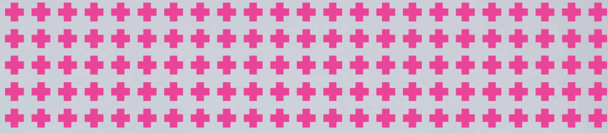
The Queen's Nursing Institute

# School Nurse Stories

Health and care for children, young people and families



Edited by Suzanne Gordon

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** All names have been changed*

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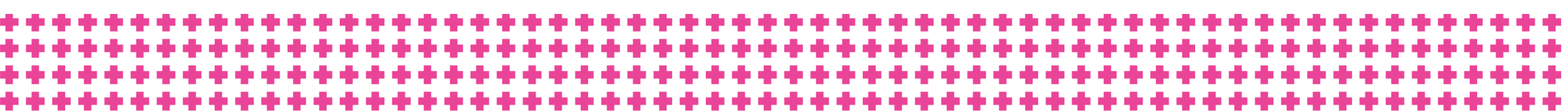


# Foreword

Suzanne Gordon

In the spring of 2018, when the QNI invited me to London to give a lecture at their annual conference, and hold two workshops following it, I don't think either I or the organisation imagined that this new relationship would result in this collection of stories that illustrate the power and importance of the work of community nurses. Over the past thirty years, I have given countless lectures to nurses all over the world. I have encouraged them to give voice to their work by moving beyond discussions of nurses' caring and trustworthiness and explaining how much skill, knowledge, experience, and expertise is involved in nursing practice.

I have also followed up these lectures with hands-on workshops that teach nurses to tell their stories in lay language so that their families and friends, as well as members of the media, policy makers and politicians get vivid picture of their important work. More often than not, I parachute in and inspire a few nurses to tell their stories. Periodically, when I encourage their professional organisations, the hospitals for which they work, or the educational institutions in which they study, to truly support nurses as they tell their stories, people nod politely and then give nurses awards that portray them in the most gendered and stereotypical fashion. They are depicted as daisies linked in a chain, or angels executing spiritual commands from some higher being – whether a physician, hospital or nursing executive, or cabinet minister.

The QNI was different. My lecture was greeted with great enthusiasm. People came up to me in the reception that followed brimful of stories which they excitedly relayed in actual lay language. I'd expected that a few nurses who attended the two workshops that followed this lecture would produce some useful and interesting stories. I was, however, surprised by the alacrity with which participants grasped the message and recounted very detailed stories – again in comprehensible language – about their work.

What was even more surprising was how quickly the nurses in these workshops began, not only to craft compelling stories but to encourage one another to acknowledge and take pride in their accomplishments. At lunch at the first workshop, a nurse who works with people experiencing homelessness told a story about her work. Four of us listened, awestruck not only by her caring and compassion but by her skill, grit, and persistence dealing with this particular rough sleeper. The nurse concluded her story by insisting that, 'Well, really all I did was use my common sense.' Before I could disagree, one of the attendees jumped in, 'What do you mean common sense?' Everyone at the table proceeded to laud her considerable achievements and insist that none of her work was a matter of commonsense. Instead, it was the result of years of study, knowledge, curiosity, reflection, and experience on the job. They all urged her never to downplay her skill and I know she took their words to heart.

After my workshops, the QNI arranged for me to follow a district nurse, Liz Alderton QN, for a day. Liz and I visited numerous patients in their homes. She coordinated care with other team members including the GPs with whom she works. In just one day, I estimated that she must have saved the NHS literally thousands of pounds – not to mention delivering high quality healthcare services and preventing pain and suffering for her patients. I was so moved and impressed that I decided I had to write up the experience and share it with the public. Thanks to the QNI, the article was published in the I (Independent online).

After my week in London, I was convinced that the stories

of community nurses deserved a much wider audience. The QNI totally agreed. We decided to launch a much larger story telling project. The QNI asked me to return to London in June of 2019 to do two more workshops that would help recruit more nurses whose stories we would then publish. One workshop was for community nurses and another focused on the work of school nurses. During this time, the QNI videoed an abbreviated version of my lecture so that nurses all over the UK could learn how they too could move from silence to voice and explain the value of their work to the public. I was also thrilled when Crystal Oldman told me I would receive the highest of honors – becoming a Fellow of the Queen's Nursing Institute, an award I received at the June 2019 induction of a new cohort of Queens' Nurses at the QNI's annual Awards Ceremony.

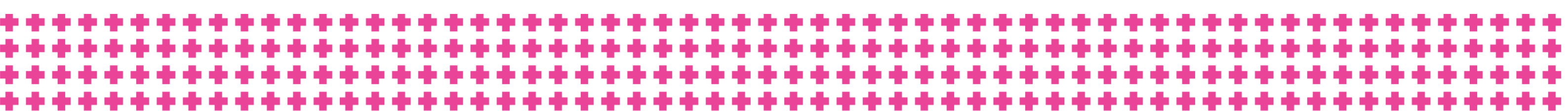
I have been very privileged to help lead this Voice and Value project. The QNI was an amazing partner. Their leaders and staff – particularly Crystal Oldman and Matthew Bradby – devoted a huge amount of work to solicit the stories collected here. To do this, the QNI reached out to a variety of Queen's Nurses, asking for their participation, prodding and cajoling until we had the wonderful stories I then edited to eliminate any nursing or medical jargon that might make the narrative less clear or comprehensible to lay readers.

Although we wanted to launch the result of this project in the Spring of 2020, the Covid-19 pandemic interrupted this effort. Now, after a year in which community nurses have worked so hard to keep patients out of hospital and care for those suffering from long Covid, the QNI is launching a project which will help you see the value of nursing during more normal times. Just imagine how difficult this work has become during the pandemic.

The QNI has posted these stories on its website and compiled them into a short book that can be downloaded and made available to members of the media, policy makers, healthcare administrators, politicians and even other nurses who may not understand the value of community nursing. What is more the QNI is determined that this project is not a one-off event and we will be working together to collect the stories of community nurses during the pandemic.

When I do story telling work with nurses, I always learn an enormous amount about what it means to be a nurse, think like a nurse, and look at the world of sickness and health through the educated eyes of a nurse. The stories we have chosen illustrates how the National Health Service – and the patients it serves -- benefits from the work of community nurses. Yes, each of these nurses is very caring, committed to – and as nurses consistently tell me, 'passionate' – about their work. As these nurses make clear, nursing practice is not only heart work, but brain work.

The British healthcare system is very lucky to have nurses like the ones you will meet here. Every day they prevent pain and suffering, save lives and also, if you do the maths, save money. Community nursing in the UK is, I am convinced, a unique national treasure. Although nurses in my country, the United States, work in schools, in the home, community, and in care homes and long-term care, we lack anything like the well-elaborated models of community nursing that have been developed, over decades (and thanks to organisations like the QNI), in the UK. It has been both an honor and a pleasure to help nurses write about their work. I hope that more members of the public, policy makers, hospital and healthcare administrators, and even other nurses will listen to their voices and value their work.



# Introduction

## Dr Crystal Oldman CBE, Chief Executive, The QNI

I am delighted to introduce this book of stories by School Nurses in the United Kingdom.

The stories show the vast range of work that these specialist, expert practitioners undertake in schools, homes and communities, with young people and their families, every single day.

The stories were written following a workshop with the author Suzanne Gordon that took place in London in summer 2019 with the support of Public Health England. The workshop was one of two held during the same week – the second being for Queen's Nurses in other community specialisms. The stories from that second workshop will be published separately.

We originally intended to publish these stories of School Nurses in the spring of 2020 but were overtaken by the rapidly unfolding Covid-19 pandemic. We are thus publishing them a year later, as life shows signs of renewal and a return to something closer to 'normal'. If you believe, as we do, and as these stories so richly illustrate, that the work of specialist School Nurses is critically important, imagine how much more important, and how much harder to accomplish it is under pandemic conditions. We hope, in the future, to work with Suzanne to document the work community nurses have done during the pandemic and to bring those stories to a wider audience.

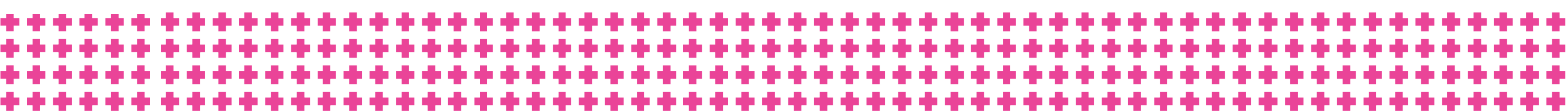
I first heard of Suzanne from QNI Fellow and former District Nurse Ann Keen, who spoke about Suzanne's passion to bring the real work of nurses to a wider audience. Suzanne has studied and written about healthcare for decades, not only in the USA but in many other parts of the world. She has campaigned for greater recognition and appreciation of the role of nurses in our society. She is also convinced that nurses need to be able to tell their own stories in a way that the public and the media understands.

Too often we are told that community nursing is 'not well understood', even by people who have worked in health services for years. This book of stories is one way in which the QNI is helping community nurses to find their voice and articulate their value, describing their work as it is actually done, rather than as imagined.

Suzanne first came to the UK in 2018 as a guest of the QNI and we began working with her to develop her messages about voice and value for a British audience. In 2019, Suzanne worked with two groups with the aim of producing what became two separate collections of stories. To help understand the process, you can see a video of Suzanne's workshop, and some of the nurses who took part in it, on our website.

Over the following months, the nurses worked with Suzanne to produce these final edited stories. By presenting the stories our goal is to bring the incredibly diverse, complex and challenging work of School Nurses to a much wider audience. We also aim to dispel some of the myths around school nursing and to support the case for improved resources for these vital services.

Time and again in these stories we read about nurses who understand the bigger picture, who use their skills and expertise to work with young people and the wider health, charitable and social care system to find a solution to their health and wellbeing challenges. This can only be done with appropriate education, training, and experience. We are incredibly grateful to Suzanne Gordon, who was awarded a QNI Fellowship in 2019, and to the School Nurses who have shared their time, skill and storytelling with us. I hope you enjoy their stories.



# 1. Supporting Children and Young People who are Carers

Amanda Street

In my School Nursing team, each School Nurse has a lead area. Mine is young carers.

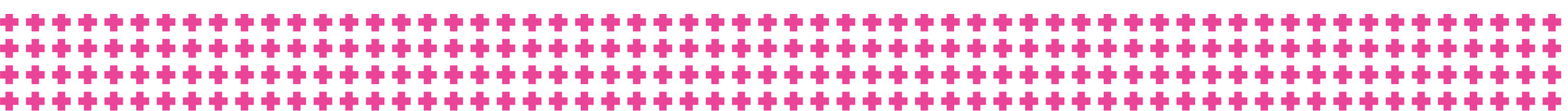
Young carers are children and young people who live in families where a parent or sibling has a physical or mental health problem, or is perhaps battling drug or alcohol problems. These children take on caring responsibilities and because of this can't do things like learning to ride a bike that other children routinely do.

Young carers are often hidden. They feel their duties are part of normal family life. They conceal the details of their home life from doctors, nurses, social workers and teachers and fear they will find out about the burdens they shoulder. The Children's Society (2013) identified that young carers are one and a half times more likely to have special educational needs or long-standing illness or disability, which adds to their vulnerability. Local and national data indicates that more than 160,000 children in England have formal caring responsibilities. This figure is an underestimate because it leaves out the many children who care for adults with drug and alcohol problems (HM Government, 2014).

The Children's and Families Act 2014 and the Care Act 2014 place responsibility on Local Authorities to take reasonable steps to identify young carers and assess and support their needs. I can do this important work when attending our borough's youth club for young carers, which is run by youth workers and supported by School Nurses. There are currently 84 young carers attending the session, which are split into two age groups of 9 to 12 and 13 to 19 years of age. The youth club is their chance to be children, giving them the opportunity to meet with others with similar experiences and take part in activities that other children and young people enjoy.

The relationship between youth workers and School Nurses is strengthening week by week. It allows School Nurses to provide pivotal links and connections between home, school, health services and other professionals. I meet with the youth worker before each session to discuss new referrals, as well as the support that may be required to improve outcomes for the young person and their family. Also, the weekly visit to the youth club means that the young carers and their family members have access to a School Nurse. Having gained their trust, they will pop into the youth club or call me.

