have a diagnosable mental illness such as obsessive compulsive disorder (OCD) but display good levels of mental health (in the same way that someone with diabetes can manage their illness and lead a full and healthy life). For someone to be diagnosed with a mental health condition (for example, emotional, behavioural, hyperactivity), their symptoms have to be sufficiently severe to cause distress to the child or impair their functioning (World Health Organization, 1993).

Turning our attention towards the statistics on children's mental health in the UK, what do we know about the current situation? The fact that it has been well over a decade since children's mental health has been surveyed on a large scale and in a systematic way (Green *et al*, 2005) gives an indication of how children's welfare is viewed in the UK. The latest report from NHS Digital certainly suggests that the mental health of young people is getting worse (NHS Digital, 2018). There has been a slight increase in the prevalence of mental health conditions in 5 to 15-year-olds, rising from 9.7% in 1999, to 10.1% in 2004, and 11.2% in 2017. More children in this group are experiencing clinically impairing anxiety or depression. One in eight 5 to 19-year-olds has at least one mental health problem now. And we know that children are experiencing more mental health issues as they get older. The research shows a prevalence rate of one in ten (9.5%) five to 10-year-olds. This increases to one in seven (14.4%) for secondary school aged children (11 to 16-year-olds) and rates of mental health issues were highest in 17 to 19-year-olds, with one in six (16.9%) experiencing at least one.

This trend is deeply concerning, especially when you consider that many children with mental health conditions are still not getting timely access to the specialist help they could benefit from (Office of the Children's Commissioner for England, 2018). What the data doesn't tell us are the reasons why more children appear to be suffering from poor mental health. Is it due to the effects of social media, or austerity, or school and exam pressure? We just don't know. It is certainly true that the research shows that children with mental health needs spend more time on social media and have more concerns about it than those children without a mental health condition, but we have no idea which way the causality runs. What this does mean, however, is that there is a greater need to measure children's mental health over time to get a better feel for what may be behind the causes of mental health conditions and, just as importantly, what promotes good mental health in children.

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National policy

Given this concerning trend of worsening mental health among children, what is the government doing in response? At the end of 2017, the government published

a mental health Green Paper, detailing proposals to create a network of support for children and young people, and their educational settings (Department of Health, 2017). The Green Paper made three main proposals:

1. That every school and college will have a designated lead in mental health by 2025

Their remit will be to:

- oversee the help the school gives to pupils with mental health problems
- help staff to spot pupils who show signs of mental health problems
- offer advice to staff about mental health
- refer children to specialist services if they need to.

2. Mental health support teams should work with schools and colleges

These support teams will offer individual and group help to young people with mild to moderate mental health issues including anxiety, low mood and behavioural difficulties. The idea is that the support teams will work closely with the designated mental health leads and provide a link with more specialist mental health services.

3. To pilot a four-week waiting time for access to specialist NHS children and young people's mental health services

This would dramatically reduce current waiting times for children who desperately need access to child and adolescent mental health services (CAMHS).

However, these proposals were not without criticism. The Education and Health and Social Care Committee criticised the Green Paper, saying it lacked ambition and would fail to help the majority of children who really needed help (Education and Health and Social Care Committee, 2018). They argued that the plans would put more pressure on schools, that funding for the proposals was not guaranteed, that pilot schemes would only cover up to a quarter of the country by 2022/23, and that not enough focus was being put on promoting positive mental health and preventing mental health problems.

Other developments include the new Ofsted inspection framework, which has gone out for consultation and places a greater emphasis on children's 'personal development' (Ofsted, 2019). Inspectors will want to see what schools are doing

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to develop children's 'character and resilience'. Additionally, plans have been published by the DfE, to make 'health education' compulsory by 2020, which would see schools having to teach children about the benefits of a healthier lifestyle, what determines their physical health and how to build mental resilience and wellbeing.

All of these proposals are certainly welcome, placing a greater emphasis on schools promoting good mental health, with greater access to services and additional support. Whether schools, who are already under great financial and political pressure, will be able to take advantage of these initiatives, only time will tell.

Whole school approaches to good mental health and the school environment

There is no doubt that promoting good mental health in primary schools needs a whole school approach to be most effective. An 'emotionally literate school' (Weare, 2006) looks at the whole school context. It regards the total experience of school life as contributing to the emotional wellbeing of everyone who learns and works there. Without a supportive whole school culture and ethos, any mental health interventions are likely to be severely limited in their impact.

Emotionally literate schools are typically strong in four key areas (Weare, 2000):

- Firstly, relationships are at the heart of them and there is a strong sense of belonging. Everyone feels listened to and respected, and that they can contribute to their school community.
- Secondly, there is a strong sense of engagement and all members of the school community are working cohesively, guided by strong values and common goals.
- Thirdly, these schools promote autonomy and independence. Rather than being rigidly hierarchical, schools that promote good mental health allow staff and children to feel like they are in control of important aspects of their lives and are given a voice.
- Lastly, mental health in schools is promoted by having high expectations of all children and clear boundaries and rules. Everyone knows what is expected of them and what the rewards and consequences are of certain behaviours and choices.

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It is important to bear in mind, however, the intense pressure many primary schools face at present. Financial pressures, accountability measures, performance targets, league tables – all of these factors can undermine the wellbeing of staff which, in turn, has been shown to have a negative effect on children's wellbeing and attainment (Black, 2001). So, emotionally literate schools must be aware of the pressures they are under and consciously work to ameliorate the effects of this pressure by prioritising staff and pupil wellbeing.

Oldham Council

Oldham Council have developed a framework called The Whole School and College Approach to Emotional Health and Mental Wellbeing. The framework offers practical guidance to schools and colleges to develop the knowledge and skills needed to promote mental health, and to prevent minor problems from escalating into more serious long-term issues.

As part of the framework, Oldham Council have set up a Mental Wellbeing Team, with co-ordinators allocated to a number of schools and colleges, assisting head teachers and college principles to embed a whole school approach to emotional health and mental wellbeing.

For more information visit: www.oldham.gov.uk/info/200807/mental_health/1795/the_whole_school_and_college_approach_to_emotional_health_and_mental_wellbeing

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What schools can do to promote good mental health

As well as the school environment being important, schools can enhance their offering by adopting specific programmes to promote good mental health among their learners and staff. Well-designed programmes teach children about mental health, tackle risk factors often associated with mental health problems, and promote protective factors such as happiness, resilience and optimism, relationship skills, and stress management. The research shows that children with mental health problems benefit the most from universal approaches targeted at everyone, rather than those focused just on them (Weare, 2006). This doesn't mean that schools cannot offer targeted interventions for groups of children struggling with mental health, but what these children need most is what is good for all children.

