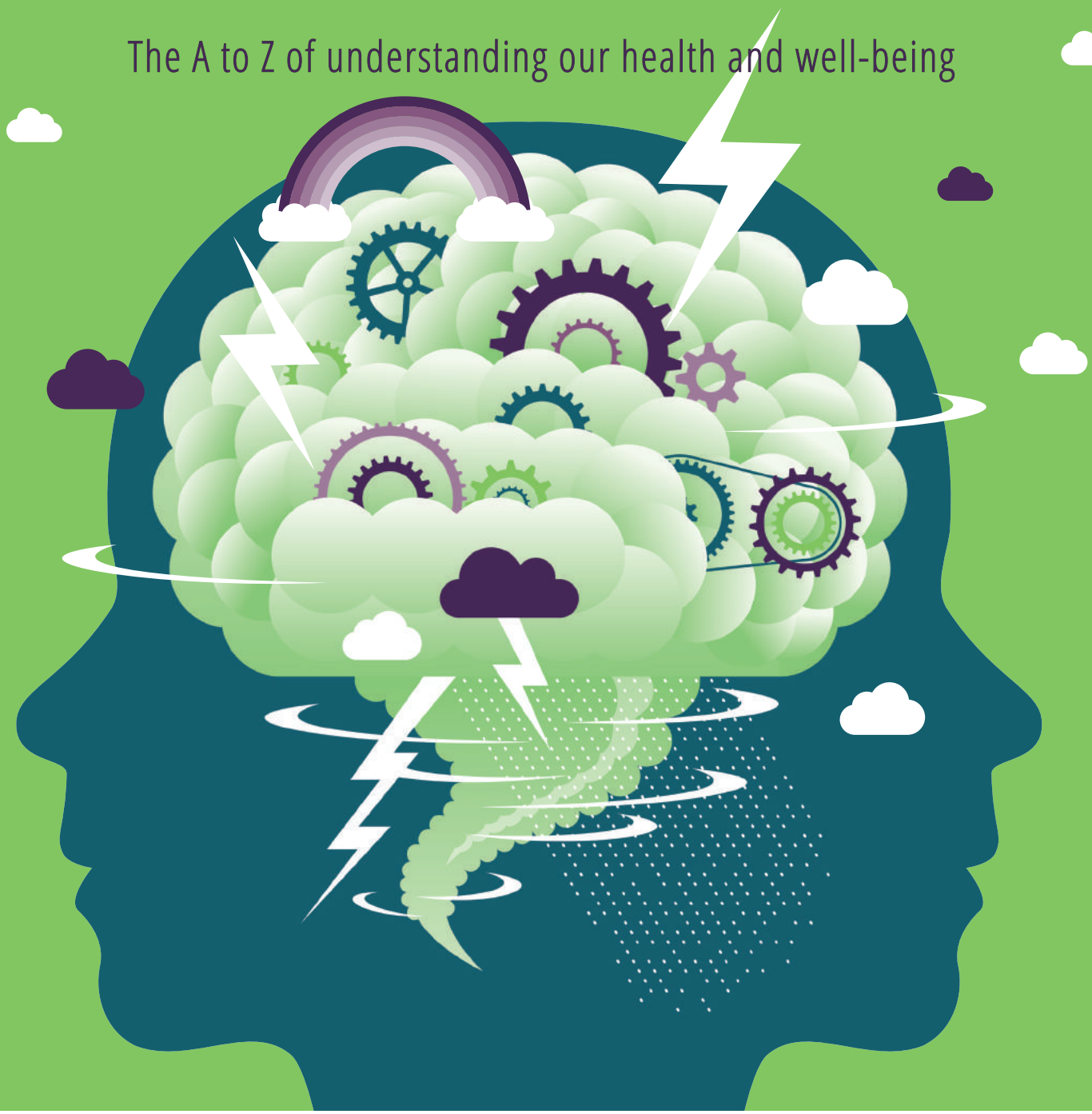
2020

MENTAL HEALTH 101

The A to Z of understanding our health and well-being



// Young people have never had so many communication tools, yet communicating with them is as tricky as ever. For parents and carers, the cyber age provides enormous opportunities but also brings many challenges.

"Technology is changing how we all communicate and forcing institutions to be more transparent, inclusive, dynamic and personalised. Trust has shifted from institutions back to individuals, reversing the historical trend with profound implications for society.

"At the same time, trust and influence grow among family, friends, classmates, colleagues and even strangers. No longer is the 'top down' influence of elites, authorities and institutions a given. That is why Parent Guides are so important in creating trust, credibility and confidence in families and has spent the past four years building capacity and collaborators.

"We want to encourage open and honest conversations between parents, carers and young people on topics such as drugs, sex, mental health, social media, respect, gambling and gaming. Our guides aim to empower adults with information and strategies to help guide these important discussions.

"With *Mental Health 101*, we discovered that suicide, anxiety, depression, ADHD, self-harm, eating disorders and other mental illnesses are all taking a terrible toll on our young people. It's time we listened."

"It has been great to work collaboratively with Parent Guides to develop these resources ... and it is great to be able to give our families concrete relevant information to walk out with after a parent information evening."

Kate Major // Director of Wellbeing, Firbank Grammar School

"These resources offer a comprehensive, but effective way to update parents on current issues ... They are visually impressive and complement other information provided to parents ... regarding student wellbeing."

Annabel Coburn // Head of Counselling, Trinity Grammar School

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// THANK YOU

Thank you to our educators and "Champions of Change" for their guidance and advice: Jo Field, Kate Major, Jenny Vincent-Green, Firbank; Annabel Coburn, Trinity Grammar School (Kew); Kirby Mackrill and Jocelyn Hill, Northcote High School; Susan Wilken, McKinnon Secondary College. Our go-to experts: Kirsten Cleland, headspace; *beyondblue*; Dr Janet Hall; Dr Helen McGrath; Australian Government Department of Health, Orygen – The National Centre of Excellence in Youth Mental Health, Mission Australia, PFLAG Australia, the Royal Flying Doctor Service of Australia, the UK Royal Society for Public Health, The Resilience Project. And our interviewees for sharing and being so open: Professor Sue Spence, Keiah Smith, Frank Zoumboulis, Kids Helpline, Professor Patrick McGorry, Maggie Dent, Russell Farmer, Professor Sarah Blunden, Hannah, Ashleigh, Adrian, Sarah and Mindhealthconnect. Our advisory committee // Dr Peter Briggs (GP), Kirsten Cleland (social worker, headspace), Shane Jacobson (partner, PKF Melbourne), Helen Kapalos (chair commissioner, Victorian Multicultural Commission), Stephanie Kelly (parent), Julie Podbury (president — Victorian Branch, Australian Principals Federation) and Julian Riekert (partner, Lander & Rogers).

Photo: iStock

CONTENTS

// STRESSORS FOR YOUNG PEOPLE

- Adolescence in general
- Increase in expectations (perceived or otherwise from parents, school or themselves)
- Bullying – cyber and in person
- Interpersonal relationships (family and friends)
- Peer pressure
- Questioning sexuality or gender
- Education
- Global warming
- Finances

Kirsten Cleland, headspace (Elsternwick and Bentleigh)

PREVALENCE

Never have parents been so worried about their children's mental health.

Young people face unprecedented pressure to do well at school, shine on social media and find meaningful employment in an ever-changing job market. On top of that, many will need to pay for their tertiary education.

The mental health of some young people has suffered as a result, with worrying rates of some conditions and suicide. Young LGBTQI+ and Aboriginal Australians face even higher rates of many illnesses and suicide than their peers. But families are more likely to access a growing number of health services and schools are much more likely to offer support.

Support services and programs are backed by a solid body of research, such as the Australian government's 2015 paper, *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing.*

Based on a survey of more than 6300 families with children aged four to 17, it followed a similar 1998 study. Overall, the prevalence of mental illness was stable and more families were accessing help. But there were several troubling trends in areas such as self-harm and suicide.

OVERALL PREVALENCE

The overall prevalence of mental health disorders did not change much between 1998 and 2013-14, but there were changes in disorders covered by both surveys. The prevalence of major depressive disorder increased from 2.1 per cent to 3.2 per cent, attention deficit hyperactivity disorder (ADHD) decreased from 9.8 per cent to 7.8 per cent and conduct disorder fell slightly from 2.7 per cent to 2.1 per cent.

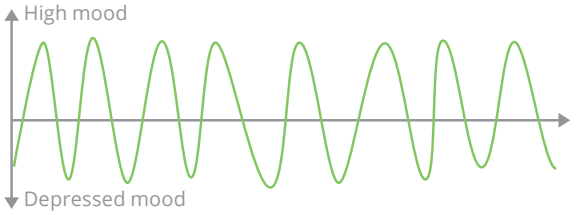
In 1998, only 31.2 per cent of 16 to 17-year-olds with mental health disorders had accessed a service in the previous six months. This rose to 68.3 per cent in 2013-14, which covered the previous year.

// TIPS FOR PARENTS

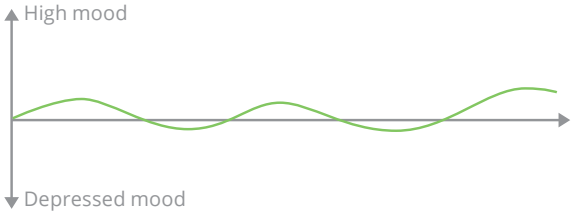
IF SOMETHING IS WRONG...

- Many adolescents have emotional ups and downs.
- Some suffer from depression or anxiety.
- If changes in mood, behaviour, school performance and social isolation last at least two weeks, consider seeing a GP.
- Seek help early. Effective treatments include counselling.

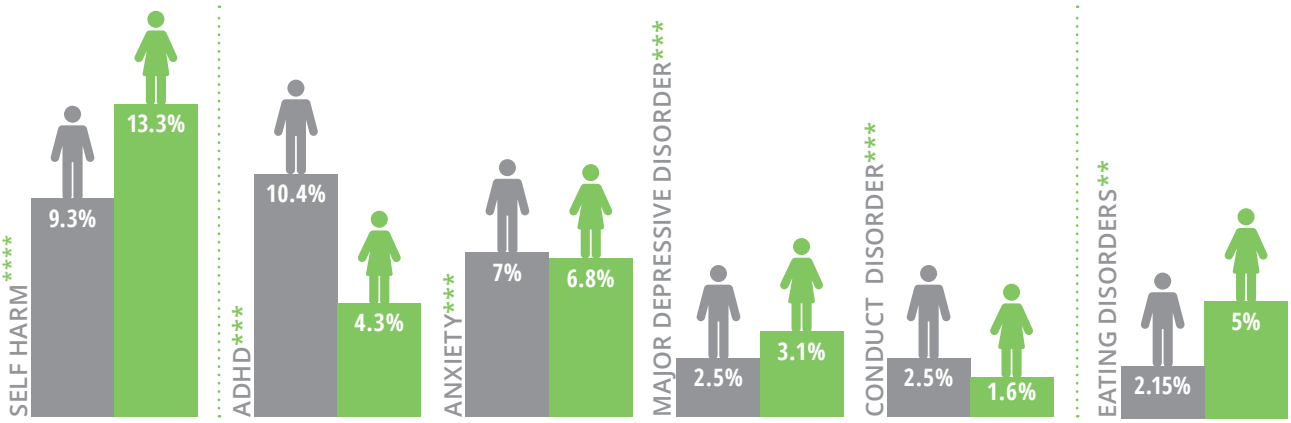
NORMAL ADOLESCENT MOOD FLUCTUATIONS



NORMAL ADULT MOOD FLUCTUATIONS



// PREVALENCE OF MENTAL HEALTH DISORDERS



**** Self-harm in the past 12 months in 12-17-year-olds, *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

*** Prevalence of mental disorders in 4-17 year-olds in the past 12 months.
The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).

** Estimated prevalence of total eating disorders in Australia in 5-19 year-olds.
Nip it in the bud: Intervening early for young people with eating disorders. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.

16.3%

11.5%

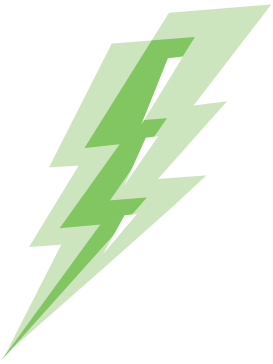
MALES WERE MORE LIKELY THAN FEMALES*

to have experienced mental health disorders

ADHD*

was the most common mental disorder

7.4%



followed by ...

ANXIETY*

6.9%

then

MAJOR DEPRESSIVE DISORDER*

2.8%

* *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

ASKING FOR HELP

1998

31.2%

16 to 17-year-olds with mental disorders had accessed a service in the previous six months

2013-14

68.3%

16 to 17-year-olds with mental disorders had accessed a service over the previous 12 months

// MISSION AUSTRALIA YOUTH SURVEY

Mental health is a huge issue for young people and a growing concern for them.

The Mission Australia Youth Survey highlights the concerns of young people aged 15 to 19 each year. In 2016, almost 22,000 respondents identified alcohol/drugs and equity/discrimination as the most important issues in Australia today, with mental health entering the top three for the first time in the survey's 15-year history, after concerns about it doubled in the previous five years.

Mission Australia also produced a *Youth Mental Health Report / Youth Survey 2012-2016* with the Black Dog Institute. It found:

- One in four young people were at risk of serious mental illness;
- Mental illness risk increases as adolescents age, becoming most prevalent in the older teen years; and
- The risk is greater in indigenous groups and young women.

The prevalence of probable serious mental illness among young people had continued to increase, even since the last report in 2015.

THE YOUTH MENTAL HEALTH REPORT / YOUTH SURVEY 2012-2016 FOUND THAT IN 2016:

- Just under one in four young people met the criteria for a probable serious mental illness, up from 18.7 per cent in 2012 to 22.8 per cent in 2016;
- Older teenagers were much more likely to have a probable serious mental illness. The proportion rose from 20.8 per cent at 15 to 27.4 per cent at 18 to 19 years;
- More than three in 10 (31.6 per cent) Aboriginal and Torres Strait Islander respondents had a probable serious mental illness, compared with 22.2 per cent of non-Aboriginal or Torres Strait Islander respondents;
- The top three issues of personal concern for those with a probable serious mental illness were coping with stress, school or study problems and depression;
- While the proportions of males and females with a serious mental illness rose from 2012-2016, the increase was higher among females (22.5-28.6 per cent from 2012-2016), than males (12.7-14.1 per cent); and
- Those with a probable serious mental illness said the top three sources for help with important issues in their lives are friends, parents and the internet. Those without an illness list friends, parents and relatives/family friends.

ON THE BRIGHT SIDE

6 IN 7 DO NOT

HAVE A MENTAL HEALTH DISORDER

While mental health is a serious issue, it is important to remember that most people don't have a mental illness.

In 2014-15, 4 million Australians (17.5 per cent) reported having a mental or behavioural condition. This meant 82.5 per cent, or about 19.5 million Australians, did not.

PROMOTING MENTAL HEALTH IN YOUNG PEOPLE

Adolescents are finding their place in the world and need a safe, caring space so they can:

- come to terms with their identity and adjust to their changing looks and new found sexuality;
- explore their own values;
- learn how to negotiate and set themselves limits; and
- plan a future they are happy with.

POSITIVE MENTAL HEALTH // PARENT TIPS

- Spend time together. Find activities that you and your adolescent enjoy and make a regular time for them. Make time to eat together and talk about current issues.
- Remember to let them know you love them. Take an interest in what is happening in their lives.
- Adolescents still need limits. Explain why you need to set limits. Let them know that you set limits because you care about them.
- Adolescence is a time of experimentation, change and increasing independence. As young people become older and more independent, families change.
- Be open to your adolescent's ideas. Adolescents can be very idealistic. If you listen and try not to be judgmental, they are more likely to share their concerns with you.
- Many adolescents will experiment with sex and drugs. Try to talk about these topics with them. There are often stories in newspapers or on TV about sex and drugs that you can use as a talking point.
- Try to just listen without reacting. There are times when you may be concerned about behaviour or problems. Try to be supportive and assist them to find solutions.