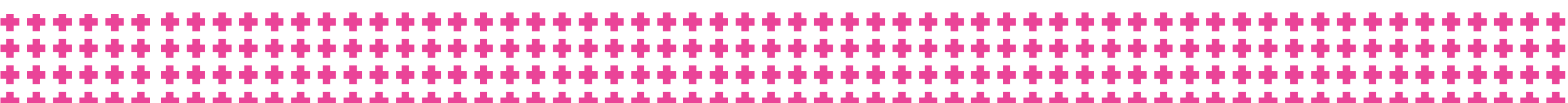
It was during one of these sessions that I met 14-year-old Nancy*. Nancy's mother had removed her from school because she had received daily telephone calls from the school complaining about Nancy's behavior. I learned that Nancy's mother is visually impaired, her father has disabilities and Nancy's younger brother has cerebral palsy. At our first meeting, Nancy opened up and told me that, although she didn't miss Physical Education, she did miss going to school. Recognising that further assessment was required, I referred Nancy to a paediatrician who is currently investigating the possibility that Nancy might



have autism. I was also able to support Nancy's mum, whose visual impairment made it difficult for her to complete the questionnaires sent from the paediatrician and Occupational Therapy.

Nancy is now back in school and keeps me updated with how her week has gone at school. I support Nancy and her mum by attending meetings at school to share what life is like for Nancy, a young carer who possibly also has autism. Without this intervention Nancy may well have not returned to school and missed the opportunity to develop her full potential.

More parents are now requesting health assessments and a higher number of parents/carers drop in for advice and support. I am able to share my knowledge about a wide variety of medical conditions and help parents understand how to manage these conditions and help young carers care for and support their family member. The impact of School Nursing involvement has led to quicker access to services such as audiology, speech and language, paediatricians and Occupational Therapy. The young carers, youth workers and I have been on a journey that has brought immense satisfaction, creating a strong relationship that will continue to grow and develop.



# 2. Supporting a Boy with Autism and his Mother

Anonymous

Kevin is a 5-year-old boy with a diagnosis of Autism. Kevin attends mainstream school and is currently on a 'My Support Plan' working towards an Education Health and Care (EHC) plan in school.

The school is supporting Kevin by using visual aids and keeping him to a consistent routine. The school referred Kevin to the 0-19 Service to provide support to his mother to help her manage his behaviour at home. Other agencies currently involved with Kevin are Speech and Language Therapy.

Kevin's mother is a single parent and struggles with managing Kevin's challenging behaviour. His mother told us that she feels that she does not have enough knowledge to support his behaviour management and feels that the way she deals with him only escalates his temper tantrums and aggressive outbursts. His mother also has issues around sleep routines and toileting (Kevin still wets the bed every night).

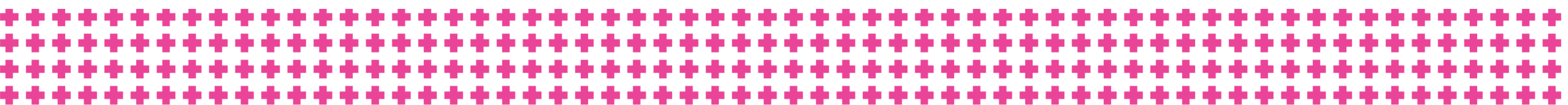
I attended my initial support visit with Kevin's mother. I asked open ended questions and tried to get his mother to reflect on some of Kevin's behaviours. In our conversation, Kevin's mother started to realise that his behaviour was worse when he was out of school and he did not have a daily routine. His mother started to think about what other situations could trigger his outbursts. She arrived at the conclusion that she could manage these situations differently.

We talked about working with the school by introducing visual aids to help provide structure for Kevin, especially with morning and bedtime routines. We talked about getting a calendar so that Kevin would know when it was the school holidays and why he was not going to school that day. His mother began to understand that this would help him to encourage more independence, build his confidence, improve his understanding and help to avoid frustration. Hopefully, this would lead to fewer outbursts. Kevin's mother then requested that I help her to implement these new behaviours and routines and we arranged a follow up home visit.

I also suggested that Kevin's mother have more time out for herself to improve her own mental health and well-being. This would help her to help her son.

Kevin's mother agreed to let me make a referral to the Community Learning Disabilities Team for further support around behaviour management, sleep routines and toileting. I also told Kevin's mother about the Early Bird Plus Programme, a three-month course for parents who have a child with a diagnosis of autism.

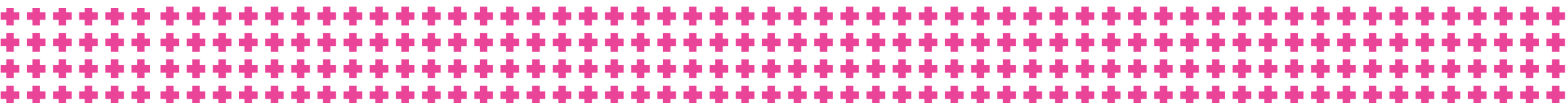
In a follow up home visit, I shared some resources that I



had found. I laminated them so that Kevin's mother could more easily post a daily morning and bedtime routine plan with Kevin. I provided advice on how to go about implementing these routines and suggested positive discipline strategies that would help her further manage her son's behaviour.

Kevin's mother was really pleased with the support she received and told me she felt she had gained a better understanding of Kevin's condition, as well as greater confidence when handling challenging situations.

https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help
https://www.autism.org.uk/services/community/family-support/earlybird.aspx



# 3. Self-harming and Asking for Help

Anita Sloane, Queen's Nurse

Whilst working as a School Nurse in a small city, a young person named Sean came to see me at one of my weekly School Nurse drop-ins. Before Sean and I began our conversation, I explained that talking to a trusted adult might prove very helpful, adding that anything he told me would be held in confidence, unless I felt he was in danger.

Sean said he would like to talk to me and then paused. I sat in silence until Sean was comfortable proceeding. After some time, Sean told me that he sometimes hurt himself (self-harms) particularly when feeling very stressed. I acknowledged how difficult it must be to talk about this and encouraged him to speak further. Sean then told me that he had not self-harmed for a while. He also said that he wanted to speak about his feelings and his urge to hurt himself with his parents and the school staff.

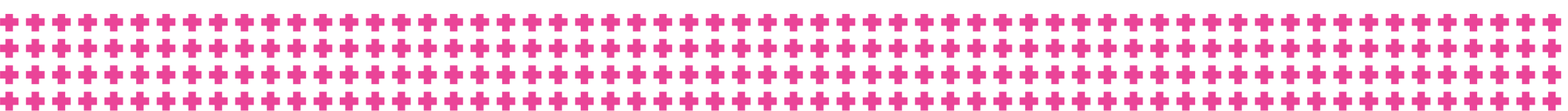
I explained that self-harm can be a coping mechanism that people use when they feel overwhelmed by their problems. Sean then began to talk about the anxieties and worries that had been plaguing him and which often led to him hurting himself. He said he often felt a build-up of emotional pressure which he could not bear.

I listened and then explained that I could help him learn better ways to cope with his stress and other disturbing feelings. I also explained that he would feel better and be able to manage his problems more effectively if he had support from his parents, specialist community mental health services, myself and school staff.

'I feel better just by starting this conversation', Sean said, adding that he felt he would now be able to talk to his parents about it. He also said that he thought he could also talk about his self-harming, and possibly seek further support from local specialist mental health services and school staff. 'I would like your help to do this', he said.

The same day, with Sean's permission and in his presence, I contacted senior school staff and told them about Sean and suggested ways that we could all help him. Senior school staff then met Sean. I was by his side and he was able to openly talk to them about his self-harming. Before the day ended, senior school staff helped Sean to meet with his mother in school and with staff present, he openly told his mother about his self-harming.

Over the next weeks and months, I and senior school staff have continued to meet with Sean. We jointly completed a referral to a specialist child and mental health service who could provide Sean with more support. In his own words, Sean wrote about what he felt and described the kind of support he wanted. After we finished the referral, Sean said that despite still feeling anxious, he felt relieved and that 'things felt a bit brighter'.



Sean has since received specialist mental health counselling. He regularly talks to senior staff in school and they continue to provide emotional support for him. They have reported that Sean's parents are actively supporting their son and are liaising with staff as they try to help him at home. Staff have reported to me that Sean is now much happier and settled in school.

Sean came back to see me and said that he felt much better because his self-harming was no longer a shameful secret but was out in the open. The fact that his parents knew about his behaviour and were trying to help him had made a huge difference in his life. Now, he continued, he was feeling much happier in himself and better equipped to manage his emotions and deal with any day-to-day challenges that arise.

Because School Nurses are approachable, visible, and accessible in school, they are critical resources who can help young people like Sean manage emotional turmoil. The reward for me as a School Nurse is the fact that Sean has reported back to me that he is much happier and feels better able to cope. Most importantly, Sean continues to have support from my colleagues and his family which, I am told, is making on-going positive tangible differences to his emotional wellbeing.

# 4. A School Nurse Intervenes with a Boy with Suicidal Thoughts

## Chris McDermott, Queen's Nurse

Recent headlines around male teenage suicides have made me reflect on the school nurse role in supporting the emotional wellbeing of teenagers.

Some years ago, I held a well-publicised and well attended weekly lunchtime 'Drop In' clinic for students in a large secondary school. One day towards the end of the summer term, the school was unusually quiet because the older pupils had already finished exams and thus the school term. The rest of the students were hanging around in the playground and school games field enjoying the sunshine over the lunch hour.

The clinic room door was propped open. As I was sitting catching up on some paperwork, I could hear footsteps coming down the corridor; I looked up and saw a boy glance into my room and then walk by. The footsteps faded and then returned. Again, the boy looked into the room and walked by. My curiosity aroused I walked to the doorway, looking down the empty corridor I could see him standing 10 yards away. He turned towards me.
'Hello', I said, 'You okay?' I asked, 'Can I help'?
He walked slowly towards me, made eye contact in the doorway, and walked in. We sat side by side on two low chairs, facing towards the now closed door. He hunched forward in his chair, forearms leaning on his legs, hair hiding his face. Expressionless, motionless, he stared at the floor. We sat in silence.

'You had lunch?' I asked.

He shook his head.

'Fancy a cup of tea? I'm having one, I'll get you one'.

The distraction of making and drinking tea appeared to reduce the silence. He appeared to relax.

'You seem sad,' I ventured, 'Is there anything I can do to help?'

He shrugged.

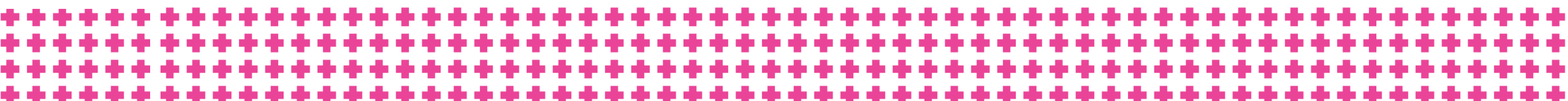
'Is this a bad day, or is every day like this?' I persisted gently.

At last some spoken words: 'Always like this.'

'Do you want to talk about it; sometimes just sharing how you feel can help?'

I was now duty bound to launch into my duty of confidentiality and information sharing statement, which I always make if I think someone is at risk. It is, however, always a conversation stopper. It was today.

He leant forward again and shifted in his chair. Time passed. I filled the void with reassuring words. Finally, he sat back



in the chair, still staring at the floor, 'I just don't want to be here anymore!'

'Do you mean at school or on this planet?' I asked.

'Anywhere, I can't do this anymore!' he exclaimed.

Finally, we were having a conversation, albeit one filled with monosyllabic comments that were stilted at times. The end of lunch bell rang. He looked about to leave but I told him he didn't have to go.

With further prompting and responding to non-verbal cues, I finally asked the question, 'Have you got a plan?'

Yes, he had a plan, he was going to jump. He had even researched sites including the school roof and how he could get up there.I further explored his feelings, and how I could get him some help. Together we thought about key people in the school we should tell. He chose the Head of School.

So now I explained my plan. I told him how I could get support to make him feel better. He nodded his head, and passively agreed to it. Together we walked to the Head's office. To my relief he was in and available. With the boy's permission I told his story. The Head was superb in his reaction, remained calm in his approach, and supportive of the boy's feelings.

The boy remained with the head teacher. The school invited the parents to come in within the hour. I called the local child and adolescent mental health team and sought advice and arranged appointments.

