that the pupil is monitored and periodically review any risk assessment seeking advice from the Housem, trusted adult and members of the pastoral team, as necessary. The assessment will include consideration as to whether medical intervention and/or a CAMHS referral should be sought.

8 Supporting pupils with mental health problems

8.1 The College ensures that all reasonable measures are taken to minimise the risks of harm to pupils' mental health and wellbeing. These include:

8.1.1 encouraging a positive, supportive and secure environment for its pupils to learn and develop;

8.1.2 raising awareness of mental health issues amongst the pupil cohort via a number of different methods, including via Key and Life Skills lessons and lectures, as well as through more informal discussion groups within the Houses;

8.1.3 equipping pupils with the skills to enable them to protect their own welfare and that of others;

8.1.4 providing medical and pastoral support that is accessible and available to all pupils;

8.1.5 identifying pupils thought to be at risk of harm;

8.1.6 supporting and monitoring those pupils.

8.2 Where a pupil has been identified as having a mental health problem or a suspected mental health problem , the College will seek to establish a structured response designed to safeguard that pupil's health, safety and welfare.

8.3 This may include, as appropriate:

8.3.1 seeking immediate assistance from the emergency services;

8.3.2 an appointment with the College Doctor or the pupil's registered GP;

8.3.3 a referral for medical assistance, including where appropriate counselling, referral to CAMHS and/or a psychiatric referral;

8.3.4 regular meetings with the pupil and monitoring of his or her progress;

8.3.5 support from a trusted adult and/or involvement (under supervision) of a peer mentor, where appropriate;

8.3.6 ongoing monitoring by staff and discussion of the issue at staff and house meetings;

8.3.7 an ongoing assessment of risk;

8.3.8 maintenance of records of meetings with pupils and action taken;

8.3.9 the development of a prevention plan, where appropriate (for example in relation to self-harm and eating disorders);

8.3.10 support when attending appointments and treatment (where necessary);

8.3.11 support for the friends of the affected pupil, where appropriate.

8.4 If boarder is required to attend a medical appointment during school time, he or she will be accompanied by an appropriate member of College staff, if so requested, who will be fully briefed in respect of his or her mental health issues and medical history before attending the appointment.

8.5 Following the appointment, that member of staff will prepare a written report for the Designated Safeguarding Lead who will ensure that appropriate information is then provided to the Medical Centre and/or parents and that arrangements are made to act upon the medical practitioner's advice and to facilitate any required treatment or follow up.

8.6 If the pupil also has special educational needs, the pupil should be referred to the SENCO, who will act in accordance with the SEN policy.

8.7 The College has also developed a number of specific protocols for dealing with the most commonly experienced mental health problems.

8.8 These are as follows:

8.8.1 Suicidal thoughts and feelings (see Appendix 1)

8.8.2 Self-harm (see Appendix 2)

8.8.3 Eating disorders (see Appendix 3)

9 Confidentiality

9.1 The College respects pupils' rights to confidentiality and to data protection and, where possible, the College will seek a pupil's consent to share confidential information arising from a mental health problem with others before doing so.

9.2 However, staff should never provide pupils with an absolute assurance of confidentiality and should explain to pupils at the outset the importance of sharing information about any mental health difficulties with others, on a need to know basis.

9.3 The College will balance a pupil's right of confidentiality against the College's overarching duties to safeguard pupils' health, safety and welfare and to protect pupils from suffering significant harm.

9.4 Where a pupil withholds consent and/or in any other circumstances where the College considers it necessary and proportionate to the need and level of risk, confidential information may be shared with staff, parents, medical professionals and external agencies (such as the WSCB) on a need to know basis.

10 Monitoring and review

10.1 Where there are concerns relating to specific individuals, these will be discussed with appropriate staff on a need to know basis and a plan to support and monitor that pupil implemented, as set out in this policy. Monitoring of individual assessments and pupils' progress will be coordinated by the Designated Safeguarding Lead.