Overleaf are some suggestions of programmes and interventions that have a good and growing evidence-base and may provide a useful starting point for thinking about promoting mental health in school settings.

Adverse childhood experiences – Rosie and Sam

Rosie (aged eight) and Sam (aged five) were brother and sister who came into local authority care following Rosie being hit by her mum. Rosie and Sam had lived with their parents, whose relationship was characterised by significant domestic violence, often fuelled by their drug and alcohol misuse. They had regular parties in their house. Their home was dirty and there was rarely any food in the house. Rosie and Sam often felt like they got in the way, and they never knew when it was safe to ask for a drink or something to eat. If it was the wrong time, they would get shouted at, hit and sent upstairs.

Rosie and Sam were exposed to several adverse childhood experiences, which would increase their risk of developing mental health problems. These experiences included:

- physical abuse
- domestic violence
- parental drug and alcohol misuse
- neglect
- emotional abuse.

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How can we support these children and young people?

Everyone involved in the life of a looked after child can help build their resilience, support them and help them reach their potential, and this can range from family and friends, frontline professionals in education, the local authority, youth justice and health, through to voluntary agencies and specialist child and adolescent mental health workers in NHS Child and Adolescent Mental Health Services (CAMHs).

What can CAMHs offer?

Assessment

'Assessments should focus on understanding the individual's mental health and emotional wellbeing in the context of their current situation and past experiences, rather than solely focusing on the presenting symptoms.'
(Milich *et al*, 2017, pp37)

Information will need to be gathered from multiple sources and will need to include:

- family history – from the social worker and their family (where appropriate)
- any psychological assessments conducted for court
- report from the caregiver
- observations in the home and school
- school report
- information from LAC reviews/medicals
- individual assessment of child/young person
- rating scales/questionnaires which look at specific difficulties, such as ADHD.

Ibrahim – assessment

Ibrahim is a six-year-old boy who was presenting with significant behavioural difficulties in his foster home. The carer and social worker requested CAMHs support to understand his emotional and behavioural needs better as they were concerned that he had an intrinsic difficulty, such as ADHD, which was driving his behaviour. Ibrahim had lived at home with his mother until he was five and had witnessed significant domestic violence and neglect before being moved into care.

The psychologist met with the foster carer in the home to gather information and to observe Ibrahim in his home environment. She then met with the designated teacher in school and observed Ibrahim in the playground and in the classroom to inform her assessment. Ibrahim then attended a clinic appointment for a play-based assessment to look at:

- his social interactions
- attention and concentration
- communication skills including language use and emotional literacy
- his understanding of his current living situation
- his attachment style.

The assessment indicted that Ibrahim had difficulties related to the trauma he had experienced whilst living in the family home and this had affected his ability to trust adults. He was often hypervigilant to the environment around him as he had developed a way of coping with the unpredictable outbursts whilst in the family home. There had also been an attempt to return Ibrahim home to live with his mother which had to be terminated due to concerns about his safety. This had increased his anxiety levels and led to a deterioration in his behaviour. The assessment was shared with the social worker and foster carer, and management approaches to supporting his anxiety were discussed.

Intervention

It is essential that any intervention for mental health problems in looked after children is guided by a comprehensive mental health assessment and detailed formulation. This is to avoid the use of inappropriate or ineffective interventions. It must be recognised that a child who has experienced a traumatic early attachment history is likely to find it very difficult to trust adults and feel safe enough to talk about their experiences. Thus, time must be given to developing the collaborative therapeutic alliance, which is recognised as a key component of therapeutic progress (Fonagy *et al*, 2016).

Often, there are many people involved in a looked after child's life, for example, family, foster or residential carers, social worker and school staff; thinking systemically about the child and their network will help to target interventions. Mental health interventions for looked after children can range from psychological to pharmacological; from individual, to care/child dyad interventions, to consultation to the network around the child. Interventions should be driven by evidence-based practice and the National Institute for Clinical Excellence (NICE) guidance (NICE, 2019) provide summaries of the current evidence-base.

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Child/young person

Direct interventions with the child/young person need to be collaborative and needs-led. They can target specific here-and-now mental health problems or address past trauma with a view to alleviating some of the difficulties the young person may be having as a result of the trauma. Often, interventions may need to be eclectic to meet the needs of these young people with complex needs.

Interventions include:

- Dialectical Behaviour Therapy (DBT)
- Cognitive Behavioural Therapy (CBT)
- Eye Movement Desensitization and Reprocessing (EMDR) or trauma-focused CBT
- psychotherapy
- compassion-focused therapy
- play therapy
- medication (as an adjunct to psychological intervention).

Child/young person and carer dyad

Interventions focusing on the child/young person and carer dyad can help in facilitating attachment security, improving the child's mental health and reducing the risk of placement breakdown. Such interventions include:

- Dyadic Developmental Psychotherapy
- play therapies eg Theraplay
- family therapy.

Carer

The importance of the carer–child relationship cannot be underestimated in terms of the protective value it adds to the child's emotional wellbeing and mental health. It is therefore essential to ensure that carers and residential childcare workers are skilled and trained in working with children who have often experienced developmental trauma and attachment difficulties. National Institute for Health and Care Excellence (NICE) guidance (NICE, 2015) recommends parental sensitivity and behavioural training. Examples of this include:

- fostering changes (Briskman *et al*, 2012)
- nurturing attachments (Golding, 2013)
- video-interaction guidance
- psychoeducation.

Professionals

Consultation with professionals in the child's network is paramount in ensuring that everyone is working together to meet the mental health needs of the child. Consultation may include:

- psychoeducation around areas such as attachment, developmental trauma and mental health
- sharing a formulation to help ensure consistency and to develop a shared multi-agency understanding of the child's needs
- collaborative reflection and guidance to think about how best to meet the child's needs in whichever environment they are in.

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Faith – consultation

Faith (aged 11) presented as being very fearful of her foster Faith. When her foster carer even slightly raised her voice, Faith started shaking. Erin would often run off and had no sense of danger. She would go up to strangers and have no fear. At school Faith was rough with her peers and controlling. She wouldn't let them choose their games and when she didn't get her own way, she would hit out.

The social worker, school staff and foster carer were offered consultation from the mental health CAMHs clinician to link Faith's presenting behavioural concerns to her past experiences. These concerns were:

- being fearful of her foster carer
- having no sense of danger
- being controlling with peers
- hitting out at peers.

Faith had been physically abused and was frightened of adults as they could be very unpredictable and hurt her. Faith was used to raised voices leading to being hit, and as such, her foster carer's raised voice triggered fear in Faith. Faith's past experiences were such that she had been passed around lots of strangers in her parents' house when they were having parties and she had not learned any stranger awareness. She had also grown up in a house where hitting was a way that people managed challenges and confrontations, and this may have become a learned behaviour.