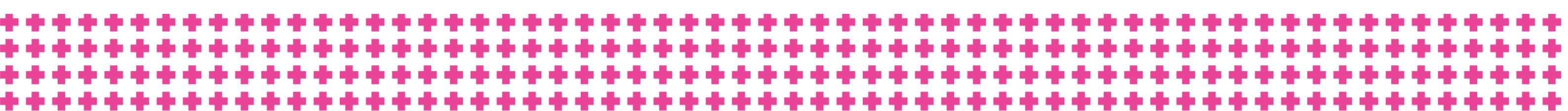
I participated in the subsequent conversation with his mother, at which the boy was present but non-communicative. He was visibly struggling with the disclosure of his feelings to his parents. His mother was also upset. She recounted that she had been increasingly concerned about his behaviour and the fact that he was becoming more withdrawn from his family and friends over the last few months.

With key people in place to support him and keep him safe until his Child and Adolescent Mental Health appointment, my role was completed. He never visited 'Drop In' again but from conversations with the Head I know he engaged with treatment for low mood and depression. He returned to school in September in a much better place.

School Nurses support young people's emotional wellbeing every day. They have the ability to be non-judgemental in their approach, have professional curiosity, are skilled at providing prompts to encourage conversations, and to read non-verbal cues. All this creates a safe place for young people to seek support. This kind of support improves children and young people's health outcomes and life opportunities.

I wonder how the story would have ended if I hadn't been in school that day. I have no idea why this young man picked that particular day to come looking for help. Nor do I know why his problems hadn't been picked up earlier by family, friends or teachers.

I will probably never know, but I'm glad he did.



# 5. Addressing the Causes of Anxiety in a Young Man

Janet Stott

I recently attended a drop in at a high school with a colleague. A young boy whom I'll call John attended the drop-in and expressed concerns that he was feeling 'anxious and panicky in certain situations'. I introduced myself to him and explained the role of the School Nursing Service. I explained that this was a confidential service. Nonetheless, if I felt he was at risk of harm to himself or anyone else, after advising him of my intent, I would have to speak to the relevant colleagues in other agencies.

I tried to be approachable and friendly and help him to feel comfortable and at ease. When I determined that his problems weren't urgent, I asked him if he would be happy to see me another time. I would then be able to spend time with him and better understand his physical and emotional needs. John agreed and was given the contact number for the School Nursing Service and information about online counselling services. I also told him about the emotional health website.

I met with John shortly after our initial contact at the drop-in clinic. I asked him if he was happy at school. Yes, he said, he had friends there. But he repeated that he felt anxious and panicky at times. I asked him if there was someone he could approach in school when he needed someone to talk to. John spoke positively about his head of year and said he felt able to approach her for support.

I asked if John had any worries and if so, did he have anyone to talk to when that happened. He shook his head and looked down gloomily. It was clear that something was, indeed, worrying this young boy.

'Are things okay at home?' I inquired.

Suddenly John opened up and told me that he was very worried about his mother's drinking.

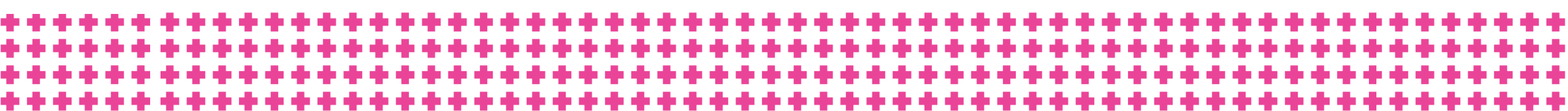
'Do you feel safe at home?' I asked John.

'Yes,' he said, 'because I can go to my Grandma's if I want to.'

I then suggested that his concerns about his mother might actually trigger his anxiety and he quickly agreed that indeed they did.

I explained the role of the local substance misuse service. This is a service for young people who need support around drugs and alcohol and they also offer support for young people whose parents have drug or alcohol problems. John agreed to be referred to the service. I also encouraged John to try and talk to his mother about his feelings and concerns. John said he found it difficult to start the conversation and didn't know what to say.

'Would it be okay for me to ring your mother and tell her that you came to our drop-in because of your anxieties about her drinking?' I asked.



‘Yes, definitely,’ he said.

We agreed to meet again a week later to check on how things were going. John told me I could talk to his head of year so the school could offer some extra support, refer to the substance misuse service and contact his mother.

I contacted John’s mother the same day and she admitted she had no idea what impact her drinking was having on her son. She immediately agreed to allow her son to be referred to the substance misuse service and said she would consider accessing support herself.

I spoke to the service and they told me they held group sessions for young people whose parents/carers have alcohol problems, and that John could attend. They also offered one-to-one support on an individual basis if required.

I saw John in school a week later to follow up. After our talk he said there had been some changes. He told me that someone from the substance misuse service had come to the school to chat with him and had arranged to pick him up from school to take him to the group. John said he and his mother had had a good talk and he felt really pleased about that. It had opened up much better communication between them, he said. After talking to his mother and grandmother about his feelings, he felt much more supported by both of them.

One month later, I saw John in school and was delighted to see that he talked positively about the support from the substance misuse service as well as his family. I made sure John knew how to contact the School Nursing Team if he required any further support.

https://youngminds.org.uk/find-help/

# 6. Dom's Story - Gender Identity and a Complex Family Life

Anonymous

Fifteen-year-old Abi came to see me at my drop-in with her friend. I want to transgend into a boy – known as Dom – Abi told me.

This was not the first time I had met Dom: he had previously spoken to me in April after a Year 10 health questionnaire interview. During this second visit, I reminded Dom that we had a confidential service and what he told me would remain private, unless I ascertained that he was in danger. Dom explained that his parents were divorced and that each had remarried. He had a mother and father and stepmother and stepfather. He said he had spoken to both parents about wanting to become a boy and to be called Dom but felt they hadn't taken it seriously. The reason he'd come to drop-in, he said, was to get help about something he felt he couldn't explain verbally. What was on his mobile phone would help me understand, he said. Dom removed his mobile from his blazer pocket and switched it on. While waiting for his phone to start up, he removed his blazer and rolled his jumper sleeve up to show me his left arm with several cuts that had stared to scab over.

I asked Dom how he had made these cuts. He explained he'd used the blade from a pencil sharpener. I advised Dom to keep his blades and cuts clean and to cover his cuts once he had finished self-harming. I also suggested some coping strategies he could utilize and gave him a red pen and a book in which he could jot down his feelings. I also handed him a snap band and stretch man – so he could 'ping' himself rather than cut himself when he felt overwhelmed by anxiety and stress.

After Dom took these items, he passed me his phone. As he did, Dom became very agitated and upset. What I read was deeply troubling. He had written a message that said that he was so depressed that he was, in fact, planning to take his own life. He had gone so far as to write letters of farewell for his family and friends. I passed his phone back and asked if he still wanted to end his life. 'Yes', he responded gloomily. 'Yes, I do and I want to do it very soon.' 'How do you intend to take your life?' I asked.

After leaving letters for his friends and loved ones, he planned to go into his beloved local woods and hang himself. Did he want to end his life because he wanted to be a boy not a girl? I asked. No, he replied, getting even more upset. It was something to do with the past, something that he'd previously spoken about with several counsellors. In spite of the fact that Dom did not immediately reveal his motivation for wanting to end his life, I told him that I would have to reveal what he told me to the safeguarding team at school and contact his parents.

I spoke to Julie, the school welfare officer and got his parents' and stepdad's contact details because Dom would need to go to A&E and also receive support from a mental

health specialist team. I tried to contact his parents and stepparents for over half an hour before his father returned my call. I explained what Dom had told me and said that we would need to attend A&E as soon as possible. His father, who was at work, said he would come straight away. Fearful that he might rush and have an accident, I reassured him that I would stay with Dom until he arrived.

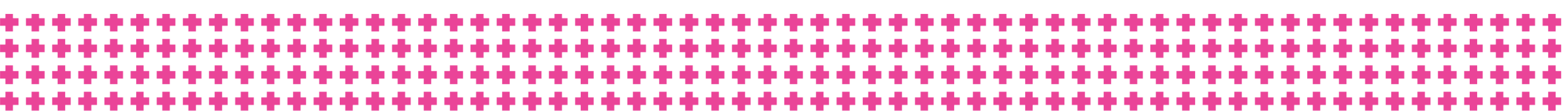
I explained to Dom that his father had returned my call and he was on his way to collect him. Dom became anxious because he said his mother would be upset because his father (from whom she was estranged) was coming. I told Dom that my only concern was his safety, and I would gladly speak to his mother if she returned my call. Dom's mother rang me back an hour later. When I explained what Dom had disclosed and told her that his father was on his way, his mother asked if I could put Dom in a taxi and send him over to her while she was at work. There was no way I would agree to put Dom at risk, and I explained that because of the severity of the situation he should not be left alone. As Dom had anticipated, his mother was not happy that I had called Dom's father.

When Dom's father arrived, I referred to Dom as Abi and asked Dom if I could share the things he'd discussed with me. Dom looked at his father for reassurance. His father said he wanted Dom to do whatever would make him happy. After explaining everything Dom had confided in me, I explained that Dom needed to go immediately to A&E where he would be assessed and supported. I told Dom's father we needed to be completely honest with the staff and show the doctor the message Dom had put on his phone. Dom's father thanked me for ringing him and for keeping his son safe.

A few days later I called the school to see if Dom was there. When I learned that he wasn't, I rang his parents. From his stepmother I learned that Dom's father had taken him back to A&E and Dom would now be seen by a mental health team, in anything from three days to two weeks' time. His father told me that the night before, Dom had gone home to his mother's house and his stepfather had started to scream at him and threaten him physically. His stepmother said Dom, who was very upset, wanted desperately to talk to me and only me. Of course, I agreed to see him straight away.

When Dom walked in to see me he was visibly upset and said he felt very low. Why? I asked. Dom confided that he was worried about how his mother would react to the fact that he wanted to live with his dad. Dom said he felt much safer with his father. After I clarified that Dom was old enough to make his own decisions, he began to feel more comfortable. The school was informed about Dom's wishes and they agreed to talk with his mother.

Dom asked if he could see me again. I was, he said, the only one who had listened to him and got him the support he really needed.



# 7. Protecting a Girl who was the Victim of Abuse at Home

## Karen Darby, Queen's Nurse

I first met Becky when she was 14 years old. The pastoral team at school asked me to see her as she had disclosed to a teacher that she was cutting herself.

When she came to my room for our first meeting, she was very quiet. I explained my role in school and that anything she told me would be confidential unless, that is, I thought she was in any danger, then I would have to share it with someone. She then admitted that for the past six months she had been cutting her arms with a palette knife.

I asked Becky if she could think of any reason she was doing this, but she said no. We discussed her family background. She lived with her mum, dad, younger brother and an older brother who was 18. Throughout our initial interview, Becky spoke very quietly to me, offering one-word answers and wouldn't make eye contact. I realised that it would take time for her to trust me and so I asked if she wanted to see me again the following week. She said yes.

Before she went, I gave Becky details of KOOTH, an online service that provides free support to young people. However, Becky didn't have access to the internet at home. I suggested speaking to the pastoral lead to ask if she could access the internet at school and she agreed. This wasn't ideal, as KOOTH is used when the young person is feeling low and needs to talk to someone. Nonetheless, I thought that using it in school was better than not using it at all. The pastoral lead agreed that Becky could have access to a computer in school whenever she needed it. Becky then went back to class.

The following week, Becky came to see me. She remained quiet, but did open up a bit. She told me that her mum had fibromyalgia and her dad was her carer. She said her mum often shouted at her and that she spent most of her time in her room. She had cut her arm twice in the last week. I asked her to explain where she was when she cut herself, what she used, and how she felt before and after. She said she used a palette knife. Again, she said she just felt sad, but didn't know why. She said that when she cut herself, she felt relieved and better.

I asked if her parents had noticed her arms, but she said they never looked at her. She said she'd used KOOTH a few times in school and it was 'okay'. I spoke to her about using an elastic band around her wrist. When she feels like cutting herself, she could 'ping' the elastic band instead. This causes pain, but without the scarring. She liked the idea and I gave her a band to try and arranged to see her the following week.