10.2 In addition, the Designated Safeguarding Lead, in conjunction with the Head, will regularly monitor and review mental health and wellbeing issues at the College in order to support affected individuals and to identify trends, issues of concern and the operation of this policy so that these can be addressed at a whole school level.

Suicidal thoughts and feelings

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

Pupils are instructed to inform a member of staff immediately if they are feeling low or suicidal, or if another pupil confides suicidal thoughts to them.

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

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

2. Report immediately by telephone to Designated Safeguarding Lead and, if appropriate, inform the Medical Centre .

3. A full risk assessment will be undertaken by the Pastoral Team, Housem. and, if appropriate, the tutor. The assessment will include a decision as to whether medical intervention or a CAMHS referral is needed.

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

5. Parents will be informed at the earliest opportunity.

Appendix 1 Self-Harm

Self-harm can be defined as the attempt to injure oneself physically without causing death and includes a range of actions that people do to themselves to injure, self-mutilate or self-poison. The actions are deliberate and usually hidden/concealed.

It is often a way of expressing deep distress or communicating feelings that cannot be put into words and has been described as an "inner scream".

Self-harm may is a broad term and may involve any of the following:

- cutting
- burning skin
- banging or Scratching one's own body
- taking too many tablets
- breaking bones
- hair-pulling
- swallowing toxic substances or inappropriate objects

It may also involve taking unnecessary risks, being addicted to alcohol or drugs, or simply not looking after one's own emotional or physical needs.

It is recognised that some instances of substance misuse/abuse and aberrant behaviour may be forms of self-harm.

Why do people deliberately self-harm?

Self-harm has been interpreted as self-management of emotional pain. People self-harm to release tension (from anger, anxiety or grief), to gain control over something in their lives, to make "real" emotional pain and to communicate a need for help. It can also be used to distract from other (psychological) pain or to self-punish. People who self-harm often conceal their actions and can be very embarrassed about them.

What can be done?

Early identification is essential to the management of self-harm in schools. Whenever self-harming is suspected or identified the College Designated Safeguarding Lead and relevant Housem must be informed. It is important to avoid indulging the culture of secrecy which often surrounds deliberate self-harm.

Self-Harm can have a negative impact on the friends of someone who is self-harming since they may feel they should take responsibility for such behaviour once it is divulged to them. The College wishes to mitigate such misplaced loyalty by encouraging a culture of openness and "reporting on" such behaviour. Pupils should be encouraged to speak to a Housem or the Designated Safeguarding Lead (or any other appropriate adult) when such behaviour

comes to light. Underlying this openness is an educational programme focussed on but not limited to Key and Life Skills lessons and tutorial periods.

Response to Self-harming Incidents:

1. Identify self-harming behaviour and report to Designated Safeguarding Lead and Housem. Record observations in writing.

2. The Designated Safeguarding Lead will discuss the behaviour with the pupil concerned. An assessment of immediate risk will be made (in consultation with the Pastoral team and Housem.) and a decision taken as to whether Medical Services and/or parents need to be informed immediately.

3. Any witnesses to the behaviour will be spoken to as necessary.

4. The Designated Safeguarding Lead will identify a trusted adult to talk regularly to the pupil who is self-harming and, if relevant, to friends who are aware. The Trusted Adult will be supported and advised by the Designated Safeguarding Lead.

5. The Designated Safeguarding Lead and/or Trusted Adult will advise pupil of availability.

6. The Designated Safeguarding Lead will coordinate a risk assessment seeking advice from the Housem, Trusted Adult and members of the pastoral team as necessary. The assessment will include a decision whether medical intervention or a CAMHS referral is needed.

7. Friends of the pupil will be supported by the Housem and Pastoral team, who will reinforce that they (pupils) are not responsible for the care of pupils who self-harm. They will be given a clear course of action to follow if their friend self-harms further: this will be to notify the Designated Safeguarding Lead and Housem.