// WHY TEENAGERS NEED SLEEP

If you think your teenager or adolescent is trying to make life difficult when they go to bed late, they're not. Blame it on natural changes in their body clock. But getting enough quality sleep is important for mental health, says Professor Sarah Blunden, a sleep researcher and psychologist at the Australian Centre for Education in Sleep.

Sleep patterns change during adolescence because a teenager's body clock or Circadian rhythm shifts, making them feel sleepier later. At night, the pituitary gland in the brain releases a hormone called melatonin, which is a sleep hormone. During adolescence, melatonin is released later, so teenagers don't feel sleepy until later.

"Around 80 per cent of young people show a significant delay in sleep onset and if parents don't know about this delay, it can cause friction. Parents think adolescents don't want to go to bed for the sake of it, but it's a physiological issue and it's not their fault," says Professor Blunden.

If a teenager can't sleep, they will probably use a smartphone or tablet to amuse themselves. But exposure to light further delays the release of melatonin. Most teens get seven to eight hours sleep a night when they need about nine hours.

"Without sleep people are more irritable, aggressive and withdrawn. There's greater incidence of depression, anxiety and stress because teenagers haven't got the energy and capacity to cope with frustrations – and those years are filled with frustrations as they manage school, exams and learning how to be independent," says Professor Blunden.

"Learning, memory and attention are affected too. Sleep is a foundation of health. Without it, nothing else goes right."

BETTER SLEEP TIPS

- Catching up on sleep by lying in at weekends doesn't help – it continues the cycle of sleeping late and struggling to get up the next morning. Restrict weekend sleep-ins to an hour either side of weekday wake time.
- Changes to a teenager's sleep patterns are not their fault, so relax expectations that they need to sleep by a certain time – the stress will make sleep more difficult.
- Help your child with sleep hygiene. Keep their room dark, cut screen time at least half an hour before bedtime and try and get them to swap their screen for something relaxing, such as listening to calming music in the dark or using guided meditation.

DON'T IGNORE THE PROBLEM

Early diagnosis and treatment for mental illness is vital.

"Experience during adolescence predicts very strongly how young people will be doing at age 30. If you had a certain number of mental health problems during the transition from youth to adulthood, you will have fewer friends, you are more likely to not have completed your education, you will be earning less money – if indeed you have got a job – you might be on disability support, you might be homeless. And, you might be dead – from suicide." Professor Patrick McGorry, European Society for Child and Adolescent Psychiatry 2017 Keynote Speech.

In the next 20 years, the World Economic Forum expects 35 per cent of the loss of gross domestic product to be due to mental illness. Despite this alarming statistic, Professor McGorry believes there's a 'massive double standard' between recognition and treatment of mental illness versus illnesses such as heart disease or cancer.

"If you're diagnosed with heart disease, you will be taken seriously. You'll get access to expert care. But if that person presents to the same GP or health service with a significant mental health problem, there will be problems in accessing expert care and the quality of care will vary," he says.

Professor McGorry is particularly concerned about how this double standard affects young people with mental illness, such as anxiety, depression, eating disorders and psychosis. He believes early intervention is essential so young people can recover or manage mental illness. While some experts warn of 'over-treatment' if intervention happens too early, Professor McGorry says under-treatment is the issue.

"Scaremongers have promoted the idea of every minor problem in young people being labelled as a mental health problem. That's far from reality. It is still a minority of young people with these problems who get treatment."

Early intervention includes community education – young people, parents, family and friends knowing what signs to look for and helping a young person seek help. Professor McGorry says help may include user-friendly venues such as headspace and flexible outreach approaches that take support to young people in places where they feel comfortable.

First-line treatment is often cognitive behavioural therapy, followed by medication when needed. Research is providing new insights to potential effective treatments – recent studies have shown SSRIs or antidepressants can be potent in treating anxiety. Professor McGorry is about to undertake trials of cannabidiol – a component of cannabis – on young people with anxiety. Cannabidiol works on neurotransmitters in the brain and may help young people for whom traditional therapies don't work.

"Scaremongers have promoted the idea of every minor problem in young people being labelled as a mental health problem."

Photo: Supplied

Anti-inflammation treatments are also being investigated because inflammation seems to play a role in anxiety and depression.

Professor McGorry says parents have a key role to play in early intervention.

"Don't sweep it under the carpet. If the issue has been hanging round for more than a couple of weeks, talk to the young person and try to understand what they are going through. Talk to their friends," he advises.

"They may not want to talk but don't ignore the problem. If your gut feeling is to be worried, if a person has changed, is distressed, has become withdrawn, is struggling at school – don't put it off because you may regret it for the rest of your life. After a suicide, it's very sad to see parents say they had no idea what was going on because usually they had a feeling but didn't realise it was serious enough to kill their child."

If a young person won't seek help, talk to professional services yourself or consider other adults in your network with whom a young person will be able to talk.

"Sometimes it needs a few bites of the cherry before a young person gets over the line and seeks help. Just because it's been knocked back once doesn't mean it is a permanent decision," says Professor McGorry.

"And parents are critical and should be involved in the provision of care by any services, because nobody cares about a kid more than the parents."

// Professor Patrick McGorry AO is a psychiatrist, a former Australian of the Year and the executive director of Orygen, The National Centre of Excellence in Youth Mental Health. He is also Professor of Youth Mental Health at the University of Melbourne.

DEPRESSION

A study has found that depression is more common than previously believed.

Parents and carers may not realise the extent of depression in young people. A major Australian study* found that the prevalence of major depressive disorder was much higher than parents and carers believed.

One in 13 adolescents aged 11 to 17 (7.7 per cent) met the diagnostic criteria for major depressive disorder over the past 12 months. While 7.7 per cent self-reported that they had the condition, only 4.7 per cent of parents and carers thought their young person had it.

Major depressive disorder was more common in females, affecting 19.6 per cent of girls and 7.2 per cent of males aged 16 to 17. One in five adolescents (19.9 per cent) had very high or high levels of psychological distress. The incidence was almost twice as high for girls – 25.9 per cent compared with 14.8 per cent for boys.

IMPACT

Major depressive disorder has a bigger impact on schooling than other mental illnesses. Those who have it miss an average of 20 school days a year due to the symptoms. One in three young people with major depressive disorder (34.3 per cent) say their schooling is affected severely; another one in three (34.1 per cent) say it is moderately affected*. Two in five (42.8 per cent) report that their disorder has a severe impact on their general functioning, while 35.8 per cent reported a moderate impact.

BARRIERS TO SEEKING OR RECEIVING HELP

The most common reasons that 13 to 17-year-olds with major depressive disorder gave for not seeking or receiving help related to stigma or poor mental-health literacy. Two in three (62.9 per cent) worried what others might think or didn't want to talk to a stranger. Almost two in three (61.7 per cent) thought the problem would get better by itself and 57.1 per cent wanted to work the problem out without help from family or friends[1].

SELF-HARM

Young people with major depressive disorder are much more likely to self-harm than those who don't have it. One in two young females (54.9 per cent) and one in four young males (25.8 per cent) with major depressive disorder have harmed themselves in the past year[1].

STAYING POSITIVE

Two in three adolescents (62.9 per cent) say they are receiving informal help or support for emotional and behavioural problems, mostly from parents and friends. This is much higher (93.9 per cent) for adolescents who self-report with major depressive disorder.

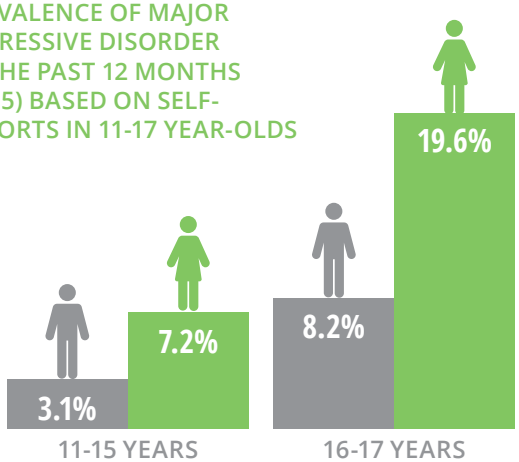
Two thirds (66.4 per cent) of all young people use other strategies to help manage or avoid emotional or behavioural problems. Most did positive things, such as more exercise or sport (37.9 per cent), more activities they enjoyed (45.1 per cent), seeking support from friends (24.4 per cent) and improving their diet (23.2 per cent).

Almost one in 12 (7.9 per cent) reported smoking cigarettes, or using alcohol or drugs to help. The proportion was much higher (31.5 per cent) for those who reported having major depressive disorder[1].

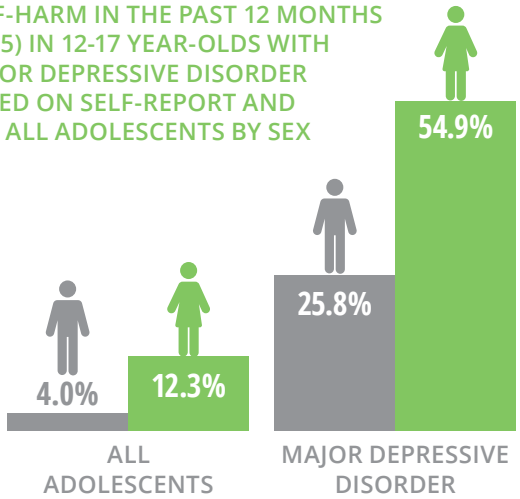
[1] Symptoms of these conditions can range from mild to severe. They are treatable and the sooner treatment is sought the better. Find out more // **healthyfamilies.beyondblue.org.au**

// PREVALENCE OF MAJOR DEPRESSIVE DISORDER AND SELF-HARM*

PREVALENCE OF MAJOR DEPRESSIVE DISORDER IN THE PAST 12 MONTHS (2015) BASED ON SELF-REPORTS IN 11-17 YEAR-OLDS



SELF-HARM IN THE PAST 12 MONTHS (2015) IN 12-17 YEAR-OLDS WITH MAJOR DEPRESSIVE DISORDER BASED ON SELF-REPORT AND FOR ALL ADOLESCENTS BY SEX



* *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

// TYPES OF DEPRESSION

MAJOR DEPRESSION

Sometimes called major depressive disorder, clinical depression, unipolar depression or simply depression, major depression involves low mood and/or loss of interest and pleasure in usual activities, as well as other symptoms most days for at least two weeks.

MELANCHOLIA

A severe form of depression with many of the physical symptoms, melancholia sees a person start to move more slowly and be more likely to have a depressed mood characterised by complete loss of pleasure in everything, or almost everything.

PSYCHOTIC DEPRESSION

Psychotic depression occurs when someone with a depressive disorder loses touch with reality. It can involve hallucinations or delusions, or paranoia about being watched or followed.

ANTENATAL & POSTNATAL DEPRESSION

Women are at an increased risk of depression during pregnancy (known as the antenatal or prenatal period) and in the year following childbirth (known as the postnatal period).

BIPOLAR DISORDER

Bipolar disorder used to be known as manic depression because the person experiences periods of depression and periods of mania, with periods of normal mood in between.

CYCLOTHYMIC DISORDER

Often described as a milder form of bipolar disorder, this disorder involves chronic fluctuating moods over at least two years, periods of hypomania (a mild to moderate level of mania) and periods of depressive symptoms, with periods of up to two months of normality between.

DYSTHYMIC DISORDER

The symptoms are less severe than major depression but last longer.

SEASONAL AFFECTIVE DISORDER (SAD)

This mood disorder has a seasonal pattern characterised by mood disturbances (either periods of depression or mania) that begin and end in a season such as winter.

beyondblue

TALKING ABOUT DEPRESSION // PARENT TIPS

- Choose a time when the young person is relaxed and unlikely to be distracted.
- Be natural and don't overthink it. Start by sharing your concern.
- Be prepared for rejection. If they don't want to talk, try again later.
- Check your emotions and be realistic, while telling them you care and want to help.
- Discuss what you have noticed and why you are concerned.
- Ask questions about how they feel.
- Let them guide the conversation.
- Tell them it is important to discuss their feelings.
- Try to understand their reaction and help them to feel at ease. Let them know that crying is OK.
- Seek a balance between helping and encouraging their independence.
- Provide information about depression and the types of help available.
- Respect their privacy but explain the benefits of telling trusted people. Let them know that professional help is confidential and easy to access.

Other helpful tips can be found at //
healthyfamilies.beyondblue.org.au

// RISK FACTORS

- Emotional difficulties between a child and parent/parents e.g. more arguments, conflict, lack of communication.
- Physical and sexual abuse or neglect.
- Sudden death of a loved one, family member or pet.
- A loved one experiencing serious physical illness.
- Sudden separation of parents.
- A family history of depression – genetic and biological factors, such as chemical imbalances, can increase the risk.
- Social isolation and poor social/friendship networks.
- Being bullied.
- Changing schools or starting high school.
- Not doing as well at school – not getting the same kind of marks or having behaviour issues.
- Self-critical thinking and seeing oneself as a failure, a loser, unloveable, worthless etc.
- A tendency to ruminate and dwell on issues, sometimes turning them into bigger problems than they really are.
- Risk-taking behaviours.
- Having trouble sleeping and feeling irritable and grumpy.
- Lacking motivation, e.g. everything seems too hard.
- Losing interest in usual activities.
- Appetite changes, e.g. not eating regularly or overeating and weight changes.

I DIDN'T THINK I COULD RECOVER

Hannah has spoken about her experiences with schizophrenia as part of a campaign for SANE Australia.

// I was around 12 years old when I began to experience depression and anxiety, which continued throughout my teenage years. I struggled to concentrate on my school work and I stopped enjoying sport and other activities that I usually liked. I found it extremely difficult to get out of bed. Everything took so much energy.

"I constantly felt a fear that I can't describe. I had extremely low self-worth and confidence in my abilities. High school was a difficult time. Depression and anxiety weren't as widely understood when I was at school so people thought I wasn't trying, that I didn't care or that I was 'attention seeking'.

"But I couldn't control the symptoms I was experiencing and I didn't have the tools required to effectively manage them. I didn't know how to seek help from people around me and I didn't feel safe to ask. I talked to friends but they didn't know how to help me, and this caused them a lot of emotional distress, which wasn't my intention. I desperately needed understanding and support.

"The depression and anxiety eventually got to a point where the symptoms were so severe that the adults around me couldn't ignore them. I was admitted to adolescent psychiatric wards a few times. I started experiencing psychosis towards the end of high school, although I didn't really understand what was happening at the time.

"The stress and pressure of the transition from school to university, as well as a culmination of other traumatic experiences, triggered the psychosis and ultimately resulted in a schizophrenia diagnosis when I was 18. I experienced auditory and visual hallucinations, delusions, paranoia and confused thinking. This made day-to-day life extremely challenging.

"When I was diagnosed, I didn't have much of an understanding of schizophrenia at all. The only thoughts that came to mind were the 'horror movie' stereotypes that many people think about when they think of schizophrenia. I didn't think that it was possible to recover – I believed that my life was over. One of the most common myths is that people with schizophrenia are inevitably dangerous and violent. This is not the case. Another common myth is that schizophrenia causes people to have multiple personalities. This is also false.