Once her presentation was contextualised in relation to what had happened to her using developmental trauma and attachment theories, the CAMHs clinician advised the carer and professionals on strategies to help Faith experience new ways of seeing the world and to help her when she was displaying these behaviours.

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Young person's participation and involvement

Any therapeutic mental health input with a looked after child and/or their carers should be collaborative with them. However, the views and input from young people are also invaluable in all areas of service development and delivery, to ensure that services represent what young people want and need. Young people should be included in:

- working with commissioners
- mental health service staff recruitment
- co-delivery of training

Chapter 15: Depression and Bipolar Disorder in Children and Young People

Eunice Ayodeji and Bernadka Dubicka

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Key learning points

- If not managed effectively, depression and bipolar disorder can lead to complications and have a profound impact on the young person and their families.
- Children and adolescents who have had one episode of depression are at risk of further episodes.
- Depression in childhood and adolescence is rarely uncomplicated and often presents with other mental health conditions such as anxiety or conduct disorders.
- The core symptoms of depression in children and adolescents are similar to those seen in adulthood. However, there can be notable differences.
- Young people who experience depression and bipolar disorder face a number of negative outcomes, including impaired family and peer relationships, in addition to interference with academic functioning.

Keywords

Depression; bipolar disorder; adolescents; children; young people; assessment; treatment

Introduction

Depression and bipolar disorders in children and young people are serious mental health conditions which require timely evidence-based treatments to ensure

the best possible outcome. Both conditions can cause considerable distress, and can have a profound impact on the child and their families/carers. Children who experience depression and bipolar disorder face a number of potential negative outcomes including school refusal, academic failure, impaired family functioning and physical and mental health problems in adulthood (Thaper *et al*, 2012).

This chapter covers factors that can lead to the development of depression and bipolar disorder, prevalence, and outlines current evidence-based treatments.

Depression

Signs and symptoms

Depression is one of the most common mental health conditions in children and young people (Whiteford *et al*, 2013). It may often present with other mental health conditions such as disruptive or other emotional disorders in younger children and anxiety or conduct disorders in adolescence. Although it is uncommon in prepubertal children, the prevalence rate is between 1–2%, rising to 20% for adolescents (Costello *et al*, 2006; Avenevoli *et al*, 2015). The presence of other mental health conditions often indicates a poorer outcome in relation to suicidality, duration, impairment and risk of recurrence.

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Assessment and detection

It can be difficult to identify depression in this age group as it is common for many young people to experience periods of sadness and despondency. However, for a diagnosis of clinical depression there should be evidence of significant symptoms of depression and impairment in social, educational and other areas of functioning. The core symptoms of childhood and adolescent onset depression are similar to those seen in adults; however, depression in children and young people is associated with a greater number of psychosocial difficulties than in adult onset depression (McLeod *et al*, 2016). In addition, there are significant developmental differences; symptom presentation and the clinical picture is dependent on the developmental stage of the young person (see Table 15.1). For example, younger children may present with somatic symptoms such as tummy aches and headaches, as well as behavioural changes like refusing to go to school and separation anxiety (Yorbik *et al*, 2004). Older children may present as being 'bored', irritable and oversleeping, as well as presenting with more typical symptoms such as hopelessness, lack of energy, weight loss and suicidality.

Table 15.1: Red flags for depression across childhood

Symptom	6 years	6–12 years	Adolescents
Somatic	Failure to thrive sleep/eating problems	Headaches, tummy aches sleep/appetite changes	Headaches, tummy aches sleep and appetite changes
Behavioural	Disruptive behaviour social withdrawal reduced enjoyment (observed)	Irritability, boredom, apathy fatigue, decreased enjoyment (observed or self-reported)	Apathy, boredom, social isolation increased sexual activity, aggression, self-injurious behaviours
Developmental	Developmental delay or regression	Decreased ability to concentrate at school	Decreased ability to concentrate at school, decreased academic performance

(Chung & Soares, 2012)

Due to the differences in presentations, it can be difficult to recognise depression and the symptoms of depression may be overlooked (NICE, 2019). Therefore, a detailed biopsychosocial assessment is essential, including enquiring about all possible symptoms. In order to receive a diagnosis of depression, at least five of nine symptoms (see Table 15.2) need to be present during the same two-week period in addition to impairment in functioning. One of the core symptoms must be present at all times, either depressed mood, irritability, or marked diminished interest or pleasure in almost all activities.

A number of screening rating scales such as the Revised Children's Anxiety Scale (Chorpita *et al*, 2000) and Mood and Feelings Questionnaire (Angold *et al*, 1995) are available. However, there is limited consensus regarding their use (Simmons *et al*, 2015). The scales are not generally used to diagnose depression, but to assess and monitor symptom severity.

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Table 15.2: DSM-5 criteria for depression

Major depressive episode (adult)*	Provision for children and adolescents
Depressed mood	Persistent sad or irritable mood, increased Irritability, anger or hostility
Loss of interest or pleasure	
Significant weight loss or reduction in appetite	More than 5% of body weight or failure to make expected weight gain Frequent vague, non-specific physical complaints
Insomnia or hypersomnia	
Psychomotor agitation or retardation	
Fatigue or lack of energy	Frequent absences from school or poor School performance
Feelings of worthlessness or guilt	
Decreased concentration	Being bored
Recurrent thoughts of suicide or death	Reckless behaviour, alcohol or substance misuse
*Diagnosis requires five or more symptoms, including either depressed mood or decreased interest/pleasure in activities during the past two weeks.	

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Risk and protective factors

There are a number of psychosocial risk factors associated with depression (see Table 15.3) as well as resilience factors (see Table 15.4) which can protect against the development of depression in children and adolescents. Parental depression is associated with higher rates of depression in offspring, hence the treatment of parental depression should be considered. Studies have demonstrated that remission of maternal depression is associated with significant improvement in the child's depression (Brent *et al*, 2016).

Table 15.3: Examples of psychosocial risk factors for depression

- Being female
- Parental depression
- Past history of depression
- Life events
- Family discord
- Authoritarian parenting
- Adversity and trauma
- Drug and alcohol misuse
- Smoking
- Medical problems
- Poor sleep
- Bullying
- Deprivation
- LGBT youth
- Academic demands
- Symptoms of borderline personality disorder
- Refugee status
- Homelessness
- Living in institutional settings
- Deprivation

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Table 15.4: Mental health resilience in adolescent offspring of parents with depression

- Main parent positive expressed emotion
- Co-parent support
- Good-quality social relationships
- Self-efficacy
- Frequent exercise

(Collishaw, 2015)

Treatment and management

Depression in children and young people is an important public health problem and associated with increased suicidality (Avenevoli *et al*, 2015), therefore early intervention is paramount in order to reduce risks and ensure the best possible outcomes. Findings from a British longitudinal study have highlighted the importance of early referral to child and adolescent mental health services (CAMHS). In this study, adolescents at age 14 with depression who have had no contact with CAMHS were seven times more likely to report depressive symptoms by age 17, when compared to those who had contact (Neufield *et al*, 2017).