8. Once a Trusted Adult has begun communication with the pupil concerned, s/he will try to identify any underlying causes and consult with the Pastoral team to establish a Structured Response designed to safeguard the pupil and reduce the instances of self-harm. These might include:

    a. A Prevention Plan (e.g. identifying triggers and early warning signs, and agreeing action and frequency of monitoring).

    b. Professional Counselling;

    c. Psychiatric referral;

    d. Ongoing Assessment of Risk;

    e. Medical support (to prevent wound infection etc);

    f. Regular meetings with the pupil;

g. Keeping a diary documenting the nature, frequency and extent of the self-harm;

h. Involvement (under supervision) of Peer Mentor(s).

9. The strategy in relation to individual pupils will be reviewed initially every two weeks (or sooner if warranted by severity/frequency of self-harm and/or impact on peers). This review will include views of Trusted Adult and peers as appropriate.

10. Response to strategies will be closely monitored to assess progress; the pupil who self-harms will be expected to show a clear attempt to use relevant strategies to reduce self-harm. If progress is not made, or if the pupil does not co-operate within an agreed period of time, a meeting with parents/guardians will be set up to discuss future management. This may include a break from school and/or further professional help/advice.

11. Incidents of self-harm which lead to hospitalisation or significant medical intervention will lead to an enforced time at home. Return to school may be dependent on medical/psychiatric advice.

Appendix 2 Continued: Policy for Self-Harm Admission to Medical Centre

Following a self-harm incident, or if a pupil discloses intent to self-harm, a pupil may need to be admitted to the Medical Centre for observation and emotional support.

As numbers can vary considerably, and the nature of other admissions that may come in to the Medical Centre are unpredictable, there should always be a second person called in to assist the Nurse on duty.

Initially, the Nurse Manager should be notified, (by the nurse on duty), and she will make a decision on the staffing level and who to call in. The DSL or Deputy DSL should also be informed if a pupil is admitted to the Medical Centre because of risk of, or actual, self-harm.

The second person called in may be the Nurse Manager, Health Care Assistant or other member of staff.

As it may take some time for the second member of staff to arrive at the Medical Centre, the Nurse on Duty should not be left alone with the pupil. The DSL or Deputy DSL, Deputy Head Pastoral or one of the House staff should stay in the Medical Centre to assist the Nurse.

Any injuries to the pupil will be cleaned and dressed appropriately and the pupil's emotional well-being supported, including being given the opportunity to explain their feelings and their understanding about self-harm. The pupil should be settled into a side room, if available, with the door open.

¼ hourly or ½ hourly observation of the pupil will be commenced depending on the emotional distress and mental health of the pupil.

Laptops and/or phones will be removed from the pupil, especially overnight, and kept locked away in the Nurse's office and will only be returned to the pupil when deemed appropriate.

Observation of the pupil will continue ½ - 1 hourly as appropriate throughout the day or overnight. The emotional well-being of the pupil will be supported throughout.

All sharp objects, i.e. knives, can openers, razor blades, scissors, etc. and all medications will be locked away securely.

The Vaccination fridge will be locked overnight.

If at any time the Nurse on duty feels the pupil requires emergency care to ensure the safety and wellbeing of the pupil or others in the Medical Centre, they must call 999 or ensure the pupil is taken to the nearest Hospital A and E department without delay. The Nurse Manager and Designated Safeguarding Lead must be informed.

The Designated Safeguarding Lead will visit the pupil at the earliest opportunity and a Plan of Care decided, which will include ensuring that the pupil is aware of their rights and options in this context.

The pupil will remain under the Medical Centre care until the Plan is in place. This may require further staff being called upon to ensure 2 staff are present at all times.

Appendix 2 Eating Disorders

Eating disorders (ED) comprise a range of symptoms encompassing physical, psychological and social features. Whilst the acute physical complications of these disorders may provoke great concern in family members and school staff, anorexia nervosa and bulimia nervosa are frequently chronic conditions, with substantial long-term physical and social sequelae, from which recovery can be difficult.

The impact of a person's eating disorder on home, family and school life is often considerable and family members and friends may carry a heavy burden over a long period of time.