Photo: Supplied

"One of the main things that struck me when I was diagnosed were the low expectations that many people had of me – particularly mental-health professionals. I was told that I would most likely have schizophrenia for the rest of my life. Not once was I given any sense of hope, or told that it's possible to recover and live a fulfilled life.

"For me, recovery will most likely not be a complete cure but I have worked hard to build an arsenal of supports, coping skills and strategies. I have been prescribed medications, but, unfortunately, they cause me some serious side-effects. I see my psychologist regularly. Volunteering and becoming involved in mental-health advocacy has played a huge role in my recovery. It has given me a sense of purpose and confidence. I know how essential it is for people who experience psychosis or schizophrenia to be empowered to develop self-efficacy and to have a meaningful input into their treatment, because finally being given that opportunity was instrumental in my recovery.

"I'm not a parent, but I can understand how powerless people can feel and how terrifying it can be when someone you love is suffering from a mental illness.

"No matter how out of reach or hopeless recovery may seem, I believe that it is always possible with holistic support and love. Continue to see young people as themselves, not as a diagnosis. Always show them that they are worthy of respect and love, and remain hopeful that they can recover – whatever recovery looks like for them."

// SANE AUSTRALIA

SANE Australia is a national mental-health charity working to support 4 million Australians affected by complex mental illness including schizophrenia, bipolar, borderline personality disorder, eating disorders, OCD, PTSD and severe depression and anxiety.

Find out more // **www.sane.org**

// Hannah, 24, is studying a bachelor of human services and is a mental-health advocate. She is also a volunteer at headspace.

A FRIEND IN NEED

When a friend turned to Russell Farmer because they were experiencing depression and suicidal thoughts, Russell didn't know the best way to help.

"We live in a society where it's not OK to not be OK. There's stigma around talking about how you feel, particularly if you're a guy. You have a problem and your first reaction is to deal with it on the inside, to try to fix it yourself rather than asking for help.

"We don't like to accept that things aren't perfect. In social and friendship groups, we want to be laid-back and fun – not a burden. We want to be the person that is looked up to, not the guy who is sad and bumming everyone out. We talk about the footy more than how bad our Saturday night was because we were stuck in bed feeling anxious or depressed.

"I want to challenge the idea that we all have a perfect life. It's normal to struggle sometimes. Things come up that are out of our control – we don't get the ATAR we want, we get sick or our parents split up – but those things can be dealt with. Research suggests three in five young men who acknowledge they are struggling don't seek help.

"I realised this during year 11 when a friend was struggling. I was quite clueless until they started sharing things with me and I had no idea how to deal with it. I was quite shaken. They had anxiety and depression and felt suicidal and they were trusting in me and another friend to help them get back on their feet.

"They didn't want to speak to their parents initially and I needed help to help my friend. I chatted to a school counsellor, then directed my friend towards a psychologist and got their parents involved. It was about keeping our friendship while involving the right people. They're getting help, and I've learnt through that experience.

"I want to challenge the idea that we all have a perfect life."

"I think it's a natural thing initially not to want to tell your parents. It can be uncomfortable and sometimes you don't know how they will react. For a while my friend's excuse was that they didn't want to worry their parents and that they already had a lot on their plate. They were very supportive but I think it can be hard for parents to get an insight into how their kids are going – it may be that their friends more quickly see a problem.

"Friends have a responsibility to ask their friend if they are all right and to be serious about it. Don't ask in passing. Give friends an opportunity to say if they aren't doing well, but be a normal friend to them. Don't try and be their psychiatrist or the only person to make them feel better – get support yourself. Acknowledge they're having a rough time, be sensitive, but don't change your friendship. Keep the normal parts of their life secure and strong so they can hold on to those while other parts of their life are not going so well.

"Parents need to make it clear that they are on the same side as their teenager. Get professional help so you know how to best help your child and make sure they know you love them."

EDITOR'S NOTE // R U OK? DAY is Thursday 13 September 2018.

Photo: iStock

// Russell Farmer, 18, is a former vice-captain at Trinity Grammar School in Melbourne. Russell had spoken at school assemblies urging young people to ask for help if they or a friend are struggling with their feelings.

HOW TO BE BRAVE

Professor Sue Spence is a clinical psychologist who focuses on the prevention and treatment of anxiety and depression in young people.

"We know about 7 per cent of young people experience anxiety disorder to a level that it interferes in their daily life and justifies treatment – it is one of the most common problems in mental health. Many teenagers don't just grow out of it and a lot of adults with anxiety will tell you that the problem started when they were young and they suffer for years," says clinical psychologist Professor Sue Spence.

"Some degree of anxiety is a good thing. Evolution-wise it's a good idea to be afraid of wild animals and high places from which you could fall, for example. So there is commonsense as to why we've evolved a degree of fear. Some worry is also useful because it helps us pay attention to a situation, to prepare and to remember to do things.

"But anxiety and worry transition into a problem when they stop people doing things that are important in their life, like going out with friends, not going on school camp, spending a lot of time at home and not wanting to go to school. When it starts to disrupt their lifestyle, it becomes a problem, and the sooner you do something about it the better."

To lessen the incidence and impact of anxiety for young people, Professor Spence developed an in-clinic program, where children and families attended a clinic. Young people did 10 therapy sessions and parents completed six sessions. The program achieved positive results and Professor Spence and her colleagues, Dr Caroline Donovan and Dr Sonja March, converted it into an online format, BRAVE Online, to help a wider group of young people and parents.

The sessions look at the different kinds of anxieties that teenagers experience, the symptoms, and typical feelings and bodily reactions. Sessions also look at the relationship between thoughts and feelings; how we can learn to change our thinking and swap negative thoughts to more positive and effective thinking, and so reduce anxiety. Teenagers also learn coping skills and relaxation methods to help them reduce their anxiety.

The program uses an exposure hierarchy that breaks fears into small parts and helps young people begin facing their fear step-by-step.

"Each week a teenager gradually does something that is a little scarier. So if they have a fear of talking in front of others in the classroom, they might start practising talking in front of a mirror. Once they are comfortable doing that, they then find a parent or someone they trust to practise with them and gradually they work up to a point where they feel confident enough to talk in front of the class," explains Professor Spence.

Photo: Supplied

"Parents can try and make sure they don't inadvertently reward fearful behaviour by allowing young people to avoid a situation."

BRAVE also has dedicated sessions to help parents recognise and support a child with anxiety. Sessions begin by explaining different types of anxiety and how to distinguish between normal worries versus problematic worries. The sessions also illustrate parenting styles that can help a young person with anxiety.

Parents are shown how to help their child with the exposure hierarchy – by ensuring steps between tasks are not too big and encouraging them to practise their tasks.

"Parents can try and make sure they don't inadvertently reward fearful behaviour by allowing young people to avoid a situation. When a teenager doesn't want to go to school, parents need to be firm and say, 'you really have to go to school', rather than saying 'you poor darling, I can see you're worried, take today off and stay home with me'," says Professor Spence.

"Don't give too much attention when young people express fears and worries but always be supportive, loving and warm."

// Professor Sue Spence helped develop BRAVE Online, a free online treatment program for anxiety that offers support to young people and to parents. To find out more, visit // **brave4you.psy.uq.edu.au**

ADHD

Attention deficit hyperactivity disorder is more common than you may think.

Attention deficit hyperactivity disorder (ADHD) is the most common mental-health disorder in children and adolescents. A major Australian study* found 7.4 per cent of those aged 4-17 had ADHD, followed by anxiety disorders (6.9 per cent), major depressive disorder (2.8 per cent) and conduct disorder (2.1 per cent).

This means about 298,000 Australian children and adolescents have ADHD. Most cases – 65.7 per cent – are mild, and more boys than girls – 10.4 compared to 4.3 per cent – have had the condition in the past 12 months (2015).

Girls are less likely to have ADHD as adolescents (2.7 per cent compared with 5.4 per cent at ages 4-11), but there is little difference for boys (10.9 per cent at 4-11 years old and 9.8 per cent at 12-17). In the past 12 months (2015), students with ADHD took an average five days off school due to its symptoms.

WHAT IS ADHD?*

ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity more frequent and severe than in other individuals at a similar developmental stage. Children and adolescents may find it difficult to pay attention and see tasks or activities through to the end or make careless mistakes with schoolwork or other tasks.

Children and adolescents with hyperactivity problems may talk excessively, have trouble staying still when it is appropriate or expected, and act like they are always "on the go".

// CONDUCT DISORDER

WHAT IS CONDUCT DISORDER?

Conduct disorder is repetitive and persistent behaviour that violates the basic rights of others, major societal norms or rules in their aggression towards people or animals, destruction of property, deceitfulness or theft and serious violation of rules. Behaviours often include bullying, frequent fights, deliberately destroying others' property, breaking into properties or cars, staying out late without permission, running away from home or frequent school truancy.

WHO HAS IT?

About 2 per cent of Australian children and adolescents – or 84,000 – have conduct disorder. More boys (2.5 per cent) than girls (1.6 per cent) have it. Like ADHD, conduct disorder is more prevalent in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

More young people outside capital city areas have conduct disorder than those in the city (3.2 per cent compared with 1.4 per cent). Compared to other disorders, a higher proportion of those with conduct disorder had a severe impact in the family domain (29.5 per cent). Only 4.3 per cent of those with conduct disorder have no impact on their family.

// PARENT TIPS

- Work with health professionals to develop a behaviour management plan that teaches skills to boost co-operative behaviour and reduce challenging behaviour.
- Give clear, easy-to-follow instructions while maintaining eye contact.
- Ask them to repeat instructions to ensure they understand them.
- Avoid over-tiredness by encouraging a healthy diet, good rest/sleep patterns and manageable screen time.
- Have regular routines using lists and timetables.
- Teach strategies so they can self-monitor their behaviour and deal with conflict.
- Speak to teachers about classroom strategies such as a visual checklist of tasks.

Find out more at Raising Children Network //
www.raisingchildren.net.au

// ADHD RISK FACTORS*

- **Original families where at least one child lives with both natural, adoptive or foster parents without step-children have the lowest ADHD rates (5.7 per cent). The rate for those in lone parent or carer families is 11.1 per cent and blended families 13.4 per cent.**
- **ADHD is most prevalent in children in the lowest-income families (less than $52,000 a year) – 11.7 per cent. It falls to 6.6 per cent in middle-income and 5.2 per cent in high-income families.**
- **Of those whose parents left school in year 10 or below, 11.7 per cent have ADHD, compared with 5.4 per cent whose parents had a bachelor degree or higher. Rates are also higher in families with both parents unemployed.**

// AUTISM SPECTRUM DISORDERS

Autism spectrum disorders (ASD) refers to a group of developmental disorders — Autistic, Asperger's, Childhood Disintegrative Disorder, Rett's and Pervasive Developmental Disorder — that often affect a person's ability to interact socially and communicate with others. The signs and symptoms of an autism disorder will typically manifest before the age of three and can include repeating activities, showing an extreme resistance to changes in routine and various speech problems.

* *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

RESILIENCE

Children need to experience life's ups and downs to become resilient young people.

Helping adolescents and young people build resilience is one of the most valuable gifts a parent can give their child. Why is resilience important, and how do parents and carers help their child develop this essential characteristic?

"We are living in a time when children are less resilient, so by the time they get to adolescence they are floundering in a world that has changed more rapidly than ever. It's tricky out there. We've always had a generation gap, but now it's a chasm," says Maggie Dent, a parenting and resilience author and educator.

"We have a generation of wonderful young people whose parents have done so much for them that they've disabled those young people from doing things for themselves."

Dent says a generation of millennial adolescents are growing up and entering adulthood without resilience – a quality or characteristic she defines as being able 'to manage your day-to-day life and to recover from setbacks and adversity'.

WHAT IS RESILIENCE?

The *Promoting Resilience in the Millennial Adolescent* report, prepared by Dent with the Department for Communities' Office for Youth in WA, says resilience refers to "the ability of a person to successfully manage their life, and to successfully adapt to change and stressful events in healthy and constructive ways. It is about survivability and 'bounce-back-ability' to life experiences – both the advantageous ones and the challenging, traumatic ones".

Dent says the failure to build resilience begins in younger children.

"We've changed games like pass the parcel so every child gets a prize. Everyone gets trophies and ribbons even when they don't win. We've softened children's natural ability to experience things like disappointment and setbacks," says Dent.

"Yet we've changed the education system to become such a testing regime, so children are experiencing more opportunities to fail without having the capacity to manage failure. And, with great love, parents are doing too much for their children and are further reducing their capacity to do things for themselves."

WHY RESILIENCE MATTERS

Researchers say a lack of resilience in adolescents and young people is leading to issues, including depression, anxiety disorders, stress, low self-esteem, drug abuse, family dysfunction, disconnection and struggles at school. Resilience is protective against these kinds of problems and helps young people deal with adversity.

"Adolescence is a time of transformational change on all levels. They move from being a child to being an adult. They are searching for identity and at the same time young people are marinated in a sexualised culture," Dent says.

"They see the world through a distorted windscreen and develop self-loathing and self-disgust. At the same time, an adolescent needs to learn to separate from their parents."

Dent says resilience helps young people safely navigate a rapidly changing modern world and helps them be competent to make the right choices and decisions in their life.

// THE RESILIENCE PROJECT

After spending time volunteering in an Indian village, former teacher Hugh van Cuylenburg was inspired to create The Resilience Project, which educates Australian parents, children and organisations about the importance of gratitude, empathy (compassion) and mindfulness. "In this desert community, there was no running water, no electricity and no beds; everyone slept on the floor," van Cuylenburg says. "Despite the fact these people had very little to call their own, I was continually blown away by how happy they were."

The Resilience Project delivers presentations to a range of organisations incuding elite sporting clubs and primary and secondary schools. In addition to the presentations schools receive they have the opportunity to complete a curriculum specifically designed to encourage self-awareness through focusing on what you have as opposed to what you don't have, understanding the benefits of helping others and being healthy and active. Here are some simple tools to build resilience:

KEEPING A GRATITUDE JOURNAL

In the journal, answer these two questions every night.

- What are three things that went well for you today?
- What are you looking forward to most tomorrow?

This simple exercise will help build positive emotion and reduce levels of anxiety.

MEDITATE

Meditation has many well-known benefits. Most notably, it teaches you to appreciate the moment you are in.

BE KIND

Try to perform one random act of kindness a week. It can be something small, such as giving someone a compliment. When we do something kind, our brain releases a hormone called oxytocin, which makes us feel happier.

SLEEP

Never underestimate the power of sleep. Adolescents require 8-10 hours of sleep a night for optimal cognitive development. A child at primary school requires 10-12 hours.

EXERCISE

Research tells us that regular exercise is linked closely to our resilience and well-being. Twenty minutes a day is enough. Even if it's just a brisk walk, make sure you are putting time aside to be active.

For more information, visit // **theresilienceproject.com.au**

HELPING CHILDREN BUILD RESILIENCE

Parents and trusted, significant adults – whom Dent calls 'lighthouses' – play a pivotal role in helping young people develop resilience. 'Lighthouses' are adults who have a caring, genuine and meaningful involvement with a young person and who are willing to support them in their bumpy journey towards adulthood.

LIGHTHOUSES

'Lighthouses' support adolescents as they develop and build resilience in a number of ways. They:

- Have knowledge and understanding of adolescence;
- Have the courage to care;
- Are trustworthy and respectful;
- Give hope and encouragement;
- Build connectedness through genuine acceptance;
- Encourage mastery and teach life skills;
- Help adolescents manage 'big ugly emotional states';
- Practise caring, empowering communication;
- Give guidance when asked; and
- Strengthen the spirit – including laughter and lightness.

Dent says parents need to focus more on being a 'lighthouse' and less on being the 'perfect parent'.