There are a number of available evidence-based treatments for depression. For mild depression NICE recommends 'watchful waiting' for a period of up to two weeks as a first line approach. If there is little or no improvement in symptoms, digital CBT, group CBT, non-directive supportive therapy, group interpersonal psychotherapy, attachment-based family therapy and individual CBT should be offered. The evidence base for psychological intervention in 5–11-year-olds with moderate to severe depression is very limited, however for this age group family-based interpersonal psychotherapy, family therapy (family-focused treatment for childhood depression and systematic integrative family therapy), and psychodynamic psychotherapy, individual CBT are recommended. For young people aged 12–18, the evidence base suggests that there is little indication one type of psychological therapy is more effective than other types. For the treatment of moderate to severe depression NICE recommends interpersonal therapy for adolescents, family therapy (attachment-based or systemic), brief psychosocial intervention, psychodynamic psychotherapy (NICE, 2019). For further review of evidence-based treatments see (Hussain *et al*, 2018).

The use of medication for this age group remains controversial, nevertheless medication remains an important therapeutic option for moderate to severe depression (Brent *et al*, 2018). NICE currently recommends the antidepressant fluoxetine in combination with a psychological intervention. It is important that both the risks and benefits are discussed in a collaborative way between the child, family and the mental health professional (Dubicka & Wilkinson, 2018), and consideration is given to what outcomes matter most for the child or young person (www.minded.org.uk; *What Really Matters in Children and Young People's Mental Health*, Royal College of Psychiatrists, 2016). Clear information in relation to common side effects such as tiredness, headache or nausea and less common side effects, such as potential interactions with other medications, should be discussed in a transparent manner. In particular, the short term reported increased suicidal thoughts and behaviours should be stated. Clinicians should contextualise this information by explaining the

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risk factors and complications associated with untreated depression, including suicidal behaviour. The decision to prescribe medication will depend on the severity of the depression, whilst the risks and benefits should be assessed on an individual basis. It is essential the monitoring of any adverse reactions and general progress takes place on a regular basis. For the majority of children and adolescents, depression is often best treated in the community, and hospital admission is unwarranted and, in some circumstances, counterproductive, for example if the young person is self-harming (Royal College of Psychiatrists, 2019, in press). Nevertheless, there are circumstances when admission should be considered, for example when it is not possible to safely manage the level of risk, and if the severity of symptoms is increasing and not responding to treatment. In severe cases where the young person makes choices that are against their best interests or safety, compulsory admission under the appropriate legal framework may be necessary.

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Amelia

Amelia, aged 12, has been treated with medication for ADHD since she was 7 years old. Her behaviour has always been challenging in the school and home environment and she has been permanently excluded from school on a number of occasions. With support from a variety of agencies and CAMHS, Amelia remains in mainstream provision. Over the past six months her behaviour has become increasingly more challenging and defiant. School has made a referral to a specialist provision for children with challenging behaviour. During a recent medication review at CAMHS, Amelia's parents reported that Amelia is increasingly irritable and has been complaining of headaches and tummy aches on a daily basis. Additionally, she regularly refuses to go to school, stating that school is 'boring, teachers are always giving me hassle and getting on my nerves, even my friends are giving me hassle'. Parents are wondering if these are side effects of the medication and if it would be possible to prescribe an alternative. Amelia's mother has recently noticed some weight loss and does not top up Amelia's lunchtime account as often as before since Amelia does not appear to be eating at lunchtimes, eating very little in the evenings too. Both parents have observed decreased enjoyment in activities that she previously enjoyed. Amelia has also been spending long periods of time in her bedroom alone and is reluctant to socialise with friends.

Comment: This is an example of depression in the context of comorbidity, behaviour problems, physical symptoms and school refusal. Depression can often be missed in these situations and requires careful history taking.

Introduction

Many children and young people will experience an episode of self-harm. This chapter will support professionals to explore and understand their reactions towards young people who express thoughts of self-harm or present in crisis after an episode of self-harm. We will explain ways of assessing and managing risk and models of long-term therapy. Perhaps most importantly, we will look to equip the reader with some of the core tools and techniques that can help put someone at ease and enable to get them the right support.

(NOTE: It is important to emphasise the parameters by which we are categorising self-harm in this chapter. Whilst some broader definitions may include certain eating behaviours and harmful drug and alcohol use, we are focusing on intentional acts of self-injury or self-poisoning as defined by the NICE guidelines.)

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Why we need to talk about self-harm

Many children and young people will experience an episode of self-harm. In 2018, comprehensive new NHS data was published about the mental health of children and young people in England (NHS Digital, 2018). The report was the first of its kind in over a decade, looking at the extent young people are in contact with various health, social and education services. While other mental health conditions have actually remained fairly stable, over the last decade there has been a distinct increase in the prevalence of emotional disorders and behaviours, such as self-harm.

Self-harming is not in itself a mental health diagnosis, rather a set of behaviours that may indicate someone is trying to manage difficult thoughts or feelings, to feel something or perhaps looking to gain a sense of control (Royal College of Psychiatrists, 2019). Actions might be a one-off or could persist for years, often away from the gaze of friends, partners and families (despite the inaccurate 'attention seeking' label).

Whilst the reasons behind self-harm are specific to each individual, there are regular themes that we see highlighted in our work: school life and academic pressures, changing hormones, low self-esteem, relationship issues, and worries about body image are triggers regularly cited by young people (Addaction, 2018). The overarching role of social media can exacerbate these elements, with today's adolescents getting little respite from lives which are increasingly lived online.

Self-harm is something to be taken seriously. Dismissing someone cutting or burning themselves as being attention-seeking minimises the clear risks that may motivate individuals to take such actions. It is worth remembering that of the roughly 6000 people who take their own lives each year in the UK, at least half will have a history of self-harm (NHS Digital, 2018), with around 25% having been treated in hospital for self-harm the previous year (NICE, 2019). Once a person has been hospitalised for self-harm, the likelihood that they will take their own life increases by 50-100 times (NICE, 2019).

Since 2011, the number of young people seeking medical attention for self-harm has risen in some groups by 68%. In spite of this, many young people who self-harm do not meet the threshold for specialist mental health services. A recent survey of 1000 GPs based across the UK revealed that 90% of respondents said mental health services for children and young people are inadequate, with 68% of GPs seeing more young patients self-harming within the preceding two years (Stem4, 2018).