A few days later, I was in my drop-in room when Becky came in crying. She sat down and said she was hurting. I asked where and she showed me her back and arms, which had several large red bruises. Her arm appeared to have

fingerprints around the top of it. When she stopped crying, she told me that her older brother had done this to her the night before. 'He hits me all the time,' she confided. I asked what her parents said, but she said they never did anything about it.

I explained to Becky that I would need to share this information with Children's Services. Although she said she was frightened, she agreed that this had to be done. I encouraged her to name a teacher she trusted and she chose the pastoral lead. The pastoral lead came to my room and I explained what had happened. She took Becky to her office to stay with her for the rest of the day.

I rang Children's Services to explain my concerns and completed a Multi-Agency Referral Form (MARF). A social worker came into school to speak to Becky and then went to visit the family. It was decided that her older brother would move out and live with his uncle while an assessment was completed.

A few days later, a social worker rang me to ask if I would accompany her on an unannounced visit to Becky's home. When we arrived, Becky's father opened the door and invited us in. The first thing that struck me was the smell of cats. The house was covered in cat faeces. It was everywhere. Becky's father admitted they had 27 cats. We sat down in the lounge and the social worker started to talk to the parents. However, after a few minutes, the dad told us to leave, which we did.

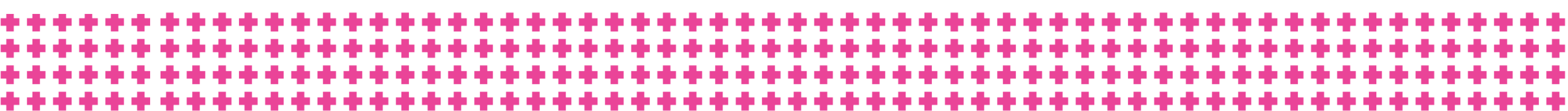
The children were then placed in child protection.

The following week, Becky came to me in school. We discussed her self-harming, which was continuing, and her thoughts and feelings when she cut. I asked her to keep a diary of when this happened and then explained that we would find ways for her to deal with her troubling feelings. Because we had bonded over our sessions, Becky was very keen to work with me and I continued to see her weekly for six weeks, by which time the self-harming had stopped.

Becky's situation at home got worse and she was accommodated in Local Authority care. This brought with it panic attacks and anxiety. I continued to see Becky weekly. She came to me immediately when she was becoming anxious, and I worked with her one-on-one until she felt less anxious and afraid. I continued to see Becky weekly until she left school. This meant that I could spot the signs of any emotional/mental health concerns immediately and could help straight away.

Becky remained in care until she was 18. I saw her a year after she left school. She came to me and introduced me to her boyfriend. She thanked me for changing her life. I explained that she had done most of the work herself. The power of school nursing was standing there, in front of me. With the help of a School Nurse like me a terrified, nervous, and self-harming girl of 14 had turned into a strong young woman attending 6th form.

https://www.kooth.com/



# 8. A Boy with Multiple Health Needs and Complex Family Life

## Karen Shaw, Queen's Nurse

I first met Simon aged 10 when his primary school contacted me because he had not been to school for over eight months. They said that his mum had reported him as having severe psoriasis and Juvenile Idiopathic Arthritis (JIA), which was leaving him too poorly to attend school. Following this referral, I visited Simon's home to offer support.

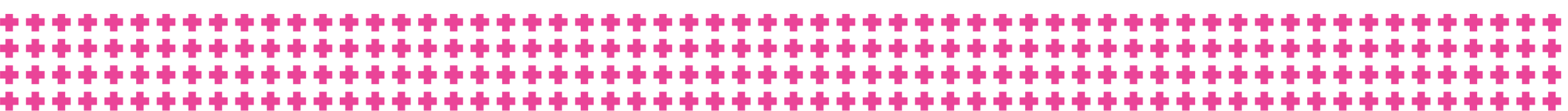
I was met and welcomed into Simon's family home by Simon and his mother. He was experiencing another breakout of his psoriasis which covered his body from head to feet; his mum said that he also had MRSA and could not attend school due to this. Both mum and Simon consented to me being able to liaise with the consultant who was managing Simon's care so that I could advise and support Simon with the aim of getting him back into school.

Simon was living with his mother, father, grandmother and his two brothers in a two bedroomed property and he was sharing a bedroom with his mum, dad and brother. Simon's mother was experiencing anxiety and chronic pain which was being investigated; she was very anxious at our meeting and relied heavily upon his grandmother to answer questions. Simon's Mum said she was also finding it difficult to leave the home, which was also impacting on Simon leaving the home. She was also taking large doses of painkillers and these did affect her functioning levels.

Surprisingly Simon himself was very chatty and upbeat; he was excited to be talking to me with the view of him returning to school. It became apparent at this meeting that Simon had not even left his family home for the past eight months other than for attending hospital appointments, which I was very concerned about. He said he loved going to the park and loved football, but he had not done any of these activities for ages.

Simon's father was upstairs for the whole of the meeting: mum informed me that he suffered with agoraphobia and never left the family home. In subsequent meetings the father was never seen but was heard shouting and swearing at his computer.

Following the meeting I contacted Simon's consultant to discuss the support we could provide to help him to return to school. Simon had a strict treatment regime for his skin condition but on some visits, I could see that he had not been applying his creams. I questioned his treatment and afterwards was able to give advice and support for the process required. I was informed that while Simon was a carrier of MRSA, there was no reason for him to be absent from school because of that. Also, his JIA was under control and providing he had a care plan for pain control and support in school there was no reason for him to be absent.



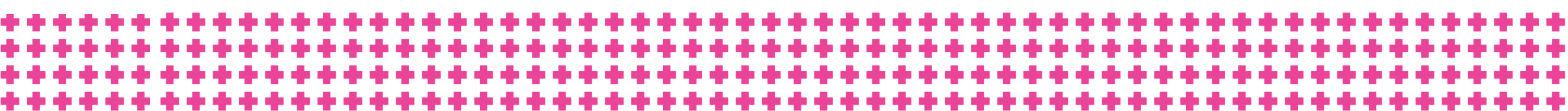
Simon was thrilled with this news, but there was a lot of disagreement from his mother and grandmother who both remained adamant that he should not attend school. Eventually we liaised with his school and arranged for a home tutor to visit until we could help him to return to school. He engaged brilliantly with the tutor and was always excited to see her and loved the learning.

The more meetings I had with the family, the more issues were being raised and finally I was alerted to the fact that the grandmother and father were very controlling and Simon's mum was experiencing domestic violence, which the children were witnessing. At this point I was able to escalate this family to child protection and with the help of children's services we addressed his mum's emotional and physical health, father's mental health, housing and financial situation. We were able to gain more support from the maternal grandparents and most importantly work with a new school to help Simon start settling in there.

Meetings were held with Simon's new high school and it was a privilege to see Simon interact with his new teacher, hugging him and talking excitedly about his new school. We devised a care plan for the school and gave advice and support on continuous treatment which would help Simon attend.

On my last meeting, Simon said that some of the other kids were staring and making comments about his condition. His teacher advised him to tell him immediately when this happened so he could address it. With Simon's consent, I also went into the school to speak to his class about his condition. This was received by his classmates with great compassion and I am now told that he attends school every day, he is playing football and has a great network of friends who look out for him.

He continues to live with his mother and father and while the home environment is not perfect, it has improved, and he is a much happier young man.



# 9. Managing Children's Anxiety Together in a Group

Laura Bickley, Queen's Nurse

My name is Laura Bickley and I have been a Paediatric Nurse for sixteen years and a Specialist Community Public Health Practitioner (School Nurse) for nine years. School Nurses deliver work across health and education systems to help provide a link between school and home. School Nurses also have expertise that allows us to protect and promote the physical, mental and emotional health and wellbeing of children and young people.

The work I recently completed in one of the primary schools I work with illustrates what School Nurses do on a daily basis. A couple of months ago I received five referrals, all from the same primary school on my caseload, requesting support for children who were having problems dealing with anxiety and managing their emotions. These children were all between 8 and 11 years old. There was one child from year group 3, one child from year group 4, one child from year group 5 and two children from year group 6.

I discussed the referrals with the school and each parent and offered a group session taking place once a week, over a period of five weeks. Had more School Nurses been available these children could have been seen individually. With just one nurse allocated to the primary school, it would have taken approximately 25-30 weeks to meet with, assess and support each of these five children. Because dealing with their problems – and preventing more serious ones occurring – was critical, I had to meet with them together.

I first met with all the children individually and explained the programme of support that was being offered to them. All the children were happy to meet together to see if they were comfortable talking in a group. As it was a small primary school, all the children knew of each other, which was a really positive start.

During the first session the children themselves established some ground rules. Here are a few they suggested:

- Listen to each other
- Show respect towards each other
- No question or statement is a silly one
- No coping strategy is a silly one.

I also gave each child the opportunity to say how they felt, what they thought their issues were and if they had previously tried any strategies to help cope with them. 'I have a stress ball that I squeeze,' one child announced. Another child said he would be taken for a 'drive in the car'. As each week went by, each child would become more chatty and happier to share any worries they had, strategies they have tried, and generally how they have felt over the week.

The first session looked at 'What is a worry?' On a gingerbread man body, each child was asked to identify and map how worries can make them feel both emotionally and physically. We then had a group discussion about the importance of sharing worries with a trusted adult. 'Identify five adults you can talk to,' I suggested, and then I asked the children to draw around their hand and write the adult names in each finger and thumb space.

I also taught the children a breathing exercise which we did at the end of each session. This not only helped them feel relaxed when they left each session but gave them a coping strategy to use to help deal with anxiety either at school or at home.

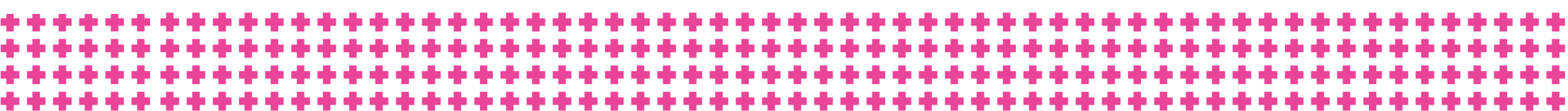
The second session looked at the worry jar, and what the children worry about. Following this, each child made an emotional health first aid kit motivation box. They identified some of their own strategies for coping when they felt worried or anxious and placed the 'tools' in their kit. This made it easier for young children to feel confident that they could reach into their toolkit and pull out a strategy they could use when needed.

The third session looked at the overall health and wellbeing of children and young people. I pulled out an Eat Well Plate diagram (the Eat Well Plate shows how much of what we eat should come from each food group in order to achieve a healthy, balanced diet) and used it to help the children grasp the concept of a healthy diet. We also talked about the importance of getting enough sleep. I emphasised how important it is to put away any devices like laptops and mobile phones an hour before bed. This I explained is to give their minds a chance to relax and unwind. Each child was asked to think of alternative ways to spend their last hour before bedtime. Reading, drawing, colouring, and breathing exercises were some of the ideas they came up with. I also talked about the benefits of exercise which not only release excess energy but also produce 'happy hormones' to make us feel good and positive about ourselves.

Discovering 'how to have a positive attitude' rather than one dominated by worry was the subject of the fourth session. 'What positive things can you focus on when worry threatens to flood over you?' I asked the children. To emphasise this point each child picked a name of someone in the group out of a hat and wrote nice positive things about that person. The children all smiled when one of their peers read stories that highlighted something nice about them. The group also made little pipe cleaner people to help encourage them to talk to someone about their worries. I once again went over the breathing exercises that encouraged resilience and reinforced the importance of coping strategies.

In our fifth and final session together, I went over the coping strategies they'd learned and encouraged them to use their emotional health first aid kit. In order to help other children in the school, the group also created some posters about what they had learnt about coping with anxiety and managing their emotions. The children presented the posters to their head teacher so they could be displayed around the school.

I asked the children to evaluate the sessions and they said they found them useful and fun. All the children said they had learnt 'how to cope with things.' One even said that he would like to 'help other children.' Their class teachers also thanked me for running the group and told me that the children had become more positive, empowered and less anxious over the following weeks. This kind of work not only helped these children be more confident and successful in school, but has also taught them techniques they can rely on throughout their lives.



# 10. Helping a Family through Bereavement

Anonymous

I first met Ann, a mother, whilst working as a School Nurse in the North of England. A referral had been accepted from Ann's Health Visitor, who was requesting that the School Nurse offer support to her and her two children following the sudden death of her husband a year ago.