"Parents want to hide their own embarrassment around their own disappointments and failures. They don't want to be seen to be a 'bad' parent. They want their children to think they have never mucked up so they don't model what to do when you get stressed or angry or fail," she says.

Be a mean but loving parent. Don't overindulge children in the pursuit of keeping them happy, adds Dent. Life isn't always going to be happy and children need to learn that and practise how to navigate disappointment, failures and things not going according to plan.

"Give them opportunities to fail well and reassure them that failure doesn't make them bad people. Reassure them that things can be bumpy but nothing they do will ever make you, as a parent, not want to be there for them. You can tell them you love them and they will probably roll their eyes! But your child needs to know you love them fiercely and unconditionally," says Dent.

Day-to-day, give young people responsibilities around your home so they learn life skills that are not only useful but that build their confidence and sense of capability.

"Give them opportunities to develop grit and persistence and an 'I can do that' attitude. And remember it's a coaching process. Don't yell and shout because that will alienate a young person. Remember that they can already feel lost and confused because of all the changes happening around them," says Dent.

"Look at what gaps they have in their coping capacities and help them fill those gaps. And have 'what if' conversations with your teenagers. Ask them what they would do if gatecrashers turned up at a party. Put them in some real-life situations and see what their explanations are."

Help young people foster healthy friendship groups and welcome and co-parent those children.

"We want their parents to co-parent our children because often children listen to the parents of their friends. Encourage friendships that can help children transition from home because when they leave home, often they consult a good friend before mum or dad," says Dent.

Photo: iStock

// PARENT TIPS

Start building life skills by encouraging your teenager to do tasks such as:

- Wiping down the kitchen bench after preparing food;
- Sweeping and mopping the floor;
- Learning basic food preparation skills;
- Knowing how to use a washing machine;
- Not leaving clothes, shoes and wet towels around the house;
- Eating meals at regular times;
- Saying hello to people when they first see them;
- Learning to be assertive without being aggressive;
- Listening when someone is speaking to them;
- Being punctual for meetings – or 10 minutes early;
- Saying sorry when they make a mistake;
- Learning how to save money, and repaying money if they borrow it; and
- Learning how to laugh at themselves when they muck up.

// Saving Our Adolescents, by Maggie Dent
www.maggiedent.com

IS MY CHILD OK?

Is your child going through normal adolescent ups and downs? Angelina Chisari shares some of the lessons she's learnt and signs to look out for.

More than half the callers to Kids Helpline are 13 to 18 years old and about one in five callers are worried about mental health – their own, or a person close to them.

"Most of the time they are seeking support and strategies to manage an already diagnosed or established mental health condition, but we also get contacts from children who aren't diagnosed and who are concerned about initial symptoms or some quite serious symptoms," says Angelina Chisari.

Most mental-health concerns involve depression, anxiety, self-harm and suicide.

"At night, they can be left with their thoughts and have difficulties sleeping, and they call us because they can't see their usual psychologist or counsellor then. They also call for crisis support if they have urges around suicide and self-harm – we build a safety net for young people," says Ms Chisari.

She says it can be hard for parents to work out whether their teenager's behaviour is normal, or whether it's something to be concerned about. And she adds that it's normal for parents to feel anxious and concerned about how to approach mental health concerns with their child.

"We know teenagers tend to be a little more emotional than at other times in life."

"We know teenagers tend to be a little more emotional than at other times in life. They are going through a lot of changes developmentally, socially, academically, physically and emotionally.

"The teenage brain is still developing, and this can leave young people feeling really tired, emotional and exhausted. Emotions like anger, sadness, stress and anxiety can be normal, but if those emotions are excessive, consistent and prolonged over weeks to months, that needs to be explored further," Ms Chisari says.

// WHAT IS NORMAL AND WHAT ARE THE SIGNS THAT A CHILD MAY BE STRUGGLING EMOTIONALLY?

"Is your child retreating from family, friends or everyday activities? Or have you noticed other changes in their behaviour? Is your child avoiding school? Have they become more irritable or aggressive? Are they using drugs or alcohol? Usually teenagers don't want to spend as much time with their parents and their focus shifts to their friends. If you see a change in how much time your child is spending with their friends, that can be a sign that something is going on," says Ms Chisari.

If your child shows persistent signs of hopelessness or pessimism, don't minimise those feelings by trying to normalise them. "When you minimise their feelings, your child is less likely to talk to you again about those issues," says Ms Chisari. "If the issue worsens and those feelings escalate from depression to self-harm. They're not going to come back to you for help."

Is your child showing increased sensitivity and heightened reactions to challenges, failure or rejection? Are they more self-critical than usual? Do they talk about feeling guilty or worthless? Your first reaction as a parent is important. "Be supportive and don't try to convey that everything is in their head, that it's normal teenage hormones and it will all get better," says Ms Chisari. "Ask your child what is going on, how they are feeling, acknowledge and validate their feelings and involve them in options for support. Ask them if they want to speak to a counsellor or a doctor or to call an anonymous service like Kids Helpline so what they're experiencing can be looked at further."

Experts usually agree that if a condition is affecting a child's ability to function day to day, or their ability to enjoy life, they may need professional help.

It's normal for parents to feel worried about how to talk to their kids about mental health. "As parents, we don't always know what to do or say. It's OK to feel this way and help is available," says Ms Chisari. Parentline is a confidential telephone counselling service for parents and carers offering information, referrals and assistance on a range of parenting issues.

Parentline // **1300 30 1300**

The Kids Helpline website has a dedicated section for parents that includes advice on how to start a conversation with a young person about their mental health. It also gives information on different forms of mental illness, signs, symptoms and support and treatment options.

Kids Helpline // **www.kidshelpline.com.au** or **1800 55 1800**

// Angelina Chisari is a senior practice supervisor at Kids Helpline, a national phoneline that provides counselling and support to children and young adults aged between 5 and 25.

AM I OK?

Parenting young people can be tough at times, but it can be even trickier if you're not feeling supported yourself.

Like young people, adults too can struggle with the challenges of life. The *Jean Hailes Women's Health Survey 2017* found about 40 per cent of women had been professionally diagnosed with depression or anxiety. Those aged 18-35 were most anxious.

Nearly half of the women surveyed said that on several days of the week they worry excessively about different things, become easily annoyed or distracted and have trouble sleeping.

Clinical psychologist Dr Janet Hall says it is a great advantage for young people if their parents are mentally well.

"Parents are their primary models and their communication, habits, routines and relationship can set a fine model for a teen," she says.

Dr Hall says if they are struggling, parents may need someone to listen to them and offer advice.

"Close relationships offer support and feedback for parents who are not thinking straight or feeling OK," she says. "The challenge may be for an unwell parent to share with the appropriate person."

Warning signs that a parent may need professional help include being unable to cope with normal life routines, no motivation, talking too fast or not at all, anxiety attacks, being unable to make decisions or solve everyday problems, lack of self-care and hygiene, explosive anger and inability to stop crying.

Dr Hall says parents often believe it's better to avoid talking to children about their mental illness to protect them from stress and confusion.

"Yet research shows that when parents talk openly about their struggles, in language their child can understand, it actually helps the child to cope better," she says.

"It can help them to make sense of the changes that they observe in you when you're unwell and to know that they're not at fault or somehow responsible for them.

"It is inappropriate, however, to 'overshare' by giving too much information about their mental illness and perhaps set up an expectation that the teen has to give the parent counselling and advice."

Keeping yourself mentally well

- Have a healthy routine – exercise, eat foods with good nutrition, have a good night's sleep.
- Communicate with people who are constructive – talk to positive friends and family regularly.
- Belong to a group of positive people who share a common interest such as sport, reading or contributing to community activities.
- Be realistic about your stress levels – learn to say no so you don't get burnt out.
- Be responsible about your choices for pleasure – avoid escaping into drugs, alcohol, social media and television. Get professional help early if you know you are abusing yourself or if others who care for you recommend that you need help.

For more information, visit // **www.drjanethall.com.au**

Photo: iStock

// SEEKING HELP

- Talk to other parents, your partner or other family and friends.
- There may be parenting groups in your area that meet and talk about adolescents.
- If talking to friends and family does not help or reassure you, talk to your child's teacher or a trusted health professional.
- Don't give up if you can't find the right person. It may take time.

Most states and territories have parent help lines, and **raisingchildren.net.au** has a good list. The following are some national numbers.

Department of Mental Health // **www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat**

Family Relationship Advice Line // 1800 050 321, 8am-8pm Monday to Friday, 10am-4pm Saturday

Lifeline // 131 114

MensLine Australia // 1300 789 978

Sane Australia Mental Health Helpline // 1800 187 263, 9am-5pm Monday to Friday

1800 RESPECT (National Sexual Assault, Domestic and Family Violence Counselling Service) // 1800 737 732

COPMI (Children of Parents With a Mental Illness) // **www.copmi.net.au**

EATING DISORDERS

Early intervention is crucial for young people who develop eating disorders.

Eating disorders are complex and can remain well-hidden unless the person living with it suffers from serious physical illness. Many people live with them for years and may never seek treatment.

A 2016 report by Orygen, The National Centre of Excellence in Youth Mental Health, paints a detailed picture of eating disorders, which are not one diagnosable illness but a set of neuropsychiatric illnesses with biological, psychological and socio-cultural risk factors.

They include anorexia nervosa, bulimia nervosa, binge-eating disorder and several other specified or unspecified feeding and eating disorders.

Those who have them may move from one to another and then back again. Some will experience an eating disorder with another condition such as anxiety, depression, drug and alcohol disorders and obesity.

Treatment requires a complex response to all related physical and mental ill-health, while recovery needs medical, psychological and nutritional treatments that, particularly for young people, also require a significant commitment from the entire family.

Orygen's *Nip it in the bud: Intervening early for young people with eating disorders*** estimates that 9 per cent of Australians have an eating disorder. This includes a significant proportion affected by binge-eating disorder.

Binge-eating disorder is the most prevalent eating disorder and rates appear to be rising.

Conversely, dieting is a big issue for many. Another study (Tucci, 2007), found 90 per cent of 12 to 17-year-old girls and 68 per cent of 12 to 17-year-old boys had been on a diet of some form.

Nip it in the bud found that many people with eating disorders were either not diagnosed or only accessed treatment after an extended period of illness. "At present, a young person with the onset of an eating disorder may potentially not seek treatment for four to 10 years," it found.

"While evidence-based treatment provided within two to three years of diagnosis has been shown to be successful, the costs of delayed, or no treatment, are devastating for young people experiencing the illness, their family and the community."

WARNING SIGNS AND TRIGGERS

Many young people, particularly girls, are dissatisfied with their bodies. Preoccupation with weight and shape is one of the most potent and replicated risk factors for bulimia and anorexia nervosa.

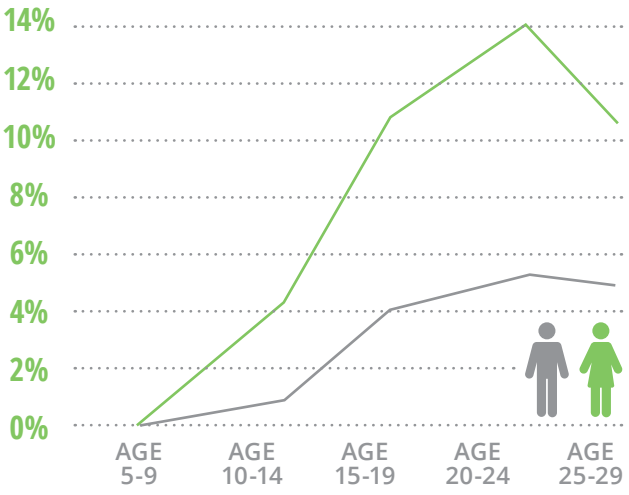
Intense dissatisfaction with body size and shape can lead to disordered eating behaviours, such as fasting, use of laxatives, self-induced vomiting and binge eating. This does not always result in an eating disorder but is a serious health problem and the most common indicator of risk for the development of an eating disorder.

An estimated one in five females have disordered eating, which could be a conservative figure given its secretive nature.

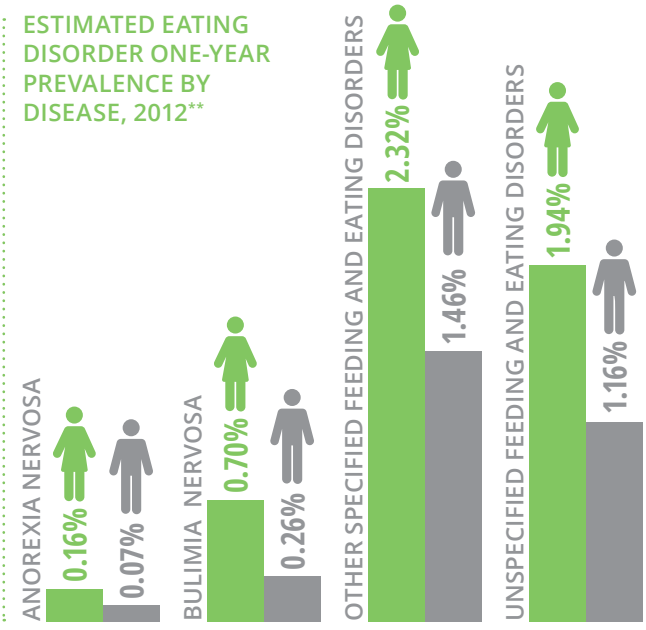
Numerous psychological, biological, socio-cultural and environmental factors may trigger a vulnerable young person into a cycle of disordered eating. It may appear to be quite minor, such as an off-hand comment by a parent about gaining weight.

// PREVALENCE OF EATING DISORDERS**

ESTIMATED AGE-GENDER PREVALENCE OF TOTAL EATING DISORDERS IN AUSTRALIA**



ESTIMATED EATING DISORDER ONE-YEAR PREVALENCE BY DISEASE, 2012**



** *Nip it in the bud: Intervening early for young people with eating disorders. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.*

// EATING DISORDER TYPES**

ANOREXIA NERVOSA

Involves a persistent restriction of energy intake leading to significantly low body weight. A person with it has either an intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though they are already significantly underweight.

It also includes disturbances in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or a persistent lack of recognition of the seriousness of current low body weight.

BINGE-EATING DISORDER

Recurring episodes of eating significantly more food in a short period of time than most people would under similar circumstances, with associated feelings of lack of control, distress, guilt, embarrassment and disgust. This occurs, on average, at least once a week over three months.

BULIMIA NERVOSA

Involves recurrent episodes of binge eating, followed by recurrent inappropriate behaviour to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting or excessive exercise. These behaviours both occur, on average, at least once a week for three months.

OTHER SPECIFIED FEEDING AND EATING DISORDER (OSFED)

Refers to situations where a person has clinically significant feeding and eating disorder symptoms but does not meet the full criteria for another diagnostic category. e.g. atypical anorexia nervosa (weight is within normal range).

UNSPECIFIED FEEDING AND EATING DISORDERS (UFED)

Clinically significant feeding or eating disorders that do not meet the criteria for another eating or feeding disorder.

** Nip it in the bud: Intervening early for young people with eating disorders. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.

// SEEKING HELP

Early intervention is critical. Those who have had an eating disorder for less than two years are likely to respond faster to treatment and have fewer physical health consequences.

However, most people with an eating disorder don't seek help. *Nip it in the bud* found only 17–31 per cent of those with a diagnosable eating disorder seek specific treatment. If they do, it is often after an extended period of illness, up to 10 years later.

Under 18s are more likely to experience good outcomes from intervention. Family therapy within three years of onset is the most effective approach for young people with anorexia nervosa.

Australia's eating disorder rates are increasing, most notably for bulimia nervosa and binge-eating disorder. The anorexia nervosa rate has been generally stable in recent years.