We also know that those accessing medical attention are just the tip of the iceberg (Hawton *et al*, 2018) with many others hiding their behaviours due to embarrassment, fear and stigma (Addaction, 2018). It is clear that existing mental health services are overstretched; to properly address this, increased funding is essential, as is investment in prevention and early intervention. In addition to this, there is a vital role to be played by professionals sitting outside of traditional clinical settings (Bradley, 2018).

Increasing demands require staff in schools, youth services and other settings to be well-informed and there are some simple ways that vital help can be offered.

What to do and say (and what not to)

The second part of this heading is actually very important. People generally have the best of intentions around this topic but some interactions actually create more problems than they solve.

In schools, creating an environment where students will feel comfortable to talk with staff members is essential. Young people may not explicitly ask for help but providing a safe space in which they can talk to a trusted person is an important foundation. When these conditions are in place, people are more likely to share their worries and ask for support.

Focus groups from the 'Mind and Body' programme have highlighted that having the right people in the right roles is especially important. Students are frequently

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directed to speak with a designated member of staff (commonly a member of the leadership team) but that person may not be seen as approachable or someone they feel comfortable with. Allowing a range of support options is ideal to give young people more encouragement to get help.

Kelly

Kelly is a 15-year-old girl who has been struggling with her school work in recent weeks. She has specific learning needs in relation to reading and spelling. She has been noted to be more withdrawn as the pressure of her exams increases. Kelly has been wearing long sleeves as the weather gets warmer.

Many professionals do have concerns that if self-harm is spoken about, other young people will have ideas about copying such behaviours. There is little evidence that this is actually the case (Knightsmith, 2015). Whilst it is important to ensure no in-depth information on self-harm is circulated which may be triggering for people, it is vital that discussions about mental health are normalised, so that there are appropriate outlets for young people to seek support.

How self-harm disclosures are received by professionals can be pivotal, potentially influencing how that person will feel about getting support both at that time and in the future. It is important that we respond well and appropriately each time. This is not said to put extra pressure on such situations as there really are some simple ways to set people at ease. It is difficult to condense all the relevant skills and techniques but our top tips are as follows:

1. *Thank them.* This may be the first time they have talked about self-harm or their mental health with anyone before. Even if not, this is something very personal and it benefits the therapeutic relationship if this is recognised.
2. *Acknowledge their distress and that it may have been hard to talk*. Let them know that you have heard what they told you, that you have really listened to them. Avoid responses like 'don't worry' or 'everything will be fine' – those are not things we can control – but reassure them that you will help how you can. For example, in the case study above, Kelly may be concerned that she will be blamed or judged, she may believe that she will be put in hospital.
3. *Remain calm, don't be shocked and don't judge*. Sharing how they feel can be a relief for some but others might feel embarrassed or ashamed. Don't look shocked or say things like 'why do you do it?' – that's likely to make people question whether they should have said anything at all. Similarly, don't downplay what they are feeling or pretend to understand what they're going through if you do not. Listen and give them time and space to talk.

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4. *Don't tell them simply to stop*. Of course we want to keep the person safe but again, this advice is unlikely to be helpful. If someone is self-harming, there will be a reason (even if they do not understand it fully themselves). Addressing feelings of low self-worth or emotional pain can be a long process, so indicating it's an easy choice shows a lack of empathy.

   NOTE: Some people also hurt themselves as a way of managing thoughts around suicide. Whilst self-harm is not a positive coping strategy, it is important to be mindful that it might keep some people in a slightly safer mind space in the short-term. Any concerns around this should be directed to a mental health specialist.

5. *Be collaborative – how do we put support in place?* Try and give the young person as much ownership over next steps whenever possible. Sharing information can be a big thing and it is common for people to worry about losing control about what happens now. Work in partnership to explore this. Set up care plans and/or safety plans together. Give them a say in who is included in this and who is notified about it, as much as you can. Look at how you can break the triggers for their self-harm together. *For example, it would be important to explain to Kelly that there is help available and that there are alternative strategies that she can be supported to learn*.

   NOTE: Safeguarding processes can dictate that information be shared against the young person's wishes whenever obvious risks are identified. Clearly setting out confidentiality and information sharing processes is essential when you start working with young people. Regular reminders ensure young people are clear on the boundaries of your work and help the escalation of disclosures feel less like their trust is being breached. We would also argue that, even if they protest, most young people know certain information will need to be shared. When they say something, it is usually for a reason, that reason being that they do want and need help.

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Assessing and managing risk

One of the most important elements to remember when you receive a disclosure about self-harm is the need to assess and manage risk. In many situations, the person who receives an initial disclosure that someone has self-harmed may be a friend, a parent or a teacher and they may not feel equipped to deal with the situation. In a hospital setting, non mental-health trained medical and nursing staff can also feel ill-equipped or trained to assess or support someone who has harmed themselves. NICE recommends that all children and young people who have harmed themselves have an initial assessment which aims to help identify any immediate physical risk so that steps can be taken to reduce this risk. On a practical level this can be as simple as trying to find out if the person needs

medical attention as a result of hurting themselves and if they have anything with them which they might be tempted to use to hurt themselves. If so, would they be willing to give this to someone else to reduce the chance of them using it – consider whether the person should see a school nurse, a practice nurse, a GP or go to a walk-in centre or whether they might need to go to A&E. As described previously in this chapter, if someone chooses to share information that they have harmed themselves, the reaction of the person being told can be central to how the person might feel about getting support so it's important that we respond well.

Treating someone with compassion, respect and dignity and supporting them to make a decision about what should happen next should not require specialist training. NICE recommends a comprehensive psychosocial assessment takes place with the aim of identifying factors which may have contributed to the person hurting themselves. This can include information about their home or family circumstances and their current psychological state, whilst seeking to identify any immediate triggers for their actions or reasons why they may be feeling low. If this is something you feel unable to do yourself, consider the other support options available for both you and the young person. Could the young person see their GP or practice nurse for advice or could you or someone else do this on their behalf? Some schools or colleges have counsellors, nurses or designated members of staff available to offer advice and support an assessment. Additionally, in some areas voluntary sector organisations can offer one-to-one or group sessions aimed at providing practical and emotional support. The 2017 green paper (DoH & DforE, 2017) identifies that evidence-based treatment for mild to moderate mental health needs demonstrate outcomes comparable with specialist services when delivered by trained non-clinical staff with access to appropriate supervision. Addaction's 'Mind and Body' programme (Joiner *et al*, 2017) provides one such example.