The aetiology of eating disorders is considered to be multifactorial. Whether or not a person develops an ED will depend on their individual vulnerability, biological predisposition and exposure to provoking risk factors and the operation of protective factors. The majority of studies show that eating disorders run in families. Severe life stresses have been implicated in the development of ED, approximately 70% of cases being triggered by severe life events.

Early intervention is paramount: please refer any pupil that you have concerns about to the Medical Centre or College counsellors.

Anorexia Nervosa

About 1 in 250 females and 1 in 2000 males will experience anorexia nervosa (AN), generally in adolescence or young adulthood; the mean age of onset is 16 to 17. Approximately 45% of patients with AN recover completely; 35% improve; 20% develop a chronic eating disorder, and 5% die from AN. Anorexia nervosa is a syndrome in which the individual maintains a low body weight as a result of a pre-occupation with body weight, construed either as a fear of fatness or pursuit of thinness. In anorexia, weight is maintained at least 15% below that expected. Weight loss in anorexia is caused by avoiding fattening foods, sometimes supported by excessive exercising, vomiting or misuse of laxatives.

The condition generally starts with dieting behaviour that may evoke no concern. After a while the commitment to dieting increases often with a number of secondary features such as social withdrawal, the development of obsessions along with physical effects such as the cessation of periods in females and lack of interest in sex in males. The diagnosis of anorexia nervosa is made on the basis of the history (preferably with corroboration from a relative or friend) along with physical examination. This may include blood tests and other investigations. The diagnosis of AN in its typical form is relatively straightforward, the main obstacle being the person's own willingness or otherwise to disclose his or her own motives, symptoms and behaviours.

In the acute stages of AN, anxiety and depression are common. AN has the highest mortality rate of any psychiatric disorder in adolescence. Typically, people with AN rarely actively seek help and are usually persuaded to seek help by family members, friends or teaching staff.

Most people with AN should be managed on an out patient basis with appropriate psychological treatment provided by the College counsellors or local eating disorder service.

Bulimia Nervosa

Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating and secondly by compensatory behaviour (vomiting, purging, fasting, use of weight reducing drugs, exercising or a combination of these) in order to prevent weight gain. Binge eating is accompanied by a subjective feeling of loss of control over eating. Binge eating and purging are commonly associated with extreme subjective guilt and shame. The prevalence of BN has been estimated between 0.5% and 1% with an even class distribution; 90% of people diagnosed with BN are female. About 50% of people with BN recover, 20% are likely to continue with the full form of BN and 30% have a course of illness characterised either by remissions or relapses or persistent but sub-diagnostic BN.

There is considerable overlap between the long term disabling consequences of BN and those of AN. Mood and anxiety symptoms are very common, as is self harm in the form of scratching or cutting.

A significant proportion of those with BN have a history of disturbed interpersonal relationships. The symptoms of low self-esteem and body image disturbance can all have a negative effect on social relationships, which in turn may be damaged by a lifestyle that may be chaotic and characterized by impulsivity. Initially, those with BN are generally secretive about their bulimic episodes, though some may leave obvious signs of their disorder such as empty food packaging and occasionally bags of vomit for friends or family members to discover. In BN the body mass index is maintained above 17.5kg/m2. People with BN tend not to disclose their behaviour nor seek out treatment readily, although they may be more likely to do so than those with AN.

The diagnosis is made on the basis of the history, often corroborated by a parent or friend. The physical symptoms are generally less severe than those experienced by patients with AN, but include fatigue, feeling bloated, abdominal pain, constipation and erosion of dental enamel. In females, periods may be irregular.

Physical examination may be normal but calluses may be seen on the back of the hand as a consequence of induced vomiting, and dental problems may be observed. People with BN are generally managed with a combination of self help, antidepressant medication and cognitive behavioural therapy.

Atypical eating disorders, including binge eating disorder

A number of people suffer from eating disorders that closely resemble AN and BN, but are considered atypical.

Binge eating disorder is a recently described condition; people with this condition engage in uncontrollable episodes of binge eating but do not use compensatory purging behaviours. The onset of AED is typically in the teenage years or early 20s. The physical problems that people with AED tend to present with are those of obesity along with low self-esteem.