Read // ***Life-Size*** **by Jenefer Shute**
Watch // ***The Karen Carpenter Story***

// RISK FACTORS **

- Women and girls are 2.5 times more likely to have an eating disorder than men and boys. Nine out of 10 of those with anorexia are female.
- More young men are reporting body dissatisfaction and eating problems, including weight control and weight gain behaviours. Up to 50 per cent of boys have reported wanting to change their body size and about one in four children with anorexia nervosa are boys.
- No single cause has been identified for eating disorders, which may develop in vulnerable individuals through a combination of biological, psychological, socio-cultural and environmental factors.
- There is no eating disorder gene, but a number of genes within biological systems that relate to food intake, appetite, metabolism, mood and reward-pleasure responses may be involved.
- Psychological factors may include perfectionism, obsessive compulsiveness, impulsivity, body dissatisfaction, neuroticism and core low self-esteem.
- There is also evidence that socio-cultural influences play a part in the development of eating disorders, particularly in Western cultures, which promote a thin body ideal through media, family, friends and sporting cultures.
- Few studies have looked at risk factors for binge eating, but those available identified family neglect, low self-esteem and low perceived social support as contributing factors.

For more information, visit // **www.oyh.org.au**
For more help, visit// **www.thebutterflyfoundation.org.au**

// PARENT TIPS

- Set a good example with your dietary habits; children learn from parents.
- Avoid dieting and don't encourage your child to. Discuss the dangers of dieting.
- Be aware of the impact of negative body talk around your children, about your own body or other people's.
- Exercise regularly, and keep the focus on health and fun.
- Be critical of media messages and images that promote thinness or masculine ideals.

www.betterhealth.vic.gov.au

// NIP IT IN THE BUD

Orygen Youth Health (OYH) is a world-leading youth mental health program based in Melbourne, Australia. OYH has two main components: a specialised youth mental-health clinical service and an integrated training and communications program.
For more information visit // www.orygen.org.au

COPING WITH ANOREXIA

People often don't realise that an eating disorder is a psychological issue. As she moved to year 7, Ashleigh's anxiety manifested as an eating disorder.

// I was 12 when the problem began. I did a lot of competitive gymnastics and dancing and put a certain amount of pressure on myself. I associated being worthy with being smaller. I also have an obsessive, perfectionistic personality – when I commit to something, I do anything to get there. I felt that I needed to be perfect to be accepted/loved and that led to an implosion. A range of factors led me to develop anorexia – it's a very complex illness.

"I was incredibly anxious all the time. Despite being very successful in all areas of my life, I felt that I was never good enough, and I felt that way every day, all the time. Anorexia was a manifestation of my anxiety and a subconscious coping mechanism – so I didn't have to worry about everything, I would worry about my food and my size. It's a spiral and it gets completely out of control. I desperately wanted to get out but I didn't know how to escape. I felt constant self-loathing and would say the nastiest things to myself. I just wanted to disappear.

"I didn't talk to anyone about what was happening because this was my activity. And I knew that if I told anyone they would interfere and stop me doing what I was doing. People were concerned but for a long time I said I was fine. The illness berates you for not adhering to the rules and it was hard to speak out because the illness is also secretive and deceitful.

"I did see a school counsellor at the start of year 8. I said I think I have a problem with food, I'm hungry all the time but I won't allow myself to eat, and she was completely dismissive. She said I was probably not hungry but thirsty and to have some water. When I told her about the anxiety she told me I should skip rope when I felt stressed. This completely fed into my disordered behaviours and self-loathing. It essentially gave my anorexia a 'free pass' as it told me that if I was truly sick, the school counsellor would have picked up on it.

"My parents were worried and tried to have a conversation and I'd say I'm fine. My illness didn't want to be disturbed so I withdrew from family and friends. From anorexia's point of view, they were an obstacle trying to derail me from what I was doing. They would get in the way of the plan.

"The illness berates you for not adhering to the rules and it was hard to speak out because the illness is also secretive and deceitful."

"Mum tried to take me to appointments with doctors and dietitians, and one night my parents sat on my bed and cried and begged me to eat. But I physically couldn't eat. You can't help it. It is similar to how people with drug addictions do horrendous things to get their hit; you are so desperate and driven by the illness that you do anything it says. But while parents can't make a child eat, the behaviour does need to be addressed with professional support – it can't be ignored.

"The next day dad said he was taking me to an orthodontist appointment and took me to an emergency department instead and I was diagnosed with anorexia. I was initially sent to an outpatient's clinic and then I was admitted for a couple of weeks but I deteriorated rapidly after I was discharged because they didn't address the psychological component and I was re-admitted. People often don't realise an eating disorder is a psychological issue.

"I began seeing a private psychologist and so began my slow journey to recovery. She taught me how to separate the illness from myself – she called it the snake. When I could separate myself, I had a foundation to help me push back against negative and self-destructive thoughts.

"As parents, don't focus on the food. Don't tell your child just to eat. We know we need to do that but we can't. Parents can be aggressive because they are worried. Self-care for parents is important, too. Get support. Eating Disorders Victoria has support groups for family and friends. Create a space so children know they aren't going to be told off or judged. Create a safe space for conversation.

"Parents tend to want to 'fix' it but that can make the illness retreat more. Instead, listen to what a young person is saying. Remind them they are loved and support them to believe in themselves because when people have belief in you, that rubs off."

For more information, visit Eating Disorders Victoria // **www.eatingdisorders.org.au** or **1300 550 236**
Body image movie *"Embrace"* // **www.youtube.com/watch?v=__2AayArYfs**

// Ashleigh, 27, lived with anorexia for 10 years. Today she is about to become a lawyer.

ANXIETY

While anxiety is normal, it can develop into a disorder.

Most of us feel anxious at times. But for some people the anxiety is serious enough to negatively affect their enjoyment of life. Almost 7 per cent of Australian children and adolescents – or 278,000 – have an anxiety disorder. Most are considered mild.

Anxiety disorders generally include social phobia, separation anxiety, generalised anxiety and obsessive-compulsive disorder. A major Australian study* found that these affected 6.9 per cent of those aged four to 17. There was little difference in prevalence between girls and boys.

Young people in the most-disadvantaged socioeconomic group (10.4 per cent) were twice as likely to have an anxiety disorder than those in the least-disadvantaged group (5.3 per cent).

Young people with an anxiety issue need support to cope with the challenges they face, such as doing well in year 12, taking on leadership roles at a younger age and pressure to feel accepted on social media. Parents must be alert for signs that they are not coping and seek professional help if needed.

// RISK FACTORS

- **A family history of anxiety;**
- **Having a perfectionistic personality;**
- **Lack of confidence or self-esteem;**
- **Family and relationship problems;**
- **Having a controlling or over-protective parent, or parents who are often critical or negative in their parenting style;**
- **Death or loss of a loved one;**
- **A traumatic or negative life experience;**
- **Verbal, sexual, physical or emotional abuse or trauma;**
- **Serious physical illness; and**
- **Girls, or women, are more likely to develop anxiety disorders.**

// ANXIETY DISORDERS

SOCIAL PHOBIA // Intense anxiety caused by social situations leading up to and during the event, such as going out with friends or giving a speech.

SEPARATION ANXIETY // An overwhelming fear of being parted from parents, carers or those to whom someone has a strong attachment.

GENERALISED ANXIETY // Excessive anxiety and worry about common issues, such as family or friends, health, work, money or forgetting important appointments.

OBSESSIVE COMPULSIVE DISORDER // An obsessive compulsion to do something, such as checking doors and windows to see if they are locked, or ensuring everything is orderly in cupboards and drawers.

// TIPS FOR PARENTS

- Anxiety is normal. Excessive anxiety is not.
- Young people with genuine anxiety disorders are not naughty or defiant.
- Look for persistent physical symptoms such as headaches, stomach aches, vomiting, tiredness as well as missing school and avoiding social activities.
- If the anxiety relates to a mental-health disorder such as generalised anxiety, obsessive compulsive disorder, phobias, social anxiety and panic attacks, seek professional help.
- Teaching and modelling resilience can help young people cope with anxiety.
- Admit when you are anxious; no one is perfect.

// PREVALENCE OF ANXIETY DISORDERS AMONG 4-17-YEAR-OLDS*

(In the past 12 months [2015] by sex and age group)

	Social phobia %	Separation anxiety %	Generalised anxiety %	Obsessive compulsive %	Any anxiety disorder %
Males 4-11 years	1.8	4.9	1.8%	1.3	7.6
Males 12-17 years	**3.3**	**3.8**	**2.3**	**0.9**	**6.3**
Females 4-11 years	1.3	4.8	1.5	0.3	6.1
Females 12-17 years	**3.4**	**3.1**	**3.4**	**0.7**	**7.7**

* *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

WHY I CHOSE TO HURT MYSELF

For Sarah, anxiety, heightened emotions and the pressure to be perfect contributed to self-harming. She describes it as an outlet for her emotional distress.

"Self-harming got pretty bad when I was 15. For me, it was the pressure of adolescence and everything that goes with that. I was OK at school but I wanted to be the best and I started getting anxious about schoolwork. I put pressure on myself. I wanted everything in my life to be 'perfect'.

"I was anxious and really stressed. I lost my appetite because anxiety made me feel sick. But then it felt good not to eat – I had control over food if nothing else in my life. In a weird way, I felt it was something I was good at. I felt I couldn't do anything well enough.

"Halfway through year 10, I stopped doing school work. I'd sit in class but thought I'd fail so I decided to fail myself – again, I had some control that way. Because I was a high achiever previously, the school was happy for me to go to class and the teachers and welfare staff who knew me well were my main support. They were part of the reason why I went to school. But I felt I didn't know what I was doing or who I was and I didn't want to face anything or anyone. I felt I was losing everything. I thought I was pretty worthless.

"I began self-harming to control the pain I felt inside, as it gave me something else to focus on. It was also a way to communicate to people that things weren't going well, because I wasn't able to openly talk to anyone about it. Self-harming was an outlet for my emotional anxiety and distress. I needed to get it out somehow. Every time I self-harmed, it helped calm me down. There were so many emotions – anxiety, self-hatred and feeling like I was alone and I didn't know how to soothe myself. It was a routine. I'd get everything set up, harm myself and then bandage myself and I'd feel calmer.

"I did minor stuff most days but a couple of times a month I needed medical intervention. I'd hide it from my family and was really angry if they found out. My parents would get angry and upset when they saw it, and that made things more difficult because I was already anxious. During an argument is not the moment to talk about self-harm. It's a scary thing for parents and so they feel they need to ask about it now. Taking a step back and thinking about how to have the conversation is more helpful. Young people need to see it is safe to talk, and it doesn't feel safe when a parent is really emotional.

"My parents would get angry and upset when they saw it, and that made things more difficult because I was already anxious."

"There's a misconception that self-harm is linked with thoughts of suicide, or leads to suicide. It's often not the case. Parents miss that. For people doing it, it can be their way of coping with the pain, distress and difficulty in their life. It can also be an attempt to take control in situations that seem uncontrollable. It's almost like a form of resilience – it's that person trying to cope with difficulty the best way they know how, and it might be all they know to get them through that moment.

"Counselling and being able to talk about what I was going through has helped. Being able to get really upset and show that to someone meant I didn't need to self-harm.

"I think it's helpful if parents focus on what is behind the self-harm rather than the self-harm itself. It's a symptom. Nobody does it for no reason. There's always a need that isn't being met. Ask what is going on for your child and how you can help."

// Sarah, now 23, is studying at university. She has worked with headspace to provide a lived-experience perspective in developing courses for young people, parents, carers and health professionals to help them better understand what's behind self-harm.

SELF-HARM

Typically associated with difficulty managing emotions, without assessment and help self-harm can become a risky mechanism for coping with distress.

Self-harm affects almost 200,000 young Australians. It involves deliberately hurting or injuring yourself without trying to end your life and is often done secretively.

A major national 2015 study* found about one in 10 Australian adolescents (10.9 per cent) reported having self-harmed at some point, which is about 186,000 young people aged 12 to 17.

Three in four (137,000) had done so in the previous 12 months. Another 7.5 per cent answered "prefer not to say" about self-harm, so the rates could be higher.

Self-harm was more common among girls than boys, with 16.8 per cent of girls aged 16 to 17 doing it in the previous 12 months and 22.8 per cent at some point. This compared with 6.2 and 9.1 per cent for boys.

Of those aged 12 to 15, 9.8 per cent of girls had self-harmed over the past year and 11.1 per cent at some point, compared with 3 per cent and 5.7 per cent for boys.

More than half of females who had self-harmed had done so four times or more, and one in 10 young people who had self-harmed in the past year received medical treatment.

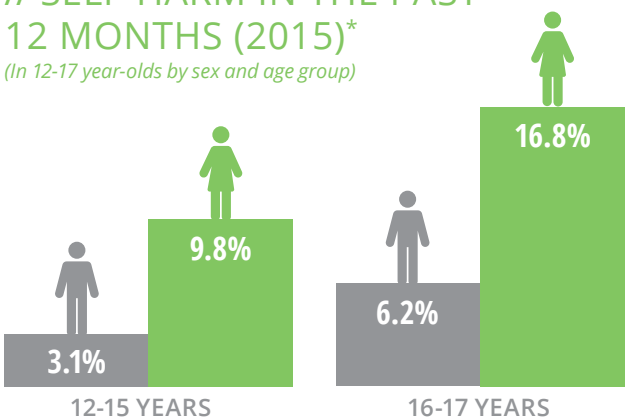
Excluding young people with a major depressive disorder, self-harm rates were higher in those from stepfamilies than original families – 14.7 per cent versus 7.8 per cent had self-harmed at some point and 6.4 per cent versus 2.5 per cent in the past year.

WHAT YOUNG PEOPLE TELL US ABOUT SELF-HARM

- One in 10 adolescents aged 12- to 17-year-olds (10.9 per cent) have ever self-harmed, or 186,000 people. Three in four had done so in the past year.
- Self-harm is roughly twice as common in girls than boys.
- It is more common in older than younger adolescents.
- Girls aged 16 to 17 years had the highest rate (16.8 per cent in the past year).
- Young people with major depressive disorder are much more likely to self-harm – 25.8 per cent of boys and 54.9 per cent of girls with it have self-harmed in the past year.
- Of those who self-harm, 0.8 per cent are admitted to hospital.

// SELF-HARM IN THE PAST 12 MONTHS (2015)*

(In 12-17 year-olds by sex and age group)



// TIPS FOR PARENTS

- Don't force or push your child into stopping self-injuring. If they could they would. Self-injury is their way of coping with stress, so before asking them to stop, we need to equip them with other, more adaptive coping skills.
- Talk openly and honestly about self-injury. Avoid fostering an environment of secrecy, shame, isolation and guilt.
- Remain calm and avoid emotional extremes: for example, anger or effusive sympathy, as this may further reinforce the behaviour.
- Be emotionally supportive, actively engage with and listen to your child.
- Watch for signs that your child is experiencing intense emotions and help distract them by employing their alternatives or simply comfort them.
- Encourage and explore alternative coping strategies with your child: for example, taking up a new hobby, sport, sit down and watch TV with them.

// Dr Madeline Wishart

www.madelinewishart.com

facebook.com/thebodyasavoice

Photo: pixabay.com

// RISK FACTORS*

- Mental-health issues including depression, anxiety and personality disorders increase the risk of self-harm.
- Low self-esteem, anger and feeling isolated are also risk factors.
- Grief or a traumatic life event.
- Childhood emotional, physical or sexual abuse.

* *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

SUICIDE

While uncommon in young people, suicide is still a big concern.

In 2015, more Australian young people aged between 15 to 24 died by suicide than any other cause, including transport accidents and accidental poisonings. A major national 2016 Orygen report** found that suicide accounted for almost a third of deaths in this age group.