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If you are a professional working with children and young people, find out – before you need to know – who in your organisation is available to offer support and advice. (Clinical supervision can be hugely important in ensuring appropriate steps are taken for the young person in question, helping to protect both them and the practitioner(s) involved.)

In terms of more formal assessment and management of risks there are a range of scales and tools used across mental health services, urgent care and emergency departments which try to assess and determine risk. However, there is no single standardised clinical tool used in practice and where they are used, evidence indicates their accuracy is limited and they should not be used in isolation to determine what treatment and support is offered (Carter *et al*, 2018;

Quinlivan *et al*, 2017; Steeg *et al*, 2018.) Working collaboratively with the young person enables a mutually agreed risk management plan to be formulated; this could include employing practical measures to reduce the risks to which they're exposed. It is worth emphasising that reducing someone's access to the means they may choose to harm themselves is a key factor in keeping someone safe from further self-harm or suicide (Hawton *et al*, 2012). Consider whether aspects of their home or family circumstances need to be addressed. Might they benefit from involvement from specialist mental health services? Any plan aimed at reducing risks to the young person should be agreed with them, shared with them (plus other relevant individuals involved in their care) and should include what they can do if they are thinking about hurting themselves as well as who they can contact in a crisis. We know that the number of young people seeking medical attention after self-harm has increased (Stem4, 2018) and it is estimated that around 10% of those who harm themselves will do so again (Hawton *et al*, 2012).

Self-harm can be a strong predictor of subsequent suicide; of the estimated 6000 people who take their own lives in the UK each year, at least half have a history of self-harm (Hawton *et al*, 2012; NHS Digital, 2018) so it is important that those in contact with children and young people work together to provide appropriate support. In terms of the case study, you would need to ensure that Kelly is not depressed and has no plans of suicide.

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When specialist support is required

It is well established that the key to any successful therapeutic intervention is the relationship between the person and their therapist – being able to relate to someone, to show empathy and warmth are important factors (Lambert & Barley, 2001.) Even those not specifically trained in mental health assessment, care and treatment can still play a pivotal role in supporting people who self-harm. Important factors to consider when deciding an appropriate route to support someone is to think about how often someone has harmed themselves, how serious it was, how distressed they are and whether they think they will do so again. For those working with and supporting children and young people who self-harm, trying to understand the factors that contribute to someone wanting to self-harm can be the key to knowing what services might be the most appropriate to offer support (Hawton *et al*, 2012). If children and young people are experiencing difficulties in their home or family circumstances or difficulties in school it can be helpful for them to have a positive relationship with someone they know and trust and can open up to and talk about things.

Any intervention or therapy should be tailored to the assessed and identified needs of the young person and should include consideration of what the person themselves wants to achieve and what they want to engage with. Psychological therapies or interventions won't be successful if the person isn't ready or in a position to engage with them. Some therapies available in more formal settings and services include family therapy, mentalisation-based therapy, cognitive behavioural therapy, psychodynamic therapy and problem-solving support (NICE). These therapies are not available everywhere and when they are, can have long waiting lists. They may also not be suitable for some individuals.

For some young people, self-harm might be linked to the way they have learned to deal with distress; for others it could be related to their neurodevelopment. For some people it might be linked to an underlying mental illness. For those children and young people requiring more specialist assessment and intervention a referral to Child and Adolescent Mental Health Services (CAMHS) might be required.

CAMHS teams are usually multidisciplinary teams made up of nurses, psychiatrists, social workers, occupational therapists, psychologists and support staff. They are usually NHS run services that work with children and young people who are experiencing difficulties with their emotional or behavioural wellbeing. They can carry out specialist assessments, make diagnoses and provide a range of therapies and treatments for children and young people. They will often see children and young people one-to-one but also involves families in some of the work they do.

Where a young person is experiencing a specific mental illness such as depression, anxiety or psychosis and has used self-harm as a way of coping with difficult thoughts and feelings associated with an illness, psychological therapies might be helpful. If someone is so unwell that talking about things is too difficult for them – for example, someone experiencing serious depression or episode of psychosis – it may be that talking therapy is not suitable until such time as the person is in a position to be able to engage with it. It could be that following an assessment by a psychiatrist, medication might be prescribed to treat the underlying illness and this in turn might alleviate or reduce distressing symptoms, enabling a young person to reduce or stop self-harming. Not all children and young people who self-harm will be prescribed medication and any decision to prescribe medication to children or young people should be made by a specialist clinician. There may also be some physical health checks required and once prescribed, the medication should be reviewed by the psychiatrist in conjunction with the young person (Royal College of Psychiatrists, 2019).

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Conclusion

Many children and young people will experience an episode of self-harm so it is important that discussions about mental health are normalized; children and young people should have the opportunity to talk about their fears and worries and be able to ask for help if they need it. We might not be able to prevent all young people from hurting themselves but the more accessible we can make support at an early stage, the less likely help will be needed later on.
Anyone working with children and young people can help to build positive relationships; mutual respect and trust provides an excellent foundation from which important conversations can take place. Within this, there is a vital role to be played by professionals sitting outside of traditional clinical settings (Bradley, 2018). It is not helpful to simply tell or encourage children and young people to stop harming themselves. Young people need to feel listened to and to be involved in decisions about what care or support they can be offered. If those supporting young people have training and support to facilitate this, and can recognise and manage their own emotional response to self-harm, they will be in a better position to safely help.

Helpful links

Twitter can be a great way of keeping up-to-date with relevant research, news and resources. Here are some of our favourite accounts which are well worth a follow:

@PookyH	@Andy_Bell_	@CYPMentalHealth
@IanA_Mac	@mirandarwolpert	@EBPUnit
@SelfHarmNotts	@sjblakemore	@CORCcentral
@MentalElf	@sisupportorguk	@SchoolMHealth
@DrAPitman	@_MindandBody	@CharlieWtrust
@AlysColeKing	@AFNCCF	@selfharmUK

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Suicide prevention is a priority

Suicide is a public health concern and globally is the second leading cause of death in 15-25-year olds (WHO, 2018). There are variations in rates due to different monitoring systems and in the UK suicide is the leading cause of death in 10-19-year-olds. It is suspected the actual rates are higher and the under reporting is due to legal, cultural, society and surveillance factors. NHS Digital (2018) found that 52% of 17-19-year-olds in a national UK prevalence study who had mental health needs reported having attempted suicide or self-harmed. In the same study, it was identified that 25.5% of 11-16-year-olds with mental needs had self-harmed or attempted suicide. There are differences between developed and developing countries and this supports the need for locally driven action plans supported by national government initiatives.