I contacted Ann a few days following referral to the School Nursing Team. As she began to tell her story it was quickly acknowledged that a series of contacts would be necessary, due to the complexities surrounding this unique and tragic life event. Ann described her family life as 'unconventional'. Prior to her husband's death her job took her away from home two to three times a week, with her husband being the primary care provider for the children. Ann's husband was a stay at home parent and was very active in the community, attending toddler groups and school activities. A year ago, while Ann was out of the country, her husband had passed away suddenly in his sleep leaving both children home alone with him overnight and during the course of the next day.

Unfortunately, Ann had not been contacted by anyone to notify her that her children had not attended school, which would have prompted her to phone home to determine if there was something wrong. As time went on Ann attempted to contact her husband to inform him that she was expected to be home later that night. After several failed attempts she became worried and began to ring around the immediate family. The police were eventually alerted around 9pm that night and found the children cuddled up in bed with their deceased father.

A year on, Ann's main concern was that Amy, her 5-year-old daughter, was displaying symptoms which she felt were associated with post-traumatic stress disorder. Amy was experiencing acute and significant separation anxiety from both Ann and her younger sibling. She was displaying signs of heightened anxiety when there was any deviation from everyday routines and would react disproportionately to everyday situations, having uncontrolled 'meltdowns'. Amy felt the need to frequently recall the events of the day that her dad died and to describe in great detail the sequence of these events. Moreover, Amy would become very distressed when she saw police or ambulance staff or vehicles.

Ann was also struggling. She was having to rebuild a life for herself and the children including establishing routines, parenting strategies and promoting attachment with the girls who were missing their father. As well as dealing with her own grief, Ann was also finding it difficult to integrate into the community and establish relationships with the other parents and school staff.

It was clear that this was a very tragic and multifaceted situation that required more than just a referral to the child

and adolescent mental health service (CAMHS). Ann had been focusing on the health and wellbeing of her children while also grieving her husband and the loss of her identity. She had been a successful executive whose work took her all over the world and suddenly she was a single parent who was trying desperately to adjust to a new role. On top of all this Ann was leading a campaign to raise awareness and change legislation that would require all schools to move down the list of emergency contacts when a child is absent, in an attempt to prevent this from happening to another family.

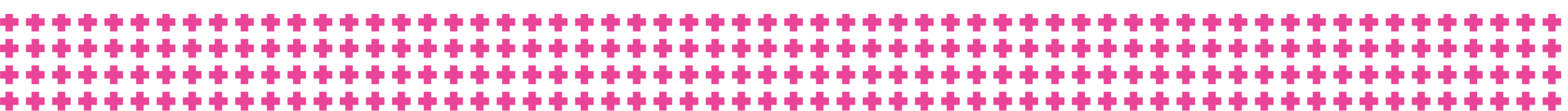
It was necessary to allow this story to unfold over a period of time, as each contact would result in Ann reliving the sequence of events which would evoke an upsurge of emotion. After a series of contacts with Ann it was agreed that I would complete a comprehensive referral to CAMHS for both girls, as this could not be classified as a normal adverse life event. Additionally, after exploring Ann's own emotional and social wellbeing, a referral was made to the adult psychological therapies service. Both referrals were quickly accepted, and Ann and her children were offered therapeutic support.

I continued to arrange follow up contacts with Ann over a period of months and by taking one step at a time, she began to fine-tune and embrace her new role and build community relationships. Nevertheless, she made the hard decision to move her children from the school that they had attended when their dad died. There were many reasons for making this decision and with careful discussion and planning the transition appeared to go smoothly.

The last contact was arranged for just after the Christmas holidays, which Ann was very anxious about. However, when I spoke with Ann afterwards she presented as a completely different person to the one that I had initially spoken to. She and the girls had spent their first Christmas together and it had been 'perfect'. It appeared that the fresh start for the whole family was very successful and the children were settled and doing very well in their new school. Ann had made many new friends within the new school community and was confidently adjusting to her new role.

This was a unique referral and one which firmly underpins the role of the School Nurse. Ann may have chosen to go to her GP for the original referral to the child and adolescent mental health service. The GP may have also referred her to adult psychological services. However, I was able to allow Ann to let her story unfold in her own time and at her own pace which was vital in understanding the complexities associated with her situation.

Many believe that the School Nurse is situated in school and is just there to offer first aid to school age children. This misconception is common and by telling my story I hope to illustrate that our role is multifaceted and aims to ensure that every child is healthy, happy and safe. In this instance, by working alongside Ann and supporting her over several months, both Amy and her sister are now flourishing in their new school and have the chance to thrive and reach their full potential.



# 11. A Looked-after Child at Risk
Paula Perkins

I am a Specialist Community Public Health School Nurse (SCPHN); I have worked with my Health Board for the past 28 years and as a School Nurse for the past 9 years.

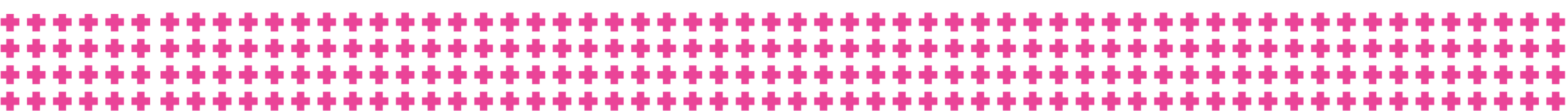
In my first year as a SCPHN, I was asked to see a young looked-after child whom I will refer to as Daisy. Daisy was anxious and quiet the first time I saw her. I know from experience and training that often looked-after children are hard to engage as they have been let down in their past. I explained to Daisy that my room was a safe place to talk and that she could tell me anything. I also explained that what she told me would be entirely confidential and that I would only share information she relayed if it was necessary to keep her safe.

Daisy told me about her home life and a little about her friends; she then asked to leave but requested to see me again the next week. Daisy was 11 years old, lived with a maternal relative but was treated as a child in the foster care system. Although Daisy was living with a relative, the family always reminded her that she was a foster child. This relationship was difficult for Daisy. Daisy did not feel she could talk about things at home, as it brought up bad feelings for her and her carer. This placement eventually broke down.

On her second visit to my room, Daisy told me she had been speaking to someone online and they wanted to meet her in the local park. Anxious not to scare her I gently probed deeper. Daisy told me it was a boy and he had asked her to share her picture with him. She'd immediately sent one via email. I asked if he had shared his picture with her but she shook her head. Daisy then told me that he had asked her for other pictures, 'You know, to show him my bits.' Daisy indicated to her private areas. Keeping calm, I asked if she had done this. Thankfully she shook her head – no she had not.

I asked Daisy if she had told anyone at home. No, she said, she was afraid to get into trouble. I assured Daisy she was not in any trouble but I wanted to be able to speak to her carer and the police about this. This was not what friends do, I told her. As a School Nurse, with a duty of care for Daisy, I had to navigate my obligation to intervene while simultaneously maintaining her trust. Because I broached the subject tactfully, Daisy agreed.

Following this incident, and then a police investigation, I saw Daisy weekly. We built up a relationship based on trust and safety. Daisy visited my room at least monthly. She would talk about her subsequent placements when Daisy was fostered into different homes, as well as her friends and relationships. Over the following years Daisy confided in me when she needed sexual health advice. She came to see me when her placements broke down (which was at one time very frequent). Daisy even asked



me to help her with forms for her GCSE options, then sixth form and eventually her college application. When she was due to leave school, Daisy wrote me a letter which ended with the sentence, 'You will never know how much your support has meant to me, you are more than a nurse you are the closest person I have ever had to a mother'.

As you can imagine the letter had me in floods of tears and I have kept it as a treasured memento. This letter from one child proved that listening, not judging, and being open and honest with children gains their trust and respect. I have worked with thousands of children in the last nine years and want to continue working as a School Nurse until I retire.

During the school year we are busy with immunisations, health promotion, safeguarding, and lots more. Our schedule is always packed and we do not have nearly enough nurses to handle the caseloads we are assigned. I had over three thousand children on my caseload. What I can tell you is that ten minutes on a regular basis can make a huge difference to a child's life. Every child deserves to be heard, to be safe and to feel cared for. Many people do not understand the role of the school nurse and dismiss us as just 'nit nurses.' In this case, the 'nit' I ferreted out could have done far more than cause an itchy scalp. It is unimaginable the harm that could have been done to Daisy had I, and then the police, not intervened.

# 12. Helping a Young Person Build a Positive View of Life

Rita Jenner, Queen's Nurse

I met 15-year-old Chloe when working as a School Nurse in a rural part of England. I received a request for help from her school because Chloe had not been going to school regularly.

Chloe was getting very upset with her friends and becoming socially isolated. She had a major problem with sleeping and had started to cut her arms and legs as a form of self-harm. The school informed me that Chloe and her family were new age travellers and her parents lived in separate caravans/trucks. I learned that her older brother had died suddenly of an undiagnosed cardiac condition. She also had a younger brother who was eight years old.

I met with Chloe about five times over a period of six weeks. As I took her history and learned more about the young girl, it became apparent that Chloe was still dealing with her older brother's sudden death. Chloe told me that she was haunted by the certainty that she too was going to die like her brother. In fact, she had recently seen the GP about chest pains. Dreams about her brother were also making it difficult for her to get a good night's sleep.

Chloe wasn't the only one in her family having problems dealing with her brother's death: her parents were struggling with their own grief too. Chloe's mother was constantly at work and seemed unable to relate to, or spend much time with her daughter. Chloe's father was drinking alcohol excessively and there were rows in the family which were a by-product of this unresolved grief.

On top of all of this, Chloe's lifestyle as a new age traveller living in trucks and caravans differed from the more conventional domestic arrangements of her fellow students and friends – many of whom were from affluent backgrounds. Chloe had self-harmed twice in the previous month and confessed that it was hard for her to resist the impulse to do so again. She said she did not want to end her own life but that she was feeling very unhappy, hopeless, lonely and worthless.

In my sessions with Chloe, we spoke in detail about the grief process; how people grieve and what is normal and abnormal grief. She had not sought any professional support to deal with her brother's grief and felt that she was the only one who had ever experienced such lingering and intense despair after the loss of a loved one.

I gave her the opportunity to talk about her brother and about how much she missed him. Chloe was distressed because she did not know how to keep the memory of her brother alive, since her parents had burned a lot of his possessions. With my encouragement she made a picture collage of her brother and wrote quotes of the things he often said. I reassured her that, although her brother had died, she still had her life ahead of her.

We also spoke at length about her sense that she was lost in the world and did not feel like she belonged or that anyone cared for her. I employed cognitive behavioural techniques in my conversations and challenged her thought process about her feelings that she did not belong in her family or with her school friends whose backgrounds were so different to hers.

We explored how Chloe might feel better if she ate better and slept more peacefully. I explained how she could have a healthier diet and better sleep habits. We also explored ways to improve her relationship with her parents. Rather that ruminating on what was going wrong, I helped her focus on what could be improved. Every time she brought up her sense of hopelessness of the future, I encouraged her to think about moving ahead on her own life's journey rather than living in the past.

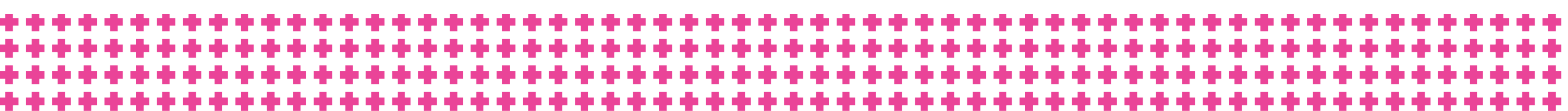
Helping Chloe, of course, involved dealing with her parents and I spoke to her mother twice. At first, she was reluctant to acknowledge that her unresolved grief was impacting on her ability to care for her remaining son and daughter. I learned that she wasn't only dealing with the death of her son but also with a stillbirth many years earlier. For her mother, this conversation represented a turning point: she suddenly realised that she had to get help and deal with the aftermath of these losses.

Because Chloe's mother was now dealing with her problems, rather than repressing them, Chloe was able to go to school every day and take all of her GSCE exams and get good grades for them. I suggested Chloe seek career guidance and she met with a counsellor from the school. She has now started sixth form at a different college and has goals and a sense of hope about her future prospects.