Twice as many young women aged 15 to 19 died by suicide in 2015 than in 2005. Despite this increase, young men still suicide at much higher rates. In 2015, 72 per cent of suicide deaths among those aged 15 to 24 were male (ABS[6], 2016).

While rare, the number of children under 14 taking their lives has also risen.

Mental ill-health is one of the strongest risk factors and is a factor in about 90 per cent of youth suicides. This includes schizophrenia and borderline personality disorders, eating disorders and a history of self-harm. Substance misuse appears to further increase the risk.

Suicide among Aboriginal and Torres Strait Islanders aged 5 to 17 are five times that of non-Aboriginal and Torres Strait Islander young people (ABS[6], 2016). Suicide, and anxiety and depression have all increased among Aboriginal and Torres Strait Islander young people in recent years.

Other factors that elevate risk include being LGBTQI+, recent contact with the justice system, living in rural and remote areas, contact with statutory care and exposure to suicide or related behaviour such as self-harm.

SUICIDE CLUSTERS

Suicide clusters are more likely to involve young Australians than adults. A cluster means several people in one geographical area or linked to an institution, such as a school, taking their lives. An Australian analysis of 12 clusters involving 190 suicides between 2010-2012 found five involved young people, accounting for 5.6 per cent of youth suicides. The adult figure was 2.3 per cent†.

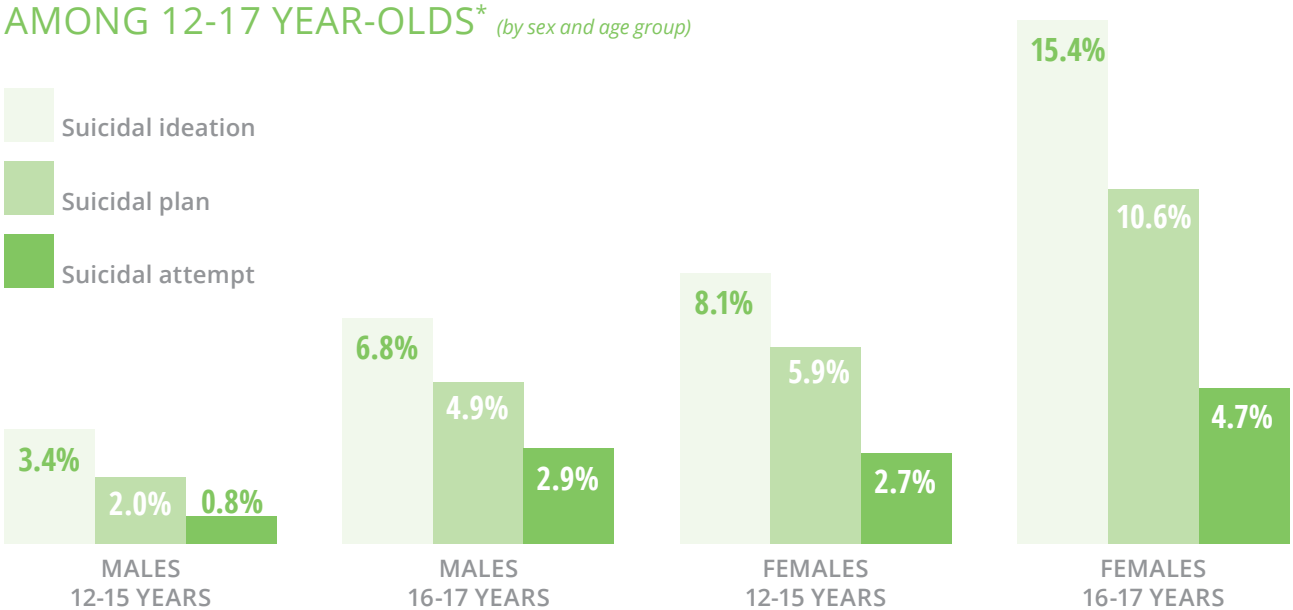
In 2011-2012, 12 young people who were at school, or had just left, took their lives in the Berwick and Pakenham areas outside Melbourne.

SUICIDAL BEHAVIOURS*

Suicidal behaviours include suicidal ideation (serious thoughts about taking one's own life), suicide plans and suicide attempts.

- About one in 13 (7.5 per cent) 12 to 17-year-olds had seriously considered attempting suicide in the previous 12 months. This is about 128,000.
- One in 20 (5.2 per cent) had made a plan.
- One in 40 (2.4 per cent), or around 41,000 12 to 17-year-olds, reported having attempted suicide in the previous 12 months.
- Suicidal behaviours were more common in females than males and in 16 to 17-year-olds compared with younger adolescents.
- About one in seven (15.4 per cent) females aged 16 to 17 years had seriously considered attempting suicide and one in 20 (4.7 per cent) had attempted suicide in the previous 12 months.
- The rates of all suicidal behaviours were markedly higher in young people with major depressive disorder.

// SUICIDAL BEHAVIOURS IN THE PAST 12 MONTHS (2015) AMONG 12-17 YEAR-OLDS* *(by sex and age group)*



* *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

** Robinson, J, Bailey, E, Browne, V, Cox, G & Hooper, C. *Raising the bar for youth suicide prevention, Orygen, the National Centre of Excellence in Youth Mental Health, 2016*

// PARENT TIPS

- Don't be afraid to ask direct questions about suicide. You can't put the idea of suicide in someone's head by talking about it.
- Remind young people that any feelings of distress are valid and warrant support.
- Acknowledge the factors that may increase a person's risk of suicide.
- Remind young people that support is available for any type of issue.
- Encourage them not to give up if their first experience of seeking help fails.
- Point out the supports available e.g. friends, family, a trusted adult (teacher, school counsellor or family doctor) or mental health service.
- Support them to seek help, if necessary.
- Encourage continued participation in enjoyable activities (such as sports or hobbies).
- Explain that suicide is complex and that many people who suicide experience mental-health difficulties, such as depression.
- Emphasise that suicide is never heroic or romantic – it is a tragedy with devastating consequences.
- Avoid judgmental language that may glamorise or sensationalise suicide, or reinforce negative stereotypes it is a 'selfish' or 'immoral' act.
- Remind them that suicide is final and those who do it do not get to witness other's reactions or experience a sense of resolution.

For more information visit // **www.headspace.org.au // www.healthyfamilies.beyondblue.org.au // esafety.gov.au // www.esafety.gov.au/YoungandeSafe**

// RISK FACTORS

- Depression;
- A history of other mental health issues, such as anxiety and bipolar;
- Drug and alcohol problems;
- Relationship problems and conflict with parents or with a boyfriend or girlfriend;
- Ongoing bullying, including online or cyber-bullying;
- The death of someone close to the young person;
- Experiencing illness or disability;
- A past suicide attempt;
- Family history of suicide;
- Being male – males have a statistically higher risk of suicide than females; and
- Talking or writing about death or suicide and/or being a burden to others.

beyondblue says that the more challenges a young person has in their life, the greater risk of suicide.

beyondblue // headspace

// MEDIA RESPONSIBILITY

Media has responsibilities when it comes to reporting on mental-health issues. They include:

- **Take the opportunity to educate the public about suicide;**
- **Avoid language that sensationalises or normalises; suicide, or presents it as a solution to problems;**
- **Avoid prominent placement and undue repetition of stories about suicide;**
- **Avoid explicit description of the method used in a completed or attempted suicide;**
- **Avoid providing detailed information about the site of a completed or attempted suicide;**
- **Word headlines carefully;**
- **Exercise caution in using photographs or video footage;**
- **Take particular care in reporting celebrity suicides;**
- **Show due consideration for people bereaved by suicide;**
- **Provide information about where to seek help; and**
- **Recognise that media professionals themselves may be affected by stories about suicide.**

www.who.int/mental_health/prevention/suicide/resource_media.pdf

// *13 REASONS WHY*

In the controversial Netflix series *13 Reasons Why*, a young woman suicides after outlining 13 reasons. She appears to seek revenge from the grave against those who "drove her to it". Concerns have been raised about the show glamorising suicide and implying that revenge is a legitimate motivation for taking your life.

In the USA, at least two families have claimed their 15-year-old daughters, who already had issues, were inspired to suicide by the show. Netflix told KTVU news: "We have heard from many views that *13 Reasons Why* has opened up a dialogue among parents, teens, schools and mental-health advocates around the difficult topics depicted in the show."

Australian schools and mental-health organisations have contacted parents to offer advice on how to handle the issue. In a fact sheet, headspace outlines the concerns raised and how to deal with them.

Dr Steven Leicester from eheadspace said clinicians working for the service had been dealing with a steady stream of concerned parents and young people since the show first aired.

eheadspace is urging school communities, parents, and mental-health services to be aware of the dangers and risks associated for children and young people who have been exposed to this content. The national suicide media initiative, Mindframe, also has significant concerns and warnings related to this content.

For the full fact sheet, visit // www.headspace.org.au/news/dangerous-content-in-13-reasons-why/ www.jedfoundation.org/13-reasons-why-talking-points/

EDITOR'S NOTE // *13 Reasons Why* season 2 will be released this year by Netflix.

MY FIRST SUICIDE ATTEMPT WAS AT 14

Keiah endured years of bullying through primary school and high school. She became depressed and attempted to take her own life.

// I was bullied my whole life but it got particularly bad when I was 10 and revealed I'd been sexually abused. I told a friend and it spread around the school and I was called a 'slut'. I was also overweight and picked on for that, too.

"I was bashed regularly at high school. Mum and dad told the school it wasn't acceptable but it continued. I was bashed walking to class, during lunch, and when I retaliated, I was suspended. It was heartbreaking and it's hard to put into words how I felt.

"I went to another high school in year 8 and was bashed three times in the first two months. I dreaded the morning alarm. The bullying caused arguments with my parents because I was so angry. I'd argue with them intentionally because I was hurting inside and I needed a release. I went down the wrong path with drugs – they took the pain away for a while. I started cutting myself and when my parents took me to hospital they were told I was attention seeking.

"My first suicide attempt was at 14, and there were a few other attempts. Even though I knew my parents loved me, and I knew they were there for me, I felt worthless. I felt I was a burden and it would be easier for them if they didn't have to look after me and fight with me to go to school. I didn't want to wake up any more. It hurt to breathe, it hurt to talk.

"People asked me if I was OK and if I said 'no', they'd want every detail and to try and fix me. But it's hard when you're depressed to have people tell you that you just need to be happy, it's not a big deal, you're young and things will be better in the future because I wasn't planning to live any longer. As a parent, you look into the future for your kids but if your child doesn't think there's going to be a tomorrow, there's no point talking about years down the track and telling them they have so much to live for.

"If they talk to you about how they are feeling, listen and hear what they are saying. Don't assume you know what they want and need because you're their parent. Don't push the point if they don't want to talk, and ask them if they would like to chat with someone else. Some kids might want to see a counsellor because they're scared of what their parents might think.

"Create a safe zone for your teenager. My mum would tell me I could talk about anything with her and that she wouldn't get angry. She might say she wasn't very happy about something but then she'd say, 'let's work this out'. She never punished me when I found courage to tell her something and I always felt better afterwards. I think parents can benefit from doing the Youth Mental Health First Aid program – it teaches parents how to have conversations with their children.

"From year 9 until the end of year 12 I went to Caldera School – a non-mainstream school for about 30 kids. It saved my life. I hated school with a passion until I went there. The teachers took time to get to know me and I felt safe to talk about how I felt.

"My life isn't perfect and I have days when I don't want to get out of bed. But I have support. I'm in counselling, I have my true friends and family and I've learnt to love who I am."

"Don't assume you know what they want and need because you're their parent. Don't push the point if they don't want to talk, and ask them if they would like to chat with someone else."

Photo: Supplied

// Keiah, 22, is studying community services, volunteers with headspace and is an instructor for the Youth Mental Health First Aid program.

BULLYING

Young people's self-esteem can be shattered by bullies.

Bullying can have a big impact on the mental health of young people. A major Australian mental health study* looked at face-to-face teasing, threatening, spreading rumours, physically hurting another person and cyber-bullying using mobile phones and/or the internet.

It found that one in three 11 to 17-year-olds (34.3 per cent) had been bullied in the past 12 months (2015). More than one in 10 (11.3 per cent) felt a lot or extremely upset when bullied. One in four were bullied every few months or less often, and 10 per cent every few weeks or more often.

The study also found that young people who had mental illnesses were more likely to be bullied than those who did not. Three in five who self-reported with major depressive disorder (62.8 per cent) had been bullied in the past year. They were three times more likely than all adolescents to be picked on every few weeks or more often (28.3 versus 10 per cent).

Four in 10 felt a lot or extremely upset when bullied. Those with major depressive disorder were also twice as likely as all adolescents to bully others (22.5 per cent).

SOCIAL MEDIA*

A 2017 UK report[2] found social media had positive and negative effects on the mental health of young people. Seven in 10 had been cyber-bullied. While much online interaction was positive, bullies could continue their abuse after school. "Instant messaging apps such as Snapchat and WhatsApp can also become a problem as they act as rapid vehicles for circulating bullying messages and spreading images," the report said.

More than one in three young people (37 per cent) were bullied "on a high-frequency basis". They were twice as likely to be bullied on Facebook than any other social network. "These statistics are extremely worrying for the overall health and well-being of our young people," the report found.

"Victims of bullying are more likely to experience low academic performance, depression, anxiety, self-harm, feelings of loneliness and changes in sleeping and eating patterns – all of which could alter the course of a young person's life as they undertake important exams at school or university, and develop personally and socially."

#STATUSOFMIND[2]

- Ninety-one per cent of 16 to 24-year-olds use the internet for social networking.
- Social media has been described as more addictive than cigarettes and alcohol.
- Rates of anxiety and depression in young people have risen 70 per cent in the past 25 years.
- Social media use is linked with increased rates of anxiety, depression and poor sleep.
- Cyber-bullying is a growing problem, with seven in 10 young people saying they have experienced it.
- Social media can improve young people's access to other people's experiences of health and expert health information.

Photo: iStock

// BE ALERT TO BULLYING

Parental and peer behaviours can influence the risk of depression in children who have been bullied at school, even after intervention, a Queensland expert says.

University of Queensland psychologist and researcher Dr Karyn Healy urges schools to focus on stopping bullying behaviours and parents and teachers to look for symptoms of depression in children who experience bullying.

Dr Healy says symptoms can range from persistent sadness and increased irritability to changes in sleep or appetite and loss of interest in previously enjoyable activities. "Parents also need to be aware that some of their parenting behaviours may increase the risk of depression in these children," she says.

These include conflict with their child, giving too many directions, not allowing the child to develop independence and aggressively attacking others in defence of the child.

Dr Healy says parents can play an important role in helping protect their child from the risk of depression by maintaining a warm, supportive relationship and coaching them in social and emotional skills with their peers.

Her paper, *Antecedents of Treatment Resistant Depression in Children Bullied by Peers*, looked at factors influencing ongoing depression in children aged 6 to 12 who were bullied at school. "Our research ... with families of children who had been bullied has found that supportive practices by parents and peers following victimisation can help reduce risks of later depression," Dr Healy says.

* *The Mental Health of Children and Adolescents; Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015).*

[2] *UK Royal Society for Public Health report, #StatusOfMind. Social media and young people's mental health and wellbeing*

THE BEHAVIOURAL INTERVENTIONIST

Clinical psychotherapist Frank Zoumboulis says 'helicopter' or 'tow-truck' parenting affects the emotional development and well-being of young people.