Any prevention strategy requires accurate data, and needs to identify specific clusters to target. In the UK, between 2003 and 2013, an average of 428 people aged under 25 died by suicide in England per year; of those 137 were aged under 20, and 60 were aged under 18 (PHE, 2016). The National Suicide Prevention Strategy was refreshed in 2016/2017. The renewed plan emphasises the need to effectively target people at increased risk of suicide, for example people in contact with the criminal justice system. Public Health England has identified 95% of local authorities are either working towards developing a suicide prevention plan or have one in place.

Previous acts of self-harm and the disclosure of suicidal thoughts are early indicators for community, families and professionals to respond to. According to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Suicide by Children and Young People in England, over half of the young people who die by suicide have a history of self-harm (Manchester University, 2016; 2017). However, a Lancet UK based cohort study by Geulayov *et al* (2018) reported that a majority of those who self-harm do not die by suicide.

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In 12-14 year-olds (Geulayov *et al*, 2018):

- For every boy who died by suicide, 109 attended hospital following self-harm and 3067 reported self-harm in the community.
- For every girl who died by suicide, 1255 attended hospital for self-harm and 21,995 reported self-harm in the community.

In 15-17 year-olds (Geulayov *et al*, 2018):

- For every boy who died by suicide, 120 boys presented to hospital with self-harm and 838 self-harmed in the community.

- For every girl who died by suicide, 919 girls presented to hospital for self-harm and 6406 self-harmed in the community.

Suicide is more common in males though females are more likely to present to services. The most common methods of suicide in 15-17 year-olds is death by hanging or asphyxiation (Geulayov *et al*, 2018; Kutcher, 2018).

Vulnerable groups are at higher risk and these include:

- looked after children
- lesbian, gay, bisexual and transgender (LGBT) young people
- CYP experiencing mental illness or with additional mental health needs
- CYP whose parents have attempted or completed suicide
- CYP who are using drugs and alcohol
- those experiencing childhood trauma or abuse
- isolated individuals with economic hardships and limited social support (NCISH, 2017; Samaritans, 2017).

Of those CYP who died by suicide in England, on average 28% were bereaved, 22% bullied and 15% abused or neglected with a quarter having used the internet in a relevant way and a quarter facing academic pressures. Of concern is that approximately 73% did not express recent suicidal ideation (NCISH, 2017). Finally, there is increasing recognition (HM Government, 2019) of the need for CYP to be kept safe online. The Government response to the Internet Safety Strategy (HM Government, 2018) notes the need for mechanisms to report concerning content relating to suicide as well as online sources of support for CYP who are experiencing thoughts of suicide.

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Suicide prevention strategies

Suicide is a preventable cause of death and is the result of biological, genetic, psychological and social interactions with far reaching effects on bereaved family, friends and the community at large. The *Comprehensive Mental Health Action Plan* delivered by World Health Organization member states have set a global target to reduce the suicide rates in countries by 2020. The suicide rate is one of the agreed United Nations Sustainable Development goals for 2030 (WHO, 2018). The international concern and call for action have been recognised nationally in the UK.

Within the UK, key national bodies have worked to commission documents to support locally-delivered initiatives with the aim of reducing the suicide rate in the general population and providing better support for those bereaved by suicide. There are policy documents, guidance and directives from the National Institute of Health and Care Excellence (NICE, 2004; 2011; 2018), the Royal College of Psychiatrists (2010) and Public Health England (2016). Further to this, the *Zero Suicide Policy* (NHS England, 2016) and the appointment of a Minister for Suicide Prevention in England adds weight to the national agenda of prevention and reduction of suicide rates (Fearnley, 2016). The Suicide Prevention National Transformation Programme has arisen from a national commitment to reduce deaths by suicide by 10%, by 2020/21 (Royal College of Psychiatrists, 2019). NHS England commissioned the National Collaborating Centre for Mental Health to work in partnership with *National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)* with eight Sustainability and Transformation Partnerships to improve quality and safety, and support local plans to reduce suicide.

There are six areas for action identified by Public Health England:

1. Reduce the risk of suicide groups deemed to be at higher risk.
2. Improve mental health in specific groups.
3. Reduce access to the means of suicide.
4. Provide better information and support for those bereaved by suicide.
5. Support media sensitivity with regards to suicide and suicidal behaviour.
6. Support research data collection and monitoring.

A multidimensional local approach that identifies and responds to suicide clusters, preventing suicide in public places and supporting people bereaved by suicide, reaching out to marginalised isolated members of society who are deemed to be at greater risk is called for. The focus is to address the pain of those who feel that suicide is the only option.

Addressing the health inequalities of CYP is a key strand of suicide prevention. This highlights the need for collaborative multi-agency working; involvement of the local authority in suicide prevention through support with housing, responding to childhood abuse and addressing employment needs. Multidimensional working with health, the local authority, education, the youth and adult justice system, the voluntary sector and the wider community enables holistic care. This can then start to address the complexity of cumulative risk and move towards preventing death by suicide.

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The development of robust multidimensional networks will enhance the wellbeing and resilience of all CYP. However, it is also important to address the vulnerabilities and risks of individual CYP. These will include working to meet the physical and/or mental health needs (including suicidal ideation and self-harm behaviours) of CYP. Supporting challenged family systems especially where there is parental mental illness and suicidal behaviours and addressing exposure to abuse and neglect.

Negative peer interactions as a result of bullying, suicide-related internet use, social isolation and withdrawal, exam pressures and academic decline are risk factors associated with suicide in children and young people. Early identification of patterns of cumulative risk is necessary and cannot be stressed enough. Exposure to early life adversities, such as neglect or abuse, increases the vulnerability of CYP. A further recent stress, such as school pressures or impact of a physical health condition, can act as a final straw. Public health campaigns and school-based awareness programmes, interagency working and close follow up of high-risk groups is required to reach out and connect to children and young people in preventing suicide.

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Table 22.1: Terms used to describe thoughts and acts of harming oneself

Suicidality, is a broad term referring to both thoughts and acts of inflicting harm to one self or ending one's life.
Thoughts of self-harm relates to having urges, contemplating or thinking about hurting oneself and is non-suicidal.
Self-harm are acts of hurting oneself with a purpose of either numbing emotional pain, regulating one's emotions or to feel physical pain without fatal intent.
Suicidal ideations are thoughts, preoccupations or feelings of wanting to end one's life. These thoughts are broader and general, often closely related to expressions of hopelessness.
Suicidal planning is the specific thoughts about an attempt to end one's life which may include details regarding method(s), access, final wishes to say goodbye, organising one's affairs and avoid being disturbed or found.
Suicidal act is a purposeful attempt to end one's life with fatal intent.