Chloe and her mother have gone to bereavement counselling sessions together. More than that they now spend time together doing things they enjoy – going to festivals, going out for a coffee, and gardening. One of the most difficult things Chloe has done is to have open and honest conversations with her father about how she is feeling, as well as her concerns about his drinking.

For teenagers like Chloe, living in an unconventional setting can make it difficult to fit in with the rest of society. Being careful not to be condescending, I helped Chloe explore how to overcome the resentment she expressed toward friends whom she considered to be more privileged, as well as immature. At her new school, Chloe has found friends with whom she feels more comfortable.

When I look at Chloe now, she is a totally different person. She eats regularly and has better sleeping habits. There are no more chest pains, and she is far more optimistic about her health and her longevity. Most importantly Chloe has not self-harmed once since I first met with her. In fact, she told me that she will never do so again and I believe her.



# 13. Looking Beyond the Obvious: Issues Troubling a Young Man

Ruth Butler, Queen's Nurse

One of my favourite things about working as a School Nurse is holding drop-in clinics in secondary schools. The School Nurse drop-in clinic is a bit like a GP surgery. You are available for anyone within the school community but you're not sure who will come through the door next. These drop-in clinics are only well attended when the School Nurse has a visible presence in the school and when the service is easily accessible and trusted by the pupils and school staff. I had been working in my secondary school for almost three years and was well known amongst staff and pupils alike. This meant that I had frequent visitors to my drop-in clinics.

One day, a 14-year-old boy whom I'll call Michael popped in to see me. He said he just had a quick question about the safety of protein supplement powders. I gave him some basic information about protein supplements including why people might use them and asked him why he was interested in this topic.

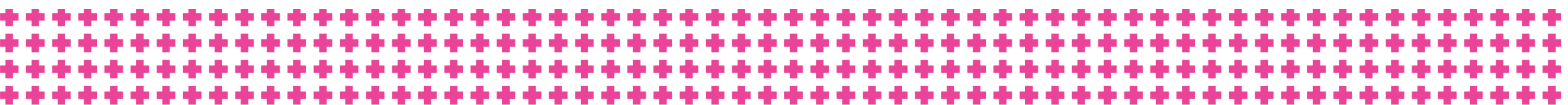
He replied vaguely that he wanted to keep healthy and fit and be stronger and also mentioned that all his friends were bigger than he was. It appeared to me that this was the real issue that was bothering him. I suggested that we arrange an appointment to see me again so we could check his growth and discuss it further.

Michael came to the next appointment and we started by weighing and measuring him, which he was keen to do. His growth was below the 2nd percentile. His last growth measurement on record was when he was 11. This showed that he had been just below the 9th percentile. I calculated his BMI for both measurements, which showed them to fall within the healthy weight category.

Michael was of Filipino origin and, based on his own estimations, both his parents seemed to be between the 2nd and 9th percentile. It was also clear that he was still in the early stages of puberty. I explained the influence of ethnicity and parental height, as well as his stage of physical development.

I was concerned that Michael was focusing on a quick fix solution to his perceived problem. As I chatted to him, I realised that there were other issues that may well have a bearing upon his concerns. Michael was in year 10, the first year of the GCSE course but had only started at the school the previous September.

He had found the transfer quite difficult and had not made any close friends since starting in this new school. He said he got on with the other pupils, although didn't seem to fit into any particular friendship group. Although he spent most time with a group of boys from his tutor group, he wasn't particularly close to any of them. Within the group there appeared to be a lot of joking about Michael's height, which he described as 'banter.' Outwardly, he had taken this with good humour but inwardly, he was suffering from feelings of inadequacy and isolation.



Although the transition between schools and his integration into his new year group had not been well managed, he showed great resilience in the way he had handled the situation. This, I believe, was largely due to the good relationship he had with his father.

I explained to Michael that how he felt about fitting in at his new school was as important as his physical well-being and suggested that we work on both areas. With his consent, I telephoned his father to discuss our consultation who also expressed concern about his son's growth. Michael's diet appeared good. He had no medical conditions and was reasonably fit and active. I therefore agreed to follow this up, working in collaboration with his GP.

Michael was reluctant to speak to his personal tutor at school but gave me permission to do so. Because of this, he developed a better relationship with his personal tutor which, in turn, led to an introduction to some of the school's enrichment programme, namely the chess club and the film club. This resulted in Michael feeling more confident in himself and more engaged with school. His circle of friends increased and he started to feel less isolated. Michael continued to be concerned about his growth but was reassured that this was now being monitored.

It is difficult to quantify the value of this intervention from the School Nursing Service. However, we do know that children and young people who feel unsupported and isolated from their peer-group are at risk of developing anxiety and depression which, in turn, puts them at greater risk of risk-taking behaviours and academic under-achievement.

As a skilled practitioner I was able to identify the issue which was troubling Michael the most and by facilitating a collaboration between him, his family and his school, I was able to help Michael address it.

## 14. A Young Man Comes to Term with his Sexual Identity
### Ruth Locke, Queen's Nurse

After working as a School Health Nurse (SHN) for nine years and based in a secondary school for the past five I know that we, as School Nurses, may be the first health professionals to see young people in need, learn about their problems and help them cope with situations that will influence how they view relationships with health professionals for years to come.

In my work, we use School Health Improvement Plans to profile our school communities and to plan and identify the work needed to improve health outcomes. I had identified that the sixth form were not accessing the SHN service as much as in previous years and I needed to address this. To remedy this problem, I ran a sexual health roadshow in lunchtime giving out leaflets and freebies (condoms, pens, keyrings, all with health messages on them) to highlight the SHN service in school.

The day after this session, a sixth former asked to see me. He told me that he was stressed by exams and was putting pressure on himself to achieve. He did not make eye contact with me and was trembling whilst talking. As part of the assessment process, I asked about suicidal ideation. The young boy, whom I will call Tom, started to cry. Everyone would be better off without him, he cried, which was why he was thinking about ending his life.

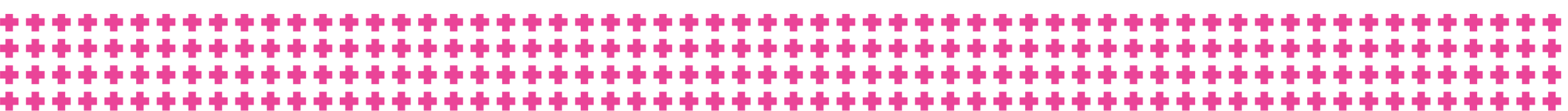
'What else is worrying you?' I asked.

He seemed like he wanted to talk but hesitated. Finally, he confessed that he hadn't told anyone about his problem and didn't know how to even begin. I told him that anything he told me would be kept in confidence and assured him that I would not judge him or share his information with anyone unless I was worried about his safety.

He then told me, that although he wished he wasn't, he was gay. 'I haven't ever told this to anyone,' he confided. It was his worries about his sexual identity, not his exam stress that was his real problem.

He agreed that I could reveal his suicidal thoughts to his mother and that I could talk to her about going with him to the GP later that day for a mental health assessment around suicidal thoughts. As we talked, he told me how worried he was about his sexuality and what his parents and friends may think of him. We discussed what he wanted to do, and I told him about the charity Stonewall and other LGBT support networks in our area.

He also said he wanted to tell the head of sixth form, with whom he had a good relationship, but was afraid to do so. I offered to do this on his behalf and he enthusiastically accepted my offer. We agreed that we would meet after his GP appointment. As he left, he turned and told me that just revealing his secret to one person – me – had really helped him.



The next day he returned to see me and appeared much brighter. Although he had not yet told her he was gay, he said he had talked to mum about his suicidal thoughts. Reassured by her understanding and love, he felt he could, with my help, tell her he was gay. With my support he wrote his mother a letter disclosing his sexual identity and was going to leave it on her pillow later that day. He had also spoken to the head of sixth form. He was very reassured by the teacher's supportive and accepting response. He had looked at some of the websites I had suggested and read some testimonials from other young people and felt less isolated.

The next day he returned to see me with some very good news. After reading the letter he had left her his mother was, he said, fantastic. She hugged him and told him he was loved unconditionally. Suddenly, he said, it felt like a massive weight had been lifted from his shoulders.

Over the next few months, I supported this young man through his first sexual relationship by discussing healthy relationships, risks, consent, online safety and sexual health advice including the distribution of condoms. He was really appreciative of the support given. In his evaluation of the service I provided, he wrote that he didn't think he would have been alive if he hadn't opened up to me that day.

# 15. Overcoming Anxiety and a Fear of Needles

Tikki Harrold

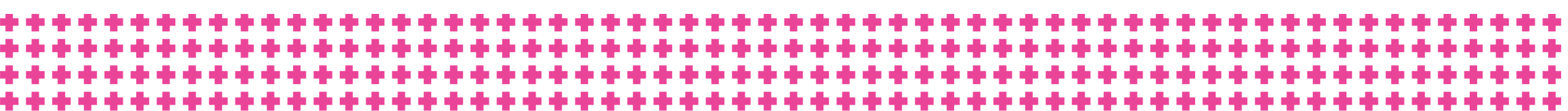
At the start of the academic year, the School Counsellor in the secondary school where I work referred a girl in year nine who suffered from general anxiety. She was very worried about her upcoming immunisations. I met with her and encouraged her to tell me about her worries so we could explore her story.

When she was a small child, around three to four years of age, she had been quite sick and had had multiple procedures, operations, and hospital stays. We talked about how these were connected to her recurrent fear of needles. She knew she needed her immunisations in March, but was very frightened about it. Just talking about them made her feel sick and anxious. Her breathing became shallow and faster; her eyes were darting around the room patrolling for any hint of danger and she was picking at the skin around her nails. I asked her to rate her anxiety on a 0-10 scale and she reported it as a 10.

With a body outline we looked at the fight, flight, freeze response caused by the stress hormone adrenaline so we could explore and then reduce some of her symptoms. Using an NHS online video, we ended our first session with a progressive muscular relaxation technique and she said she felt far less anxious. I gave her some homework: practicing this relaxation technique whenever she felt stressed or overwhelmed with anxiety. We agreed to meet again and work through a programme of graded exposure – a process of very gradual exposure to the source of the anxiety that results in a reduction of the physical symptoms of anxiety (habituation). I explained that this attempt to slowly, and in a safe place, explore and visualise her fears would be hard work. She was, nonetheless enthusiastic about taking this journey, with me as a guide.

So, we began our journey. The first stop was looking at a line drawing of a syringe and needle. As expected, this provoked a physical reaction caused by the surge in adrenaline. She began to breathe shallowly and rapidly. She felt sick to her stomach and wanted to run out of the room. But she didn't run, she stayed put and told me how she was feeling. Because I helped her find the language – and the will – to explain what was happening physically inside her, she could tolerate the image if it was at arm's length. I also guided her in some breathing techniques that would help her relax. I asked her to repeat this exercise with the syringe drawing at home over the coming week.

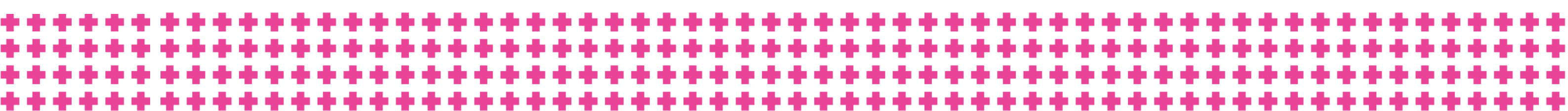
Our next step was to look at a photo of a syringe and needle. Then, over the next four, 20-minute sessions we managed to build up her comfort level so that she could actually look at an empty syringe without racing out of the room. I guided her through the same physical relaxation process and she named her syringe 'Mr Bob.' She actually took it home and ate and slept with it near her.



By the end of our work together, the young student was able to remain relaxed whilst I pretended to immunise her with 'Bob' the syringe and she was able to watch a video of children receiving vaccinations with only a small increase in her anxiety. She was so thrilled and proud of this, as it would have been inconceivable only a month before.

She agreed to continue to play with 'Mr Bob' and to practice her relaxation technique and we stopped our weekly sessions. Four months later, she was able to attend the main session of the Year 9 Tetanus, Diphtheria, Polio and Meningococcal ACWY and calmly received both her immunisations. She told me afterward that she was really grateful for my support. 'I would never have been able to get this immunisation if I had not had the help of my School Nurse,' she told me.