"Helicopter parents take an overactive and excessive interest in their child's life. All parents want the best for their child but they can become over-involved, smothering, overbearing, interfering and over-controlling. I also call them tow-truck parents because they wait for an accident to happen and then steam in and clear up the mess.

"They have clear opinions about who is the right teacher for their child, what sport they should play, they want their child to be in the popular group and they offer disproportionate assistance, rather than allowing their teenager space. These parents don't enjoy uncertainty, so they over-prepare and supervise intensely and interfere with their child's opportunity to do something for themselves and to deal with the natural consequences of their actions.

"In the 1940s and 1950s the approach to parenting was not to smother or spoil a child. John Bowlby was a contemporary British psychiatrist and child-development specialist who saw attachment as complementary to exploration. He said a child needed to feel secure enough and good enough about themselves to explore, but helicopter parents shut down exploration. They dampen a child's confidence and interfere with their ability to develop resilience and to find their own feet. Kids end up ill-equipped to deal with basic day-to-day stuff, they can't manage emotional responses and they are super-dependent on the parent. In my practice, I'll see a 16-year-old with their parent and the parent completes the child's sentences and answers their questions for them.

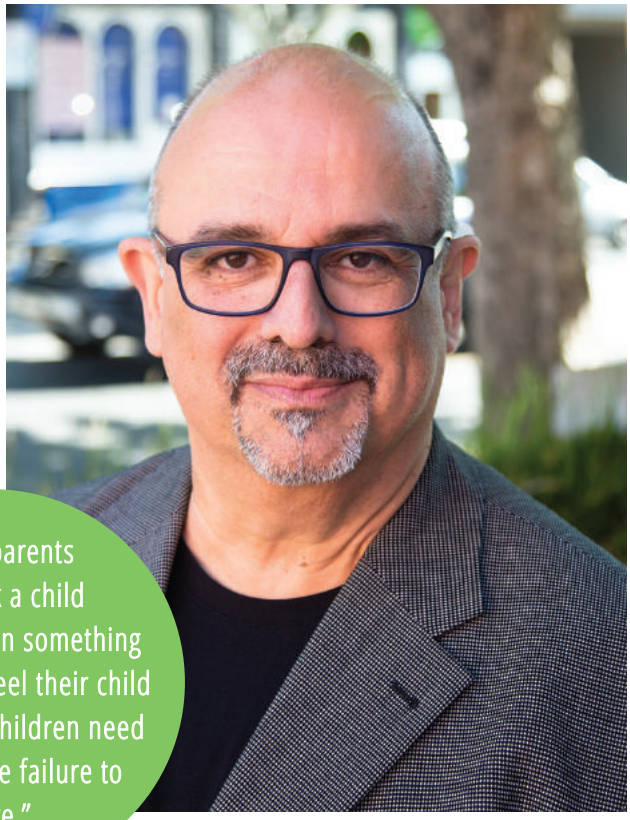


Photo: Eliana Schoulal

"Some parents don't risk a child participating in something because they feel their child may fail, but children need to experience failure to thrive."

"Helicopter parenting isn't to be confused with parents who are present – young people need a present parent. That's a parent who can manage their own anxiety so when their child challenges their authority or questions them, that parent doesn't go into a meltdown. A present parent is one who listens to their child because when your child talks, it encourages them to develop independent thoughts and they begin to have some critical thinking skills. Give your child some time with a problem so they can try and solve it themselves while making it clear you are available and allow them to come to you when they need help.

"Some parents don't risk a child participating in something because they feel their child may fail, but children need to experience failure to thrive. They need to sit with the burden of upset. Helicopter parenting alleviates that burden of suffering, but this interferes with a child's ability to develop their own experience of struggle and success, or struggle and trauma and then recovery.

"When your child feels hurt or defeated, sit with them and let them feel it and then your child will move on. Parents think that when a child is hurt and they fail at something that it is the beginning of a downhill slide and that their child will keep going downhill – they don't. A child sits with it for a while and then moves on to the next thing. Parents are more likely to be the ones who catastrophise, but that's about their anxiety of being a good enough mother or father.

"Ask yourself 'how much am I hovering?'. Ask someone who knows you and who is prepared to tell you the truth. Often parents don't realise they're stifling their child's potential for greater development. So be more of an observer rather than a doer and remember that your child needs to master the ordinary to be extraordinary."

// Frank Zoumboulis is a clinical psychotherapist in private practice in South Yarra who works with adults and teenagers.

PSYCHOSIS

Being psychotic is much more serious than simply being delusional.

Some people who have a mental illness develop a psychosis, which sees them lose the capacity to tell what's real from what isn't. They may believe or sense things that aren't real, and become confused or slow in their thinking. Psychosis often occurs as a part of other mental illnesses. It is treatable.

SANE Australia provides useful advice about psychosis and common misconceptions, such as that all people who develop a psychosis are dangerous. Psychotic symptoms vary from person to person and even between one episode and another.

PSYCHOSIS FACTS

The causes are complex: genetics, early childhood development, adverse life experiences, drug use and other factors increase your chances of experiencing psychosis.

In any given 12-month period, just under one in every 200 adult Australians will experience a psychotic illness.

PSYCHOTIC EPISODES

In most cases, a psychosis is an episode of acute symptoms such as delusions and hallucinations. But it often begins with general, hard-to-pin-down changes in a person's thinking and behaviour, such as trouble with attention and concentration, irritability, depression, anxiety, suspiciousness, insomnia, social withdrawal and trouble at work or school.

These issues don't necessarily mean someone is developing psychosis, just that something might not be right. The following changes are much stronger indicators of psychosis:

- Preoccupation with a subject;
- Speech or writing that is very fast, muddled, irrational or hard to understand;
- Talking much less;
- Loss of concentration, memory and/or attention;
- Increased sensitivity to light, noise and/or other sensory inputs;
- Withdrawing from relationships or hobbies;
- Increased anger, aggression or suspiciousness;
- Decreased or disturbed sleep;
- Behaving in a way that's reckless, strange or out of character;
- Laughing or crying inappropriately, or being unable to laugh or cry;
- Inattention to personal hygiene;
- Depression and anxiety; or
- Being unable to feel or express happiness.

If untreated, these symptoms can develop into a full psychotic episode. If a parent or carer suspects that their young person may be in danger of developing a psychosis, they should see a doctor immediately.

// CAT TEAM

A Crisis Assessment and Treatment (CAT) Team supports people experiencing a mental health crisis. The team is made up of health professionals with different areas of expertise, including psychiatric nurses, social workers, psychiatrists and psychologists. **More // Page 34**

// PSYCHOSIS SYMPTOMS

DELUSIONS

False, irrational beliefs that can't be changed by evidence and aren't shared by other people from the same cultural background.

HALLUCINATIONS

Seeing, hearing, feeling, tasting or smelling something that isn't there. The most common are voices that are often very negative.

DISORDERED THINKING

Thoughts and speech that become jumbled or slowed. They might make up words or use them in strange ways, use mixed-up sentences or change topic frequently. They may also have memory problems.

DISORDERED BEHAVIOUR

They might become agitated, act in a child-like way, mutter, swear or act inappropriately, or neglect their personal hygiene and housework. In severe cases, they may become unresponsive to the world around them.

Sane

DIAGNOSIS AND TREATMENT

If needed, your GP can make an assessment and refer you to a psychiatrist for full diagnosis and treatment. Psychosis is usually diagnosed as part of another mental illness, such as schizophrenia, schizoaffective disorder or bipolar affective disorder.

Over time, your diagnosis might change or stay the same. Treatments include antipsychotic medication, specialist psychological therapies and community support programs to help with social connection, physical health, accommodation and work or school.

Find out more // **www.sane.org.au**

HELPING SOMEONE WITH PSYCHOSIS

- Try to be calm and supportive; experiencing psychosis can be frightening and confusing.
- If you are worried about a friend/family member, see your GP or local mental-health service, and encourage the young person to get professional treatment ASAP.
- Practical help, such as paying bills or getting them to appointments, can assist a person to stay safe and feel secure.
- If someone is suggesting they will harm themselves, call your mental-health service or hospital for urgent specialist attention.
- Remember the person may be responding to things that are real to them but do not make sense to you.
- There are support groups for family and friends of people with psychosis.

Find out more // **www.headspace.org.au**

TRUE TO YOURSELF

Adrian, 22, knew in primary school that he was gay. When he came out at high school he endured bullying and struggled with self-acceptance.

"I wasn't drawn to the more masculine activities such as sport and wrestling and those stereotypical male things. I naturally gravitated towards females – I felt more comfortable. Although I felt different from other boys, that feeling was authentic and natural to me. I didn't question it because I knew it was part of who I was. There was no label for the feelings I experienced. At that point, I didn't know what it meant to identify as gay. I had to allow myself to grow and acknowledge that I was different.

"Around this time, sex education played a part. It helped me realise that there isn't just a boy and a girl relationship. It is more diverse than that and it's about what the heart wants. I'd secretly find books in the school library about being gay or about sexuality in general.

"When I was 12 I knew very much that I was gay and I came out to mum. She said, 'you are telling me something I already know as a mother'. She was and still is very supportive. I wasn't initially comfortable coming out at high school but in year 8 a bully approached me in class and abruptly asked me if I was gay. For me, saying yes or no can hurt you as a person because if you say 'no' you are a liar to yourself. If you say 'yes' you are going to have more weight on your shoulders. I said yes and the bullying began.

"I was nagged and bullied for being who I was. This happened throughout high school but each year it got easier – it's about perception. If someone called me a 'poofter' in year 8, I would be upset and think my world was over. I was that teenager who walked around with his head down, long hair covering his face because I didn't want people to look at me at that point. It affected my self-worth.

"I was too focused on trying to gain people's acceptance and I couldn't accept myself. It was emotionally draining and depressing. I also felt a sense of anger because I found it unfair that I was given this life and I didn't understand why I was made this way. I went to school every day but I felt empty – I wasn't really there.

"I also felt a sense of anger because I found it unfair that I was given this life."

"By year 12, I'd developed a thick skin. I wasn't willing to let one word like that hurt me and stop me studying and graduating high school. I was very close to my nan – she helped raise me – and I'd promised her I would graduate.

"My biological dad knows I am gay but he's not fully accepting. He grew up in a very Catholic family and doesn't really accept me as a gay man. If a parent is not accepting, just be humane. You don't have to accept me as a gay man, but the least you can do is accept and respect me as a human being and we don't have to bring up sexuality. It's part of my life but I'm able to be who I am without making my father uncomfortable.

"I got help from a counsellor and I always had support from my family. Mum never gave up on me when I was deeply depressed. Parents and family can be very important counsellors and mentors – not just people who happen to live in the same house as their children."

// Today Adrian is a community volunteer and has qualifications in hairdressing and beauty therapy.

MORE AT RISK

LGBTQI+ young people and mental health.

While some young people who don't identify as heterosexual have positive experiences growing up, many face an increased risk of mental-health issues.

A disproportionate number have worse health outcomes than non-LGBTQI+ peers in a range of areas, especially mental health and suicidality. Some find it extremely difficult to come out.

It is important for parents to unconditionally support their children regardless of their sexuality or gender identity. Using inclusive language and encouraging open communication can help. Families who need it can access support services.

INCREASED RISKS[++]

Rates of suicide and self-harm are up to six times higher among LGBTQI+ young people than the general population (Dyson et al., 2003) with an association between homophobic abuse and suicide and self-harm reported in an Australian national study of LGBTQI+ young people.

A recent report exploring self-harm, suicidal feelings and help-seeking among LGBT youth in the UK found that of the young people in the study, more than 70 per cent experienced discrimination, bullying, rejection, physical and verbal violence, threats and/or other forms of marginalisation related to their sexual orientation and gender identity. Those who felt affected by this abuse were 2.18 times more likely to plan or attempt suicide than those unaffected; and almost 83 per cent had not told everyone they needed to about their sexuality and gender, and almost 75 per cent indicated that not being able to talk about their feelings or emotions influenced their self-harm and suicidal feelings either very much or completely.

++ Robinson, J, Bailey, E, Browne, V, Cox, G & Hooper, C. Raising the bar for youth suicide prevention, Orygen, the National Centre of Excellence in Youth Mental Health, 2016

// WHERE TO GET HELP

NATIONAL LGBTI HEALTH ALLIANCE
Information and support // **www.lgbtihealth.org.au**

PFLAG
Keeping Families Together booklet //
www.pflagaustralia.org.au

QLIFE
Online chat // **www.qlife.org.au** or **1800 184 527**

TRANSCEND
Parent-led peer support network and information for transgender children and their families //
www.transcendsupport.com.au

REACHOUT
Relationships and sexuality information for young people // **www.reachout.com**

More support services // Page 35

// TIPS FOR PARENTS

Every child needs different things from their family and every relationship is unique. You can show them support by:

- Focusing on the love that you have for your child or loved one;
- Learning all you can about the LGBTQI+ community; networks, support groups and issues relating to people;
- Researching social groups for LGBTQI+ people that you may like to suggest your child or loved one attend;
- Educating yourself and your child or loved one about safe sex HIV/AIDS and other STIs;
- Admitting when you do not know something, or if you are uncomfortable – but do not blame your child;
- Take the time to get comfortable. Find a counsellor if you need to;
- Deal with your disappointments and issues as exactly that – yours;
- Using the language that your child or loved one uses e.g. lesbian, dyke or gay;
- Respecting who and when they are ready to tell – do not out anyone before they are ready;
- Encourage them to introduce you to their friends and/or their partner;
- Treat their friends and partners exactly as you would if they were heterosexual;
- Encourage them to talk to you about their experiences; listen without judging; and
- If you know of an adult LGBTQI+ person that you like and trust, see if they are open to being a sounding board for you and/or a role model for your child.

PFLAG

// DEFINITIONS

GENDER DIVERSE // Gender expression or identity differs from the sex assigned at birth or society's expectations.
GENDER IDENTITY // A person's sense of being masculine or feminine, or both or neither.
HETEROSEXISM // Views or behaviours that assume everyone is, or should be, heterosexual and other sexualities/gender identities are unnatural or not as good.
INTERSEX // Born with natural variations in genital, chromosomal or other physical characteristics that differ from stereotypical ideas of female or male.
SAME-SEX ATTRACTED // Feelings of sexual and/or emotional attraction to the same sex.
SISTERGIRLS/BROTHERBOYS // Aboriginal, Torres Strait Islander and South Sea Islander terminology for someone assigned female or male who identifies or lives partly or fully as another gender.
TRANSGENDER // Umbrella term for people whose gender identity is different from that assigned at birth.

PERSONALITY DISORDERS

Complex and often not diagnosed in young people, signs of emerging personality disorders need to be carefully assessed by a clinician, usually a psychiatrist.

Personality disorders are extremes of the normal personality spectrum. They are the expression of a person's characteristic pattern of thinking, behaving and relating to others. The resulting behaviours are deeply ingrained and maladaptive.

The behaviour of young people with a personality disorder, such as narcissistic, antisocial or borderline, can vary considerably. Factors such as upbringing and life experiences can affect how the disorder manifests and how seriously. The person has often experienced trauma as a young child that can contribute to the development of their condition. They can struggle with emotional regulation, possibly due to being abandoned or rejected at a pivotal time in their development. This can be particularly true of borderline personality disorder.

Someone with a personality disorder often lacks empathy, but they can change their behaviour by making a conscious effort, possibly with the help of a trained psychologist or psychiatrist.

IS A PERSONALITY DISORDER A MENTAL ILLNESS?†

A mental illness significantly impairs a person's mental functioning and judgment, including their perceptions of reality and what is right and wrong. Most legal definitions describe it as a clinically significant medical condition that significantly impairs (temporarily or permanently) the person's mental functioning and judgment and strongly indicates that they need care, treatment and/or control.