Procedures for care of pupils with eating disorders:

- A core team of medical and House staff will co-ordinate to manage the condition. This will occur by formulating a personal care plan and ensuring that the relevant people are aware of it. The team will meet as frequently as is thought necessary, depending on the severity of the pupil's condition.

- The care plan may need to include a realistic educational plan for the affected pupil, being flexible while balancing realistic workloads, deadlines and the College's responsibility to ensure the pupil fulfills important learning goals. Consideration should be given to any potentially stressful decisions/situations in the pupil's life (e.g. exams, UCAS, career decisions). The care plan will include eating patterns and exercise and will be discussed with the pupil and core team and frequency of follow up will be arranged according to the severity of the pupil's condition.

- A member of the team will be designated to communicate with parents (usually Housem or Medical Officer) depending on the pupil's ability to consent and respect for confidentiality.

- Referral for counselling will be strongly encouraged. The following agencies may be involved: College Counsellor, Eating Disorders Association and Adolescent Psychiatry Unit.

- Exercise restriction may be imposed in some pupils if deemed necessary on medical grounds.

- Management and Care Plan will be kept in the pupil's confidential medical record.

- The College and Medical Team will not be able to manage some pupils with eating disorders. For such pupils it will be better for them to be managed at home or as a hospital in-patient. Depending on the ability of the pupil to give consent, this decision would be made by involved members of staff.

- The policy will be available on the web site for all staff, pupils, parents and the College Council. It is important that parents are aware that the College has a policy on eating disorders and it will be explained to parents of pupils affected.

Broaching the subject: advice that may be useful when first addressing the pupil causing concern:

- Take time to sort out what you have observed to make you feel that there is a problem. Once you are reasonably sure there is cause for concern do not be deflected by family members, or friends who may try to brush it aside or tell you that you must be mistaken.

- Think about who would be the best person to approach them – friend, family member, another teacher, possibly more than one person?

- Decide where and when it would be best to talk.

- Avoid talking about your own or another person's experiences – this may elicit a competitive response from the sufferer.
- Responses to the confrontation may range through outright denial and fury, through to grateful relief. However, the person confronted may change their mind about their initial response once they have had time to think about it, so be prepared for that too.
- Be realistic about what you want the outcome of the confrontation to be. Stopping the damaging eating behaviour overnight is not realistic, but encouraging the person to start talking about their issues may be one possible outcome.
- Engagement in a supportive, empathetic way is crucial to enabling the person to reveal fears about weight, dieting, excessive exercise or purging behaviour.
- Encourage the pupil to see the Medical Centre staff and Counsellors and ensure they are aware of issues about confidentiality.

Practical and emotional support for other pupils concerned with a peer suffering with an eating disorder include:

- Provision of training and education regarding the subject of eating disorders.
- Consider the needs of the pupil's immediate friendship group. They may be feeling a loss in their friendship circle or confusion about how to relate to their friend.
- Encourage pupil's friends to continue usual activities with the person experiencing the eating disorder.
- Remind friends that they are not responsible for their friend's eating disorder or recovery.
- Be mindful of other pupils' reactions to the eating disorder.

Strategy to prevent the spread of eating disorders within the school:

- Close monitoring of pupils who have been in contact with another pupil with an eating disorder.
- Informal discussion groups within the Houses, led by Housems.
- Eating disorders to be part of Life Skills, raising awareness and understanding within the pupil body.
- Encouraging an open attitude to eating disorders, where pupils and staff feel comfortable to discuss and raise concerns where necessary.

Training and Education strategy for staff and pupils:

- Education focused on eating disorders will be delivered via Life Skills lessons, as well as through more informal discussion groups within the Houses.

- Training is offered for staff – this is refreshed at regular intervals to ensure knowledge is kept up to date.
- Eating disorders will feature in INSET for teaching and non-teaching staff.

More information can be found at www.b-eat.co.uk