This young woman gained confidence by facing a fear and conquering it. Although the skills I taught her were specifically tailored to her needle phobia, they are transferable to other areas of her life and will continue to empower her.



# 16. A Boy with Acute Mental Health Problems

Eve Thrupp, Queen's Nurse

I've been a nurse for 15 years. When I first qualified as a nurse, I worked in a children's hospital. For the past ten years, I have worked as a School Nurse, mostly in the inner city. Now, I cover a caseload of four schools in Dudley, just outside Birmingham.

Several months ago, teachers in a large high school reached out to me because they were concerned about the behaviour of a 14-year-old boy whom I will call James. James seemed to be extremely angry: he was hitting himself, doors, walls, anything close to hand. He was also disrupting class and being rude to staff.

Students are often too frightened or intimidated to come and seek help from a professional like myself. So, once I am told about a student who needs help, I walk down to the classroom and find the young man or woman myself. This makes it much easier for a student to get support.

For our initial visit, I went to get James from his classroom and took him to a small room where we could talk privately. I explained my role as school nurse to James and told him that what he said to me would be held in the strictest confidence. I told him that I would only talk with him if he agreed to participate in our conversations. Since my goal was to make him feel safe and elicit his trust, I spoke quietly and tried not to bombard him with too many questions. As I talked with him, he kept his eyes down and I could feel his sense of despondency. Often School Nurses receive referrals for an issue, that requires some further unpicking and investigation – so I started by building a relationship with James.

We began to talk about the teacher who had expressed concerns about his behaviour. I asked if the teacher had talked with him before talking to me. James glowered and exclaimed, 'Well they are just a bunch of pricks,' and added, 'I don't care'. As he said this, he looked at me to gauge my reaction. I remained calm and acknowledged his feelings without judging them or arguing with him. 'I understand you must be angry,' I said, then asked him to tell me about what he did to try and calm down when he is angry. 'Chill with the boys,' he said, 'go out and smoke and drink.'

As soon as he said this, I saw red flags. In our child exploitation training, we have learned that when young people let off steam by drinking and smoking, they may be vulnerable to adults who may try to exploit them. Who are these boys, I wondered? Where are they meeting? What are they doing? Since James was so young, no one would be legally allowed to serve or sell him alcohol.

As we talked, I discovered that James would often go drinking or smoking in places that police have identified as 'hot spots' – places where gangs or drug dealers

congregate and prey on vulnerable teenagers. They also seek to recruit troubled teenagers as drug dealers. We continued to chat, about his friends, girlfriends, and school. I asked about his aspirations and future plans. I wanted to know what motivated James. He said he knew that he could do better in school but felt helpless about improving. I asked him if he wanted help.

'Yes,' he said, 'I want to do well. I want to get my own car and house.' This was clearly a goal we could advance toward together.

I continued to see James for about nine weeks. Although the school noted some improvement in his behaviour, he was riding a rollercoaster of emotions – doing better one day and acting up the next. About three weeks after I began to see James, he suddenly appeared in my office.

When I asked how he was, he blurted out, 'I'm fucked up man!'

'Tell me what's going on with you,' I said.

'I need to tell you I'm crazy. You need to know I'm crazy,' he repeated. 'Why do you think you're crazy?' I asked.

'Wait till you hear. I know you will judge me,' he warned.

'Try me,' I suggested.

James then confessed that when he was much younger, he'd been out playing with friends and saw someone get stabbed. Years later, he was still plagued by these images. He told me he hears and sees things most days. For example, he saw a dead body on his bedroom floor. He said he found it difficult to concentrate at school, because when it was quiet the voices in his head seemed louder. That's why he thought he was going 'mad.'

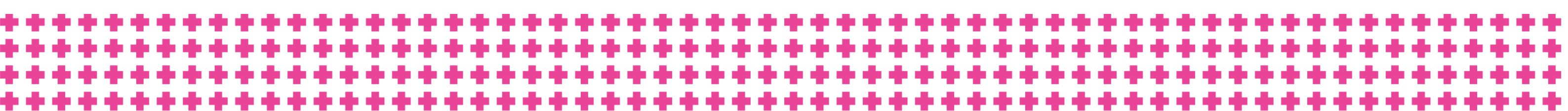
I listened carefully and said I was impressed that he had managed things for so many months all alone, without seeking help and thanked him for reaching out to me. He replied that he needed to reach out to me because, 'It's getting worse and I can trust you'.

I explained that he could get help from mental health services, and hopefully we could manage his symptoms through either medication or psychotherapy. He would make that decision, but I told him he should not continue to try to deal with this on his own. James nodded and said he wanted help but did not want his parents informed about any of his problems. Under the Fraser competence guidelines James, who was over 13, was legally competent to make decisions about seeking support without parental consent.

In order to get James the support he needed, I booked a GP appointment so he could get a referral to mental health services. I also asked James' permission to refer him to a local exploitation specialist team – to which he also gave his consent. He asked me to accompany him to his GP appointment, which I gladly did. The GP put in an urgent referral to mental health services, which meant he would be seen within two weeks.

While he was waiting for his appointment with mental health services, I saw him walking down the hall in the school. Several members of staff were following him. He had blood on his face and arms. Very concerned, I asked him what had happened. He said, 'I'm not doing well,' and stormed away.

The teachers told me that James was very upset and they couldn't cope with him. They urgently wanted my help. I went and spoke with James and tried to calm him down. After talking to him and assessing his condition, I realised he was having an acute mental health breakdown and needed to be seen immediately, whether he agreed



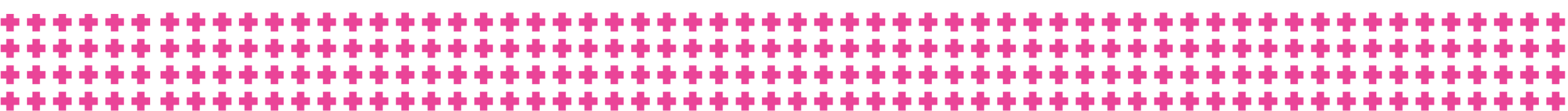
to this or not. I also told the teaching staff that they had to reach out to James' parents. Although James had been adamant that he didn't want his parents to know about his situation, it was clearly so serious that we had to breach confidentiality.

His parents were called and came to the school. After sitting with James and succeeding in calming him down, I called in his father. James became angry and again I had to assuage his distress. I also spoke to his GP to seek an immediate appointment for an assessment. Within two hours James and I went to the GP and he was given an appointment with a mental health team. Although he refused to involve his parents in any of his appointments, he asked me to go with him when he saw a psychiatrist, which I did.

James started therapy sessions, which are ongoing. His parents, now aware of everything that's been happening, are providing significant support and James's relationship with them is much better than it was. Although my door will always be open to James, he is now getting consistent support from the mental health team.

James would never have got the therapeutic services he needed had I not, as a School Nurse, been available to guide him. Had I not been in his school and been willing to persist in gaining his trust, he could easily have chosen to continue dealing with his problems by running away from them – smoking, drinking, taking drugs and getting into more and more trouble. He could have faced legal problems and frightening exploitation by adults who prey on troubled children. For James, the consequences of failing to get help would have been huge.

James is only one of the many young men and women whom I help every day in my work. Unfortunately, there are too many young people like James and not enough School Nurses to care for them appropriately. In spite of the overwhelming caseloads School Nurses like myself shoulder, we continue to make sure that vulnerable students don't fall through the cracks and they get the help they need.



# 17. Offering Emotional Support to a Young Man

Fiona Louth, Queen's Nurse

In May 2019, school staff from a Leeds high school asked the Clinical Triage Team in the 0-19 service for some support with a young man, whom I will call James, who was disengaging from school and who had entered the school with a knife in his bag. James' parents were very worried and desperate for some support with their 15-year-old son.

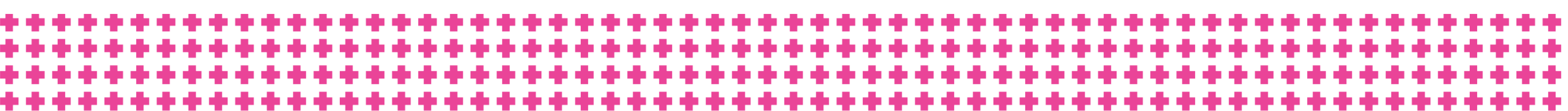
The referral was passed to me through the Clinical Triage team. James and I met in the school. I introduced myself and the 0-19 service to James and explained about confidentiality and my role. James said it would be okay if I completed a health/ emotional health and wellbeing assessment with him.

In the three 30-minute sessions with James, he was able to explore his feelings and reflect on the spiralling situation in which he found himself. Using a device called the 'Blob Tree,' James was able to identify significant, caring and protective people around him. I also drew a snake diagram in one session, with each segment of the snake representing a year of James' life and I asked him to share with me any good or bad memories he had about each year.

Within the first 15 minutes of our first session together, James told me that his father was black and his mother was white. It was important I know this, he said, because he did not think I would have guessed it from looking at him. As we talked together James told me he was very proud of his heritage. He was also clearly worried that I might judge him because of his mixed race. I assured him I would never be judgmental or prejudiced and would accept him for being the person he is. At this point James smiled at me and his body language became more open and he looked more relaxed. During this session James also revealed that he had been bullied in the past.

In our sessions, we explored how and why James was bullied. James thought the situation stemmed from primary school and the interaction he had with one particular boy. James was able to recognise and acknowledge this negative behaviour and that of others and changed some of his friends. Although this was his decision, it was not easy for him. I also made sure James was aware of how to contact the 0-19 service in the future if he needed to do so and I told him about the CHAT Health service which had just just started in Leeds. This is a confidential text service for young people aged 11-19. A Specialist Public Health Nurse will respond to any text message and offer support to a young person.

In our sessions, James also told me that he had once carried a knife to school as protection and assured me that he had had no intention of using it.  Knife crime is a serious issue in England, and many young men risk either being

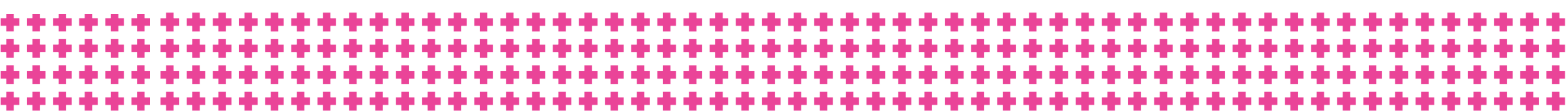


killed, hurt, or going to jail because they carry knives or are involved in a knife or gang fight. Knowing this, I made sure to talk with James about the implications of carrying a knife, as well as the risks of fighting on the street or being involved in gang conflict. James told me that he had never committed a crime but he had been involved in an organised fight in the park. This fight had been advertised and replayed on social media. The young man's mother was not happy about this at all and reported the fight to the police.

One of the significant things we talked about was James' relationship with his mother. He no longer related much to his mother. Although they lived in the same house, they did not eat together. James would go his room without talking to his mum and would leave the house without saying a word. He longed for their relationship to improve. James wanted to spend quality time with his mum, for example, going to the gym or walking the dog. We thought of strategies that James could use to rebuild his relationship with his family. These included sharing a meal or walking together to the gym.

James and I worked together for eight weeks. By the end of the third session, James had built a better relationship with his family and his school. James told me that he was enjoying spending time with his mum and he wanted to know 'how I did it'. I told him I only listened to him. He had already come up with a lot of the strategies himself and I simply helped him figure out how to implement them.

I set aside a fourth session for James during his exam period, just in case he needed someone to talk to. One day in the summer term I received a message from the school staff informing me that James wanted to tell me that he was fine and did not need the fourth session. James managed to sit his GCSE exams that summer and I later heard from the school staff that James had achieved good grades and was due to start college in September. James had a lot of hopes and dreams that he initially felt he could not realise. It was in our work together that he learned how to find a path forward and take the first steps toward a new life.



# 18. Investigating Fears of Female Genital Mutilation

Fiona Rogers, Queen's Nurse

'I feel frightened, please don't take me back... swords,' an 11-year-old girl named Abasco begged me, as she sat in my office. Abasco lived in a seaside town in the North West of England. She lived with her mother and two sisters – one younger and one older – as well as an older brother. Abasco and her mother and other siblings had immigrated to the UK from Kenya seven years ago while their father still lived in Kenya. Her mother worked at the local supermarket. All the children were settled in their schools and had never been referred to or seen by any other agencies.