Mental illnesses, such as schizophrenia and bipolar disorder, are more likely to be, at least in part, influenced by a biological dysfunction for which medical treatments can be effective. Personality disorders are defined as a mental illness in the DSM 5, but on their own may not involve such impaired mental functioning.

However, people with personality disorders can also develop those symptoms and may need treatment. Early intervention is critical to help develop skills to emotionally regulate themselves.

WHAT IS THE DSM 5?

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5) is the American Psychiatric Association's classification and diagnostic tool for psychiatric diagnoses. It is the universal bible for diagnosing mental-health disorders, including mental illnesses and personality disorders.

Visit // **psychiatry.org**

FIND OUT MORE

Spectrum Personality Disorder Service for Victoria // **www.spectrumbpd.com.au** or 03 8833 3050

Australian BPD Foundation Limited // **www.bpdfoundation.org.au** or 03 8803 5588

// SOME TYPES OF PERSONALITY DISORDERS

NARCISSISTIC PERSONALITY DISORDER

- A need for admiration.
- Inflated views of oneself not backed up by reality.
- Exploitation of others.
- A strong sense of entitlement.
- Marked arrogance.

They see themselves in a class of their own for looks and ability and entitled to the best of everything.

BORDERLINE PERSONALITY DISORDER

- Poor emotional regulation that appears as extremes in reactions, feeling and relationships.
- Intense fear of rejection.
- Impulsive behaviours.

Its severity is strongly connected to experiences of violence and abuse in childhood.

ANTISOCIAL PERSONALITY DISORDER

A pervasive pattern of disregard for and violation of the rights of others since age 15 years. Typical patterns may include:

- Deceit;
- Manipulation;
- Impulsivity;
- Irresponsibility;
- Lack of remorse; and
- Maybe aggression.

They can be relatively fearless and are often described as psychopaths and sociopaths.

AVOIDANT PERSONALITY DISORDER

- A pervasive pattern of social inhibition and lack of social confidence.
- Feelings of inadequacy.
- Hypersensitivity to negative evaluation.

Other personality disorders include obsessive-compulsive, schizotypal, dependent, histrionic and paranoid.

† DSM 5, APA, 2013

REMOTE AREAS

Children living in isolated areas may need extra support.

A major Royal Flying Doctor Service mental-health report[+++] found suicide and self-harm rates were higher in remote and rural Australia than in major cities. Those in very remote areas were twice as likely to die from suicide as city residents.

The report found that each year, about one in five, or around 960,000, remote and rural Australians experience a mental-health disorder. The overall prevalence was the same as that in major cities, but suicide and self-harm rates were higher in remote and rural Australia than in major cities.

Residents in remote areas were twice as likely to die from suicide as city residents. Several factors exacerbated mental health acuity in remote and rural Australia. They included:

- Poor access to primary and acute care;
- Limited mental-health services and mental health professionals;
- Reluctance to seek help;
- Concerns about stigma;
- Distance and cost; and
- Cultural barriers in service access.

Rural residents faced universal mental-health risk factors such as family history, stressful events, physical health problems, substance use, personality factors, and changes in the brain. But they also faced factors that heightened suicide risk such as economic hardship, easier access to means of death, social isolation, seeking help less and reduced access to support services.

"With poorer service access that results in people in very remote areas accessing mental-health services at about one-fifth of the rate of people in major cities, remote and rural health services are less able to intervene in response to signs of known risk factors," the report found.

SUICIDE RISK FACTORS[+++]

Farmers, young men, older people and indigenous Australians in remote areas are at greatest risk of completing suicide. In 2015, those living outside greater capital cities (16.2 deaths per 100,000 population) were 1.5 times as likely as residents of capital cities (10.8) to die from suicide (ABS, 2016). The difference was greatest in very remote areas.

A Royal Flying Doctor Service report found that risk factors included financial hardship, easier access to means such as firearms and pesticides, social isolation, less help-seeking and fewer support services.

Young males aged 15 to 29 in remote and rural areas are almost twice as likely as those in major cities to complete suicide. Risk factors include high use of drugs and alcohol, pressure to conform, pessimism, unemployment, relationship issues, a sense of having nothing to do, greater availability of lethal means, social isolation and a lack of available services.

// INDIGENOUS MENTAL HEALTH

Young Aboriginal Australians, particularly those living in remote areas, face higher rates of mental illness than non-indigenous young people.

A Mission Australia report[++++] found that in 2016, more than three in 10 (31.6 per cent) Aboriginal and Torres Strait Islander respondents had a probable serious mental illness, compared to 22.2 per cent of non-Aboriginal or Torres Strait Islander respondents.

The Royal Flying Doctor Service mental-health report[+++] found farmers, young men, older people, and Aboriginal and Torres Strait Islander Australians faced the greatest risk of suicide.

Indigenous Australians were 1.2 times more likely to die from mental-health disorders than non-Indigenous Australians and 1.7 times more likely to have hospital treatment for mental health disorders.

Indigenous young people aged 12–24 were three times more likely to need hospital treatment for a mental-health disorder than their non-indigenous peers.

Indigenous Australians of all age groups were between 3.5 and 40.6 times more likely to be retrieved by the Royal Flying Doctor Service for a mental health disorder.

The rate was highest in indigenous Australians aged 35–39 (3.25 per 1,000 population), followed by 25–29 (2.57) and 30–34 (2.24).

Rates for non-Indigenous Australians ranged from less than 0.01 retrievals per 1000 people (non-indigenous children under 10) to 0.12 (20–24 years, 30–34 years and 40–44 years).

WHAT WORRIES YOUNG ABORIGINAL PEOPLE[++++]

Aboriginal and Torres Strait Islander young people have similar concerns to others their age.

The Mission Australia Youth Survey Report 2016 found coping with stress was their main concern, with 38 per cent either extremely concerned (20.9 per cent) or very concerned (17.1 per cent) about it.

School or study problems were a major concern for 33 per cent.

Body image was also an important issue of concern for 31.6 per cent.

Just under three in 10 Aboriginal and Torres Strait Islander respondents were extremely concerned or very concerned about family conflict and depression.

[+++]Bishop, L., Ransom, A., Laverty, M., & Gale, L. (2017). Mental health in remote and rural communities. Canberra: Royal Flying Doctor Service of Australia. © 2017 Royal Flying Doctor Service of Australia

[++++] The Mission Australia Youth Mental Health Report / Youth Survey 2012-2016.

INTERNATIONAL STUDENTS

Cultural differences and expectations can lead to problems.

"For most students the transition to a new learning environment such as a new school or a university is a challenge bringing with it the need to fit in, to make friends and to meet the demands of academic standards and family expectations. In the case of international students all of these issues are amplified. For international students, the issue of 'settling in' is made more complicated by the key challenges of having to adjust to different cultural norms, different teaching and learning styles to their native country and different perceptions about help-seeking and mental health issues. There is a correlation between stress, loneliness/ isolation and poor mental health so international students are particularly at risk.

"Students moving from one culture to another face new unwritten/unspoken rules which they have to figure out. This frequently occurs in the context of being far from their family and friends and at a time in their lives where a sense of social belonging is so important to their identity. As a result, especially in the first year of this transition they may feel isolated, experience a lack of personal control and uncertainty or inadequacy.

"Western culture tends to emphasise students drawing on different sources of information to come up with their own ideas, however, many Eastern cultures tend to have a far more teacher-centred model of learning where hierarchy is much more explicit. So students coming from these countries may find the new learning environment lacks clear cues as to their role as students, which can lead to general confusion about what to do and how to get information. This brings anxiety and sometimes avoidance of class, teachers and peers. Even for students born in Australia to parents educated overseas, there can be a disconnect and lack of relating between parents and young people. Young people often report how parents do not understand what it is like trying to complete study, part-time work and other social stressors.

"There is a correlation between stress, loneliness/ isolation and poor mental health"

"As well as having to adjust at many levels to an unfamiliar environment, there are the financial stressors associated with moving to a new country to live, and many describe a strong sense of obligation and pressure to succeed in order to make their families proud.

"With the unique combination of challenges and stressors that international students face, it is important that support is offered in an explicit and proactive way. There can be strong cultural beliefs that seeing a counsellor is only for the seriously mentally ill, or that to seek help may bring shame upon themselves and family. To remove these blocks to support it is important to normalise and validate help seeking. Counsellors/psychologists working within educational settings need to be accessible, approachable, and open to the challenges faced by international students.

"Having fellow international students share their own experiences and encourage the use of supports such as counselling or additional language help is critical. Peer mentoring programs which provide ongoing support to new students by older or more experienced students, are a proactive and prosocial way to help students transition to new schools/universities."

// John Coburn is a psychologist and works at Deakin University in the Health and Wellbeing Service.

// CRISIS ASSESSMENT AND TREATMENT TEAM

A Crisis Assessment and Treatment (CAT) Team supports people experiencing a mental health crisis. The team is made up of health professionals with different areas of expertise, including psychiatric nurses, social workers, psychiatrists and psychologists.

The CAT Team responds to mental-health crises 24 hours a day. Crises can include but are not limited to psychotic episodes, self-harm and people feeling suicidal.

The CAT Team can be called by the family or friends of someone experiencing a mental-health crisis, or by the person experiencing the crisis themselves. Police, GPs and other treating health professionals can also call a CAT Team.

The CAT Team carries out a psychiatric assessment of the person's mental state and reviews their psychiatric history and available social supports. In some cases, hospital treatment will be required or, where possible, intensive treatment and care can be provided at home.

In some cases, the intervention of the CAT Team will lead to a treatment order under the Mental Health Act 2016 where a registered mental-health professional or a doctor requests an authorised psychiatrist to examine the person in crisis. The treatment order may then be upheld and which may require an admission to a psychiatric unit.

After the crisis has been managed, CAT Team members may refer the patient and their family to community services that can provide appropriate ongoing care.

ASSISTANCE

// EMERGENCIES

Ambulance/Fire/Police // 000

Lifeline, 24-hour counselling // 13 11 14

Suicide Call Back Service // 1300 659 467 or **www.suicidecallbackservice.org.au**

// WHERE TO FIND HELP

Anxiety Recovery Centre Victoria (has links to other states) // **www.arcvic.org.au**

Australian Institute of Family Studies // **www.aifs.gov.au**
More detail can be found at // **aifs.gov.au/cfca/topics/mental-health-and-illness // aifs.gov.au/cfca/publications/helplines-and-telephone-counselling-services-children-young-people-and-pare**

Australian Psychological Society find a psychologist // **www.psychology.org.au/FindaPsychologist**

beyondblue // 1300 22 4636 or **healthyfamilies.beyondblue.org.au**

Black Dog Institute // **www.blackdoginstitute.org.au**

CAT Teams // **www.health.vic.gov.au/mentalhealthservices/adult/**

headspace // 1800 650 890 or **www.headspace.org.au** or **www.eheadspace.org.au**

Health Direct services directory // **www.healthdirect.gov.au**

Health on the Net. Health information // **www.healthonnet.org**

Kids Helpline // 1800 55 1800 or **www.kidshelpline.com.au**

Lifeline // 13 11 14 or **www.lifeline.org.au**

MensLine Australia // 1300 789 978

Mind Australia // 1300 286 463 or **www.mindaustralia.org.au**

Mind Health Connect parenting help // **www.mindhealthconnect.org.au/parenting**

Mind Matters // **www.mindmatters.edu.au**

Minus18 // **minus18.org.au**

National LGBTI Health Alliance // **www.lgbtihealth.org.au**

QLife // 1800 184 527 or **www.qlife.org.au**

ReachOut // **www.reachout.com**

Royal Australian College and New Zealand College of Psychiatrists find a psychiatrist // **www.yourhealthinmind.org/find-a-psychiatrist**

Safe Schools Coalition Australia // **www.safeschoolscoalition.org.au**

Sane Australia // 1800 18 7263 or **www.sane.org**

Transcend (transgender support) // **www.transcendsupport.com.au**

// PARENT HELP LINES

NSW // 1300 1300 52

Victoria // 13 22 89

South Australia // 1300 364 100

Queensland: 1300 301 300

Northern Territory: 1300 301 300

Tasmania: 1300 808 178

ACT: (02) 6287 3833

Western Australia: 1800 654 432

// APPS AND ONLINE TOOLS

MOOD DISORDER APPS VIA REACHOUT
au.professionals.reachout.com/apps-and-online-tools/mood-disorders

ANXIETY DISORDER APPS VIA REACHOUT
au.professionals.reachout.com/apps-and-online-tools/anxiety-disorders

TOOLS FOR GENERAL WELL-BEING VIA REACHOUT
au.professionals.reachout.com/apps-and-online-tools/wellbeing-apps-and-tools

REACHOUT WELL-BEING TOOLBOX
au.reachout.com/sites/thetoolbox

REACHOUT APPS FOR OTHER MENTAL HEALTH ISSUES
au.professionals.reachout.com/apps-and-online-tools/other-mental-health-issues

BEACON 2.0. PORTAL FOR ONLINE MENTAL AND PHYSICAL DISORDER APPLICATIONS
www.beacon.anu.edu.au

// MEDICARE

If needed, your GP can prepare a Mental Health Treatment Plan that outlines the problem(s) needing attention. This is shared with the treating allied health practitioner, such as a psychologist or qualified social worker, so they are aware of the general issues when the sessions begin.

In the above scenarios, you can be referred for up to six Medicare rebatable individual or group mental health sessions per year. If your health professionals deem it necessary, four more rebatable sessions can be added. If you access more than 10 over 12 months, the extra sessions are removed from the following year's rebatable quota.

For information contact Medicare Australia // **132 011** or **www.humanservices.gov.au/individuals/medicare**

WHAT PEOPLE SAY ...

"The magazine-style format is fresh and different and, frankly, much more engaging than a lot of the educational information commonly encountered in the health sector ... it was a very non-confrontational, un-alarming and pleasant way of communicating really important information. Seeing sexual health through your 'lens' e.g. the journalistic/media lens, is very different to how most of us in the health sector communicate."

Dr Alana Hulme Chambers // Research Fellow, Department of Rural Health // Centre for Excellence in Rural Sexual Health, Faculty of Medicine, Dentistry & Health Sciences, The University of Melbourne

"The best resource I have ever read on the subjects of children's exposure and involvement with drugs, sex and internet evils. Every GP should read these informative booklets: every parent should have this information at their fingertips. I have urged my daughters to read them. (My two oldest grandchildren are both 11)."

Dr Ann Kelmann

"The Social Media 101 parent guide is a valuable resource for our parents. We now live in a society that is rich with information where we can find everything we need to know online. However, parents often face the dilemma of filtering through information and having to work hard to find reliable sources. Social Media 101 is a well-balanced, easy-to-read, carefully collected guide that has provided information and support to many of our families."

Pitsa Binnion // Principal, McKinnon Secondary College

// AVAILABLE TO BUY ONLINE

DRUGS 101

Is taking drugs and drinking alcohol a rite of passage? For many it is. Prepare yourself.

SOCIAL MEDIA 101

Social media can be a godsend and a nightmare. We tell parents what their kids are doing online.

SEX 101

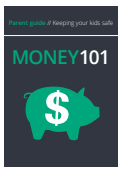
Don't feel comfortable talking about sex? Join the club. Check out the research.

MENTAL HEALTH 101

We're all talking about it but what's really going on? And why? You'll be surprised.

RESPECT 101

No longer just a word to be sung, R.E.S.P.E.C.T. is all about kindness and community.



COMING UP ...

Gambling & Gaming 101 will tackle the next elephant in the room. Video games and smart phone apps that we think are harmless and educational are turning our children into addicts.

School parent panel night events, contact Eileen Berry // 0407 542 655
To purchase resources or for school bundles, visit // parentguides.com.au