13% of LGBT people aged 18-24 took drugs at least once a month	
19% of LGBT people aren't out to any healthcare professional when seeking care	40% of bi men and 29% of bi women aren't out to any healthcare professional when seeking care
14% of LGBT people have avoided treatment for fear of discrimination on the grounds of their sexual or gender identity	

Higher rates of mental health needs can also be seen in the recent NHS Digital (2018) survey of the mental health needs of CYP. While the number of lesbian, gay and bisexual CYP who participated was small, it is important to note that 1 in 3 CYP in this cohort experienced a mental health condition as opposed to 1 of 8 CYP who identified as heterosexual.

Building a shared language

Words can be a source of pride or a hate crime. The key to respectfully describing and understanding people is to understand the terms that they may use to describe themselves:

- **LGBT** – Lesbian, Gay, Bisexual and Transgender, a collective description for gender and sexual diversity.
- **Lesbian** – person who identifies as female and is attracted to people with female gender identities.
- **Gay** – person who identifies as male and is attracted to people with male gender identities.
- **Bi** – person who is attracted to people with male and also female gender identities.
- **Homosexual** – person who is attracted to people of the same gender identity as themselves.
- **Heterosexual** – person who is attracted to people of the opposite gender identity to themselves.
- **Pansexual** – person who is attracted to people on the full spectrum of gender identities.

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- **Transgender (abbreviated to trans)** – person whose gender identity is not the same as their sex assigned at birth.
- **Gender fluid** – person who does not perceive their gender in binary terms. Often uses they/their pronouns.
- **Gender queer** – person whose gender identity does not lie within the parameters of masculine and feminine.
- **Non-binary** – person who does not perceive their gender in binary terms – often uses they/their pronouns.
- **Binary** – person who perceives their gender as female or male – uses she/her or he/him pronouns.
- **Cisgender** – person whose gender identity corresponds with their gender identified at birth.
- **Intersectionality** – theoretical model for understanding how gender identity intersects and interacts with other social factors such as race and ethnicity.

Think about the pronouns that you use: one way to convey an understanding of this important concept is to introduce yourself and include the pronouns that you use 'Hello, my name is Louise and I use she/her pronouns'.

How do LGBT people experience prejudice?

Whilst overall attitudes are changing and there is more representation of LGBT people in public life and on TV, CYP learn about and experience prejudice from a very early age, often before they have developed an awareness of their sexual and gender identity. Prejudice is transmitted both directly through what is said, indirectly through assumptions and stereotypes and, importantly, through what is not said or seen.

CYP may hear direct prejudice such as 'bi people want the best of both worlds, trans women are not real women, gay people and trans people are sexual predators' – they hear this at home, at school in the playground or alarmingly in the classroom, in the community and in the media. Indirect prejudice is less overt. It is concealed in the fabric of society expressions such as 'that is so gay' or assuming that a person is either straight or gay. As gay authors well beyond our teenage years, people still assume we have heterosexual partners. After decades of being 'officially out', with friends and family knowing, we still have to 'come out' regularly.

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The media – news outlets, social media and entertainment platforms continue to demonstrate homophobia, biphobia and transphobia. This is combined with the relative invisibility of LGBT people in education except perhaps the odd mention in Relationships and Sex Education. Lesbians, bi and trans people experience amplified invisibility, as do those whose identity intersects with other liberation groups such as those who are black, Muslim and/or disabled. There is evidence that LGBT CYP experience emotional and physical bullying in the playground (Stonewall, 2017), in their communities and, sometimes, in their families.

This provides the backdrop against which LGBT CYP talk to you. It is not enough therefore to assume they know you believe them, that you value them and their identity, we have to be proactive. We have to reach out and tell them that we reject prejudice and hate and that we will do all we can to support them. Below are some pointers on ways you can do that well, and how to avoid inadvertently reinforcing the prejudice they have experienced.

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Top tips for excellent conversations

Do

1. *DO work hard at being an ally* – remember that LGBT CYP are constantly disclosing their identities which can be lonely and tiring. Do everything you can to ensure LGBT people know they can trust you – a rainbow pin badge, a Stonewall poster in your office – anything that helps young people feel safe. Your role as an advocate is invaluable. Model the values of acceptance and understanding through what you say and how you say it: be sure to use the correct use of language and a positive tone with parents, carers, other professionals and peers.
2. *DO accept you are human, will have prejudices and then reflect on them* – we are as intersectional and diverse as the children and young people we work with. If you are struggling to accept or understand an LGBT identity think about why that might be. If possible, make use of safe and confidential supervision. If you don't have supervision, ask yourself how else you can get the support and opportunity to face into your biases.
3. *DO educate yourself/get trained (see the end of the chapter for websites and organisations)* – of course it is okay to ask questions, but children and young people will be grateful if you understand their identity and share your understanding with the team around them. If you can do your own research this can be very valuable.
4. *DO think about individuals not categories: throw unhelpful categories out of the window* — gender and sexuality are only one aspect of a person's intersecting

identity, listen to each child and young people and understand their experience and reality.

5. *DO make asking about and using the right pronouns an everyday thing* – we are so conditioned to see the world in him and hers, and it is embedded most strongly in our pronouns. We can make the world a better place for everybody by simply asking what pronouns they use. You will probably have to explain what pronouns are to some people and that is ok. To a young person who wants to define their own pronouns being asked will be music to their ears. It is okay to acknowledge that you might make mistakes if you have been working with a child or young person for a long time, but apologise when you make mistakes and keep trying.
6. *DO cheerlead children and young people and make sure you validate their feelings and experiences even and perhaps especially when you don't fully understand them* – we all celebrate our identity and what makes us unique, channel your knowledge of yourself and celebrate the identities of others.
7. *DO identify role models* – do your research and make a note of positive LGBT role models. Think about the individual young person and look for examples that would resonate for them, perhaps local figures, or people in sport, the media or politics. Many high profile LGBT role models have talked about the prejudice they have experienced, or some of their struggles – find ways to connect to their whole story, not just the glittery bit.
8. *DO find LGBT friendly and positive experiences for CYP* e.g. film festivals, local youth groups, novels and graphic novels.

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Don't…

1. *DON'T assume the gender or sexual identity of any CYP* – expression is a complex process for everyone, reflect on assumptions that you may have about the ways that LGBT people present and then keep an open mind and develop good practice that you use with all CYP.
2. *DON'T make cis and heteronormative assumptions which cause CYP to feel 'othered'* – asking about relationships is a sensitive process and must be undertaken thoughtfully but without awkwardness. Think about your language and remember that may be creating a much-needed safe space.
3. *DON'T describe their identity as a phase* – yes, gender and sexual identities can develop and change, but to imply that an LGBT identity is transient is an invalidating and potentially alienating attitude. Make it clear that you respect the identity that has been disclosed and remember how hard this may have been for the CYP.