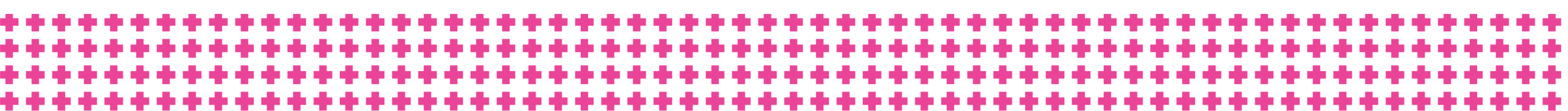
Children's Social Care (CSC) had asked me to help this young girl after her mother had taken her to her GP because she seemed to be very anxious, was not sleeping, constantly bursting into tears and harming herself by cutting her body with a knife.

The General Practice Nurse (GPN) was concerned because the family had recently returned from holiday in Kenya. During her initial consultation, Abasco mentioned swords and said she was fearful about returning. When the GPN asked her to talk more about her fears, she was not able – or perhaps willing – to explain what precisely she feared about a future visit. Aware of the prevalence of Female Genital Mutilation (FGM) in Kenya, the GPN was concerned that Abasco was displaying worrying symptoms of someone who has been, or fears being mutilated in this way. FGM is illegal in the UK and seen as a form of child abuse. The GPN followed local Safeguarding Procedure and referred the family to CSC.

Social workers met the family and following their assessment were satisfied there was no evidence FGM had taken place. They then referred the family to the School Nursing Team which has, in recent years, become more aware of the problem of Female Genital Mutilation and trained to provide help to at risk children by Safeguarding Children's Nurses, who have furnished school nurses with tools like the NSPCC PANTS (the underwear rule) resources for the youngest child.

The underwear rule has been widely publicised on TV and teaches children that 'If you want to say 'No', it's your choice. No one should ever make you do things that make you feel embarrassed or uncomfortable. If someone asks to see or tries to touch you underneath your underwear say 'No' – and tell someone you trust and like to speak to.' Furnished with these and many other tools, the team was well positioned to provide emotional health support to the family as well as give them information that would keep them safe.

I planned an initial visit to the home to meet Abasco's mother and her family and explain my role and responsibilities. She understood why I had been asked to meet her and her children and welcomed me into her home. After explaining



to Abasco's mother that I was there to reinforce the work carried out by CSC the girls joined us and listened intently as I introduced myself. Their brother refused to join the meeting.

We made a plan to meet Bishara - the youngest child - at home with her mother present. Abasco and Chuki, her older sister, chose to be seen at school. The boy, Darweshi, also declined an appointment. After a discussion with the Safeguarding Nurse, we decided not to push any further meetings and simply tell the Social Worker about his decision while continuing to monitor the situation at school and at home.

Bishara was a lively chatty eight-year-old who did not appear nervous when I went to her house after school the following week. She excitedly told me about her upcoming birthday and what she had done in school that day. She had no outstanding health needs. She made regular visits to the dentist, had had her eyes tested and was a healthy weight. She smiled, laughed and engaged with me as we sat on the floor together completing the NSPCC PANTS presentation. She chose her favourite colouring pencils to colour in the pants and we sang the Pantosaurus song together at the end. I had no safeguarding concerns and she displayed an age appropriate awareness of her body and how to keep safe.

Following our positive interaction coupled with her mum's engagement in the session I concluded I did not need to meet Bishara again. She was aware of who she could talk to at school if she had any worries.

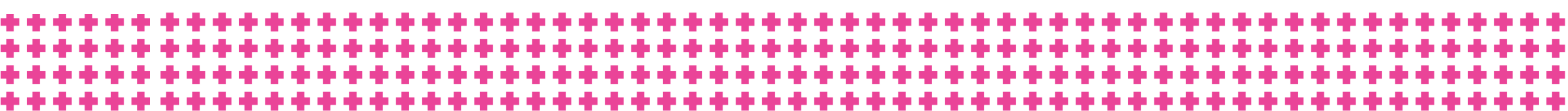
Abasco and Chuki chose to be seen in school. I saw Abasco first. Although she was slightly apprehensive, she soon relaxed when I explained why I had been asked to see her. Sitting on the edge of her seat, she made little eye contact and spoke quietly. I reassured her and explained about confidentiality and tried to develop a rapport with the anxious child so that I could work out if she was in danger.

It didn't take long for Abasco to visibly relax, sit back in her chair and tell her story. She explained articulately how frightened she had been when visiting Kenya. It was so different, she told me, from the UK. She then became upset as she continued to talk about her fears. She said she didn't want to upset her mother, who had a wide family network in Kenya.

Although the team had feared that Abasco was at high risk of FGM, it seemed that this was not her problem. What troubled her was a general fear of leaving the country she loved and called home and being separated from her friends and school. No other health issues were identified and the plan was to meet over the coming weeks to share evidence-based strategies how to manage her emotions, improve her sleep and encourage her to share her fears with her mother,

Abasco said she had a close relationship with her older sister. We discussed the importance of having identified people in her life who she could talk to about her feelings or worries. Over the subsequent six weeks, Abasco and I met three times and she talked about her feelings and concerns. At the end of the last session, we evaluated how she was feeling and she said she was happier, less anxious, sleeping better and hadn't self-harmed for a month.

I met Chuki in school too. She was relaxed and chatty. She was studying for her exams, aspiring to go to university. Chuki said she had a very close relationship with her mother with whom she could share her worries and



concerns. No further appointments were arranged and she had contact details for the School Nurse Team.

My evaluation concluded that I had no evidence to support suspicions FGM had taken place and Abasco never disclosed any further information, except being fearful to leave the country she called home. I felt confident that Chuki could rely on her mother for help. Bishara completed the keeping safe work and when I asked her sisters there was always a story to tell about her latest antics! We never met with Darweshi, but neither the school nor his mother expressed any concerns about his welfare. The family are now aware of the role of the School Nurse Team and how to make contact if needed in the future.

Although we found no evidence of Female Genital Mutiliation, our actions were critical in making sure this would not be a problem in the future and that all the female children in the family were aware of how to keep themselves safe from any kind of unwanted sexual intrusion or aggression. My involvement with the family did more than assure that female children were protected from this particular kind of harm. It helped anxious children understand that they could talk about their fears and hopes and find help from supportive school nurses as they moved through their teenage years.

https://learning.nspcc.org.uk/research-resources/schools/pants-teaching

# 19. Supporting Children and Young People who are Asylum Seekers
Sharon Edge

In my School Nursing Team, each nurse has a lead area. My area of expertise is helping asylum seekers get support so that they can recover from trauma, access healthcare and social services and attend school. To be effective in this work, I have received special training that has helped me better understand the needs of this specific group of people.

We define asylum seekers as those children and young people who come from non-British families and who have come to the UK to escape war and conflict, economic deprivation, or even forced marriages. There are an estimated 3590 asylum seekers living in the West Midlands, where I work. The largest numbers of asylum seekers are from Zimbabwe, Pakistan, Afghanistan, Iraq and Iran.

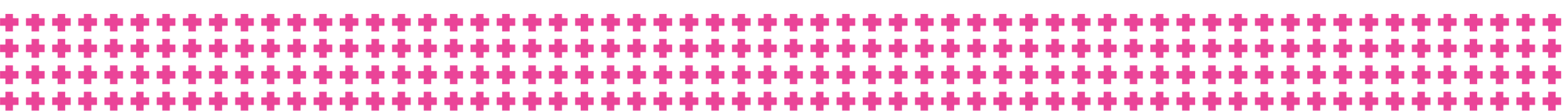
One of the children I worked with was a girl who escaped to the UK when she was 12 years old, only to be treated as a virtual slave by her family. When she arrived, her auntie promised her she would go to school and get a good education which would, in turn, lead to a good job. Instead, she was forced to cook and clean and kept a prisoner in the house. Local authorities could not help because they weren't even aware she was in the country.

At the age of 17 she managed to run away. However, she was groomed into a domestically violent relationship and had three children. After managing to flee this relationship, she was living in asylum seeker accommodation with her children. When I met her, she appeared to be a positive young lady and had three adorable children. She was determined to get an education so she could provide for them.

Another family I met had lived as prisoners in their home for months as they faced endless warfare in their country of origin. The child I worked with had never been to school and they were unable to access health services. The father had scrimped and saved to pay to be smuggled out of his country in a lorry. When the family prepared to embark on their journey, the smugglers refused to allow the father to go with them. They still have no idea what happened to him and the mother now struggles on alone, in an alien country and culture, with her son. With my help and that of other agencies, the family has been able to adjust, recover from their trauma, and the child attends school on a regular basis.

These families all struggle with social isolation. Much of this stems from the traumas they have experienced and is exacerbated by the fact that they often come to this country with little or no knowledge of English. This often means they do not understand how to get help from the health, social care, or educational systems.

Helping these families involves a great deal of teamwork and coordination. Interpreters, for example, are central players on this team. They do more than translate words and sentences. Their understanding of the different cultures with which we work helps me to provide the right support and advice as these families confront, and



hopefully, overcome the challenges they face.

When caring for and guiding these children, I must constantly be vigilant about the fact that these children are at high risk of having TB or sexually transmitted diseases. I am also alert for signs of abuse and neglect and problems that arise from genital mutilation.

Because many of these children and families have never before encountered healthcare professionals, I educate them about how to access and make effective use of NHS services. This is not always easy. Many of these families harbor a deep distrust of any authority figure. Some cannot comprehend the concept of free health services.

To get them needed support, I help families get care from GPs and dentists and educate them about how they can better care for themselves and their children. When people need more emotional support, I coordinate with and refer them to Child and Adolescent Mental Health Services (CAMHS). This is critical because early intervention can enhance their emotional health and wellbeing.

I attend monthly multi-agency meetings with the local asylum seeker and refugee support association and collaborate with my colleague in Health Visiting, who supports vulnerable families with younger children. I use my local knowledge of services to direct asylum seekers to their nearest food banks and to ESOL language classes. Working with the local support association, I ensure the children have clothes and toys. When a safety issue emerges, I work with the local authority's Child in Need programme, which can better address their safety needs. Getting a child enrolled in and regularly attending school is very difficult for many of these families. I help them navigate this process and offer schools and other service providers the benefit of my knowledge so they can better support these children and young people.

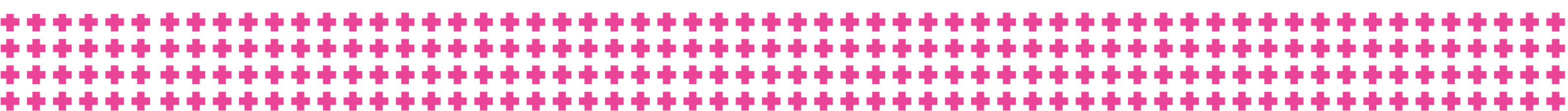
One of the children I worked with experienced the trauma of being separated from her mother. When they contemplated leaving Iran, her family decided that her father was the only person who would be able to protect her during the arduous trip. Her mother stayed behind. The girl's father told me that, to protect the young girl, he had to drug her into silence as they were smuggled out of the country in the back of a lorry.

One day, as I visited the family in their lodging on a busy road in a Midlands town, I observed how this traumatic experience, which had happened several years earlier, continued to impact her life. While we were talking, sirens wailed outside the house. Panic stricken, she froze and seemed absolutely paralysed. Not surprisingly, she had attachment anxieties and was fearful of being away from her father.

Also deeply traumatised by his experiences, her father nonetheless walked her to school every day. Because he spoke so little English, he would wait outside the school all day because he didn't know – and felt incapable of inquiring – when school finished.

Because they had so little money, his daughter was initially told she couldn't come to school because she couldn't afford to purchase a school uniform. After her father gave me permission to share this with the school, who didn't even know she was an asylum seeker, the school provided uniforms, funds for trips, school meals, and a bus pass. After reaching out to colleagues in School Nursing, we also provided her with clothes and toys. I made a referral to CAMHS so she could access support to process her trauma. She is now doing well academically in school, and coping emotionally.

Each of the families I work with has its own haunting story and I am pleased that I have the skill and knowledge to help them work through their traumatic experiences and support their children to attend and succeed in school.



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